

OMB#: 0925-XXXX  
Exp. XX/XXXX

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# HCHS/SOL Medical/Family History Questionnaire

ID NUMBER:

FORM CODE: MHE  
VERSION: A 06/28/07

Contact Occasion

SEQ #

Acrostic: \_\_\_\_\_

## ADMINISTRATIVE INFORMATION

0a. Completion Date: //

0b. Staff ID:

**Instructions:** Place a check in the appropriate box for the response. Unless instructed, mark **ONLY** one response. If age of onset is unknown enter the special missing value, "=", in the item.

*Did you or any of your blood relatives have any of the following conditions? Do not include half-brothers or half-sisters.*

### 1. Has a doctor ever said that you have high blood pressure or hypertension?

No 0

Yes 1  → **FOR WOMEN: GO TO QUESTION 1a**

1a. Was this during pregnancy only?

No 0

Yes 1

Has a doctor ever said that these relatives had high blood pressure or hypertension?

1b. Mother No or Don't know 0  Yes 1

1c. Father No or Don't know 0  Yes 1

1d. Brother(s) or sister(s) No or Don't know 0  Yes 1

### 2. Has a doctor ever said that you have high blood cholesterol?

No 0

Yes 1

Has a doctor ever said that these relatives had high blood cholesterol?

2b. Mother No or Don't know 0  Yes 1

2c. Father No or Don't know 0  Yes 1

2d. Brother(s) or sister(s) No or Don't know 0  Yes 1

### 3. Has a doctor ever said that you have angina?

No 0

Yes 1  → **GO TO QUESTION 3b**

3a. At what age were you first told this?

Age in years

Has a doctor ever said that these relatives had angina?

3b. Mother No or Don't know 0  Yes 1

3c. Father No or Don't know 0  Yes 1

3d. Brother(s) or sister(s) No or Don't know 0  Yes 1

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**4. Has a doctor ever said that you had a heart attack?**

No 0  → **GO TO QUESTION 4b**  
Yes 1

4a. At what age were you first told this?

Age in years

Has a doctor ever said that these relatives had a heart attack?

4b. Mother	No or Don't know	0 <input type="checkbox"/>	Yes	1 <input type="checkbox"/>	Age	<input type="text"/> <input type="text"/>
4c. Father	No or Don't know	0 <input type="checkbox"/>	Yes	1 <input type="checkbox"/>	Age	<input type="text"/> <input type="text"/>
4d. Brother(s) or sister(s)	No or Don't know	0 <input type="checkbox"/>	Yes	1 <input type="checkbox"/>	Age	<input type="text"/> <input type="text"/>

**5. Has a doctor ever said that you had heart failure?**

No 0   
Yes 1

Has a doctor ever said that these relatives had heart failure?

5b. Mother	No or Don't know	0 <input type="checkbox"/>	Yes	1 <input type="checkbox"/>
5c. Father	No or Don't know	0 <input type="checkbox"/>	Yes	1 <input type="checkbox"/>
5d. Brother(s) or sister(s)	No or Don't know	0 <input type="checkbox"/>	Yes	1 <input type="checkbox"/>

**6. Has a doctor ever said that you had rheumatic heart disease?**

No 0   
Yes 1

Has a doctor ever said that these relatives had rheumatic heart disease?

6b. Mother	No or Don't know	0 <input type="checkbox"/>	Yes	1 <input type="checkbox"/>
6c. Father	No or Don't know	0 <input type="checkbox"/>	Yes	1 <input type="checkbox"/>
6d. Brother(s) or sister(s)	No or Don't know	0 <input type="checkbox"/>	Yes	1 <input type="checkbox"/>

**7. Has a doctor ever told you that you had atrial fibrillation?**

No 0   
Yes 1

**8. Has a doctor ever said that you had some other kind of heart problem?**

No 0   
Yes 1

If yes, please specify: \_\_\_\_\_

**9. Have you had a balloon angioplasty, a stent, or bypass surgery to the arteries in your heart to improve the blood flow to your heart?**

No 0   
Yes 1













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**40. Are those hormone supplements...? (Give examples if needed)**

- Estrogen alone 1
- Estrogen + progestin 2
- Other hormone combination 3

*If other hormone combination, please specify:* \_\_\_\_\_