Public reporting burden for this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-XXXX). Do not return the completed form to this address.

OMB#: 0925-XXXX
Exp. XX/XXXX

HCHS/SOL Physician Questionnaire

HCHS/SOL Center use only Version A: 09/11/07

Decedent's Name: _____ Age: ____ Date of Birth: ___/___/_____ Date of Death: ___/___/_____

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 ☐ No ☐

If **No**, skip to Item 5 on Page 3.

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 .....……..	☐	☐	☐

g. If MI **Yes**, date of most recent event: ☐☐–☐☐☐☐

Month Year

3. (cont'd) Did the decedent have a history of any of the following?

	Yes	No	Uncertain
h. Other chronic ischemic heart disease:….	☐	☐	☐
i. Stroke (CVA):……	☐	☐	☐

j. If Yes, date of most recent event: ☐☐–☐☐☐☐
Month Year

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

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 or Angiotensin II 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 & 6, skip to Item 14 on page 4. Otherwise, continue with Item 7.

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

Yes ☐ No ☐ Uncertain ☐

If **No** or **Uncertain**, skip 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 (A)
- ☐ 2 - 3 days (B)
- ☐ 1 day (C)
- ☐ At least 12 hours, but less than 24 hours (D)
- ☐ At least 4 hours, but less than 12 hours (E)
- ☐ At least 1 hour, but less than 4 hours (F)
- ☐ Less than 1 hour (G)
- ☐ Death instantaneous, no symptoms (H)
- ☐ Unknown (I)

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

Yes ☐ No ☐ Uncertain ☐

13. If No, what do you believe to be the cause of death?

	Yes	No	Uncertain
a. Pulmonary embolism ..…..	☐	☐	☐
b. Acute pulmonary edema ...	☐	☐	☐
c. Stroke .....……	☐	☐	☐
d. Pneumonia	☐	☐	☐
e. Other .....….....	☐	☐	☐

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: 16. Self (A)__ Interview (B)__ E.R. records (C) __