

OMB#: 0925-0216  
Exp. 12/2007

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ID#:

Dear ,

We would like to update the health information that we have on file for you at the Framingham Heart Study. As a participant in the Heart Study, it is important that we have information regarding diagnoses for any significant heart disease, vascular disease, stroke or cancer since we last examined you.

Please complete the enclosed medical history update form. Also, please sign and complete the consent form with the names of physicians and hospitals you have listed on the medical update form. This procedure will give us permission to obtain the necessary information from the physicians and hospitals where you may have received care. Please inform us if there is any name, address or telephone number change.

If you have questions, please don't hesitate to call Maureen Valentino, participant coordinator, at 1-508-935-3417 or 1-800-854-7582, extension 417.

Thank you for your help.

Sincerely,

A handwritten signature in black ink that reads "Daniel Levy". The signature is written in a cursive style with a long, sweeping tail on the letter "y".

Daniel Levy, M.D.

Director  
Framingham Heart Study

To Whom It May Concern:

I hereby authorize \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

to release to the Framingham Heart Study  
73 Mt. Wayte Avenue  
Framingham, MA 01702

The following protected health information my medical record.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_

Disclose the following information for dates from \_\_\_\_\_ to 2/5/2021.

- |                     |                                 |
|---------------------|---------------------------------|
| • Face Sheet        | • CT Scan (Head)                |
| • Discharge Summary | • MRI/MRA (Head/Neck)           |
| • ER Report         | • Lab Reports – Cardiac Enzymes |
| • Admission Notes   | • Consults (Cardiac & Neuro)    |
| • Progress Notes    | • Cardiac Catheterization       |
| • Operative Report  | • Exercise Tolerance Test       |
| • Pathology Report  | • Nursing Home Notes            |
| • Chest X-Ray       | • Notes near time of death      |
| • EKGs (All)        | • Other _____                   |
| • Echocardiogram    | _____                           |

The purpose for this disclosure is research.

The information disclosed under this authorization **will not be redisclosed** to anyone but the researchers conducting this study, except as required by law.

I understand I may revoke this authorization at any time by requesting such of the above referenced physician/hospital in writing. If I do it will not have any effect on actions that the hospital/physician took before it received the revocation.

This authorization expires at the end of the research study.

Date: \_\_\_\_\_ Signed: \_\_\_\_\_

**ID «Id0» - «Id1» «Id2» «Id3» «Id4»**

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<b>FRAMINGHAM STUDY MEDICAL HISTORY UPDATE</b>
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FRAMINGHAM STUDY MEDICAL HISTORY UPDATE

For Office Use Only

TYPE |\_\_|\_\_| 1=TELEPHONE 2=MAILER 3=ONSITE BONE STUDY 4=ONSITE EBCT 88=OTHER
INTERVIEWER |\_\_|\_\_|\_\_| DATA ENTRY |\_\_|\_\_|\_\_|1 |\_\_|\_\_|\_\_|2

ID

DATE OF LAST EXAM OR UPDATE

NAME

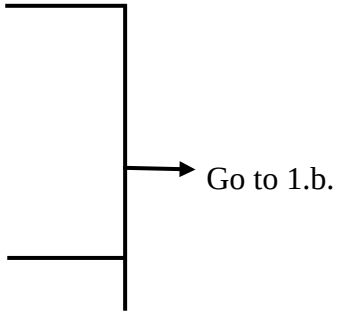
ADDRESS and PHONE (if changed since last exam/update)

SOCIAL SECURITY NUMBER |\_\_|\_\_|\_\_| - |\_\_|\_\_| - |\_\_|\_\_|\_\_|\_\_|

DATE COMPLETED |\_\_|\_\_| - |\_\_|\_\_| - |\_\_|\_\_|

1. a. First, please tell us who is completing this form:

- Frmingham Heart Study (FHS) participant whose name is above (Go to question 3)
Spouse
Family member other than spouse (Relationship)
Friend
Health care provider for FHS participant
Other



If other than participant, please answer the following questions.

b. Name

c. How long have you known the participant?

|\_\_|\_\_| years |\_\_|\_\_| months

d. Are you currently living in the same household with the participant?

- yes no

e. How often did you talk with the participant during the prior 11 months? Check one.

**FRAMINGHAM STUDY MEDICAL HISTORY UPDATE**

- Almost every day
- Several times a week
- Once a week
- 1 to 3 times per month
- Less than once a month
- Unknown / N/A

2. Have you noticed that he/she has had any memory problems or change in personality?

- yes       no

Specifically: \_\_\_\_\_

If response to #2 “yes”:

Has there been a diagnosis of dementia or Alzheimer’s Disease made by a doctor?

- yes       no

TO WHOM SHOULD WE SEND A CONSENT FORM TO BE SIGNED SO THAT WE CAN OBTAIN MEDICAL RECORDS?

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

**Please go on to the next page**

**FRAMINGHAM STUDY MEDICAL HISTORY UPDATE**

3. Since the date of the last Framingham Heart Study exam or update on the top of Page 1 of the Medical History Update form, have you seen a doctor or been hospitalized?

yes       no      If yes, did you have any of the following problems?

**a. Heart Problems, such as:**

- | <u>Yes</u>               | <u>No</u>                | <b>(Mark yes or no for each question)</b>   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain, angina or angina pectoris   |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart attack or myocardial infarction or MI   |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart failure or congestive heart failure or CHF  |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart catheterization or cardiac catheterization  |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart bypass operation or coronary bypass surgery or CABG   |
| <input type="checkbox"/> | <input type="checkbox"/> | Procedure to unblock narrowed blood vessels to your heart muscles (PTCA, coronary angioplasty, or coronary stent)                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Other heart problem (pacemaker, valve problem, aorta surgery, rhythm problem, atrial fibrillation, ventricular tachycardia).<br>(Specify) _____ |

**b. Circulatory Problems, such as:**

- | <u>Yes</u>               | <u>No</u>                | <b>(Mark yes or no for each question)</b>  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke, TIA (transient ischemic attack), sudden paralysis, vision loss, inability to speak   |
| <input type="checkbox"/> | <input type="checkbox"/> | Procedure to unblock narrowed blood vessels in your neck (carotid endarectomy, carotid angioplasty).                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Poor blood circulation or blocked or narrowed blood vessels to the legs or feet, (claudication, peripheral arterial disease, gangrene) |
| <input type="checkbox"/> | <input type="checkbox"/> | Amputation of part of a leg or toes, because of poor circulation or gangrene.  |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood clot or embolism in leg or lung.   |
| <input type="checkbox"/> | <input type="checkbox"/> | Other circulatory problem.<br>(Specify) _____  |

**FRAMINGHAM STUDY MEDICAL HISTORY UPDATE**

Since the date of the last Framingham Heart Study exam or update on the top of Page 1 of the Medical History Update form, have you seen a doctor or been hospitalized for the following:

**c. Other Neurological Problems**

Yes   No   (Mark yes or no for each question)

- Memory problems
- Other neurological problems such as Parkinson's, multiple sclerosis, seizures, head injury

Specify problem \_\_\_\_\_

- Have you had an MRI scan of your brain other than for the Framingham Heart Study?

Name of MRI Facility \_\_\_\_\_

Date of MRI |\_\_|\_\_| - |\_\_|\_\_| - |\_\_|\_\_|

**d. Other Problems**

Yes   No   (Mark yes or no for each question)

- Diabetes   If yes, please list medications you take for diabetes

\_\_\_\_\_

- Cancer (Specify type) \_\_\_\_\_

Physician \_\_\_\_\_

Place where biopsy performed \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- Fracture, broken bone (Specify including hip, back, arm, leg, pelvis, collarbone, foot, toe and others) \_\_\_\_\_

- Other (Specify problem) \_\_\_\_\_

**Please go on to the next page**



FRAMINGHAM STUDY MEDICAL HISTORY UPDATE

4. Since the date of your last Framingham Heart Study exam or update on the top of Page 1 of the Medical History Update form, have you been admitted to a HOSPITAL or gone to an EMERGENCY ROOM or seen a PHYSICIAN for other than a routine examination?

[ ] yes (if yes, please give details) [ ] no (go to question 5 on the next page)

Date |\_\_|\_| - |\_\_|\_| - |\_\_|\_|

Type\* \_\_\_\_\_

Reason\*\* \_\_\_\_\_

Hospital Name \_\_\_\_\_ Doctor's Name \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

Date |\_\_|\_| - |\_\_|\_| - |\_\_|\_|

Type\* \_\_\_\_\_

Reason\*\* \_\_\_\_\_

Hospital Name \_\_\_\_\_ Doctor's Name \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

Date |\_\_|\_| - |\_\_|\_| - |\_\_|\_|

Type\* \_\_\_\_\_

Reason\*\* \_\_\_\_\_

Hospital Name \_\_\_\_\_ Doctor's Name \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

\* Type

- 1. Overnight admission
2. Emergency room visit
3. Day Surgery/Procedure
4. M.D. visit

\*\* Reason

- 1. Heart problems
2. Stroke or transient ischemic attack (TIA), sudden paralysis, vision loss, inability to speak
3. Broken, crushed or fractured bones
4. Cancer or malignant tumor
5. Circulation problem, or blood clots
6. Other reasons (Please specify)

**FRAMINGHAM STUDY MEDICAL HISTORY UPDATE**

**Nursing Home/Rehabilitation Admissions.**

5. Have you stayed overnight as a patient in a nursing home, rehabilitation center or transitional care unit (TCU) since the date of your last Framingham Heart Study exam or update on the top of page 1?

yes       no      (if no, go to Question 8.)

6. Please list the name and location of the nursing home or rehabilitation center and the date you were admitted.

Nursing home/Rehab Center name: \_\_\_\_\_

Street address: \_\_\_\_\_

City/State/Zip Code \_\_\_\_\_

Date you entered the nursing home/rehabilitation center |\_\_|\_\_| - |\_\_|\_\_| - |\_\_|\_\_|

7. Were you an overnight patient in a nursing home, rehabilitation center or transitional care unit (TCU) at any **other** time since your last exam?

yes       no

Nursing home/Rehab Center name: \_\_\_\_\_

Street address: \_\_\_\_\_

City/State/Zip Code \_\_\_\_\_

Date you entered the nursing home/rehabilitation |\_\_|\_\_| - |\_\_|\_\_| - |\_\_|\_\_|

**Marital Status.**

8. What is your **current** marital status? Please check one

married     widowed     divorced     separated  
 single, never married     living with partner

<b>FRAMINGHAM STUDY MEDICAL HISTORY UPDATE</b>
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**Health Status. (Questions 9 and 10 to be filled out only by the participant.)**

9. In general, how is your health now?

- Excellent
- Fair
- Poor
- Good
- Don't know

10. Compare your health to most people your own age. Would you say your health is?

- Better
- Worse than most people
- About the same
- Don't know

**Primary Care Physician**

11. Please list the name and address of your primary care physician.

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

YOU MIGHT BE SENT A CONSENT FORM TO SIGN SO THAT WE MAY OBTAIN YOUR MEDICAL RECORDS.