OMB# 0925-0491
Exp 05/31/2007

# Physician Questionnaire Form

FORM CODE: PHQ
VERSION A: 05/06/2003

ID NUMBER: ☐☐☐☐☐☐☐☐ CONTACT YEAR: ☐☐

LAST NAME: ☐☐☐☐☐☐☐☐☐☐☐☐ INITIALS: ☐☐

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Decedent's Name: ______________________________ Age: ☐☐

Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐
month day year

Date of Death: ☐☐ / ☐☐ / ☐☐☐☐
month day year

Event ID: ☐☐☐☐☐☐☐ Sequence Number: ☐☐

Physician's name: ______________________________

**Please complete the following and return in the enclosed envelope.**

## A. Medical History

1. Are you familiar with the decedent's medical history?

Yes ☐

If No, Skip to Item 5 on Page 3 — No ☐

2. When did you last see the decedent?

☐☐ / ☐☐☐☐
month year

3. Did the decedent have a history of any of the following?

| | Yes | No | Uncertain |
|---|---|---|---|
| a. Angina pectoris or coronary insufficiency...... | ☐ | ☐ | ☐ |
| b. Valvular disease or cardiomyopathy........... | ☐ | ☐ | ☐ |
| c. Coronary bypass surgery.......................... | ☐ | ☐ | ☐ |
| d. Coronary angioplasty.......................... | ☐ | ☐ | ☐ |
| e. Hypertension.................................... | ☐ | ☐ | ☐ |
| f. Myocardial infarction............................ | ☐ | ☐ | ☐ |

If MI **yes,** date of most recent event: ☐☐ / ☐☐☐☐
month year

| | | | |
|---|---|---|---|
| h. Other chronic ischemic heart disease......... | ☐ | ☐ | ☐ |
| i. Stroke (CVA)......................................... | ☐ | ☐ | ☐ |

j. **If yes**, date of most recent event: ☐☐ / ☐☐☐☐
month year

| | Yes | No | Uncertain |
|---|---|---|---|
| k. Any non-cardiac condition that might have contributed to this death.................. | ☐ | ☐ | ☐ |

**If yes**, specify: ______________________________

| | Yes | No | Uncertain |
|---|---|---|---|
| l. Diabetes............................................... | ☐ | ☐ | ☐ |
| m. Cigarette smoking................................ | ☐ | ☐ | ☐ |

4. Was the decedent taking any of the following medications within four weeks prior to death?

| | Yes | No | Uncertain |
|---|---|---|---|
| a. Nitrates | ☐ | ☐ | ☐ |
| b. Calcium channel blockers | ☐ | ☐ | ☐ |
| c. Digitalis | ☐ | ☐ | ☐ |
| d. Beta-blockers | ☐ | ☐ | ☐ |
| d.1. Aspirin | ☐ | ☐ | ☐ |
| d.2. ACE inhibitors | ☐ | ☐ | ☐ |
| e. Other cardiovascular drugs | ☐ | ☐ | ☐ |

**If yes**, specify: ______________________________

## B. Details of Death

5. Are you familiar with the events surrounding the decedent's death?

Yes ☐ No ☐

6. Did you witness the death?

Yes ☐ No ☐

If you answered **No** to both 5 and 6 skip to Item 14. Otherwise, continue with Item 7.

7. Was there any pain in the chest, left arm, shoulder or jaw within 72 hours of death?

Yes ☐ No ☐ Uncertain ☐

If **No** or **Uncertain** go to item 8.

b. Did the pain include the chest?

Yes ☐ No ☐ Uncertain ☐

c. Did you think this pain was of a cardiac origin?

Yes ☐ No ☐ Uncertain ☐

**If No**, specify what you think was the cause: ______________________

8. Did the decedent take (or was he/she given) nitrates at the time of the acute episode?

Yes ☐ No ☐ Uncertain ☐

9. Was coronary reperfusion (intravenous or intracoronary streptokinase or TPA, angioplasty, etc.) attempted during the acute episode?

Yes ☐ No ☐ Uncertain ☐

10. Was CPR and/or cardioversion performed within 24 hours of death?

Yes ☐ No ☐ Uncertain ☐

11. Please give time between onset of acute symptoms to death. ( We are defining death as the point where spontaneous breathing ceased and the patient never recovered)

☐ More than 3 days

☐ 2-3 days

☐ 1 day

☐ At least 12 hours, but less than 24 hours

☐ At least 4 hours, but less than 12 hours

☐ At least 1 hour, (F) but less than 4 hours

☐ Less than 1 hour

☐ Death instantaneous, (H) no symptoms

☐ Unknown

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12. Would you classify the decedent's cause of death as due to CHD?

Yes ☐ No ☐ Uncertain ☐

20. **If no**, what do you believe to be the cause of death?

| | Yes | No | Uncertain |
|---|---|---|---|
| 20a. Pulmonary embolism | ☐ | ☐ | ☐ |
| 20b. Acute pulmonary edema | ☐ | ☐ | ☐ |
| 20c. Stroke | ☐ | ☐ | ☐ |
| 20d. Pneumonia | ☐ | ☐ | ☐ |
| 20e. Congestive Heart Failure | ☐ | ☐ | ☐ |
| 20f. Other | ☐ | ☐ | ☐ |

20f. **Specify:** ____________________

**C. Signature**

14. Form completed by: ____________________
Signature

15. Date: ☐☐ / ☐☐ / ☐☐☐☐
month day year

**Thank you very much for your help. Please return this questionnaire in the enclosed self-addressed envelope.**

**Office use only:** 23. Self (A) ______ Interview(B) ______ E. records(C) ______