OMB#: 0925-0216
Exp. 12/2007

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Numerical Data (Anthropometry)

Basic Information

|__|	**Site of Exam** (0=Heart Study, 1=Nursing home, 2=Residence, 3=Other, 9=Unknown)	
|__|	**Marital Status** (1=Single, 2=Married, 3=Widowed, 4=Divorced, 5=Separated)	
|__|__|__|	**Examiner's Number** for weight and height	
|__|__|__|	**Weight** (to nearest pound, 999=Unknown)	
|__|	**Protocol modification for weight**	0=No,1=Yes, 9=Unk/ND
|__|	**Method used to obtain weight** (0=FHS protocol, clinic or field visit with portable scale, 1=recorded in NH chart, 2=Other write in _____)	
|__|__|*|__|__|*|__|__|__|__|	**Date weight obtained** (mm/dd/yyyy)	
|__|__|*|__|__|	**Height** (inches, to next lower 1/4 inch, 99/99=Unknown)	88/88=field visit
|__|	**Protocol modification for height.**	0=No,1=Yes, 9=Unk/ND

Technician's Blood Pressure

to nearest 2 mm Hg **Clinic only**

|__|__|__| **Examiner's Number** (not done at off-site visits)

Systolic	Diastolic	BP cuff size	Protocol modification
|__|__|__|	|__|__|__|	|__|	|__|
999=Unk/ND	999=Unk/ND	0=pediatric, 1=regular,2=large adult, 3=thigh, 9=Unk/ND	0=No, 1=Yes, 9=Unk/ND

Comments on **all** protocol modifications:

_____

_____

_____

_____

TECH01

EXAM 30 Procedures Sheet

|__|	**Informed Consent** 1=Consent signed 2=Consent signed, may qualify for Waiver, 3=waiver used, 4=Other_____	
|__|	**ECG**	
|__|	**Blood Drawn** 8=not drawn due to offsite visit	
|__|	**Physician Medical History (Tech. Medical History, off-site)**	
|__|	**Observed Physical Performance**	
|__|	**CES-D**	0=No 1=Yes 9=Unknown
|__|	**MMSE**	
|__|	**Berkman Social Network**	
|__|	**Physical function: Katz, Rosow-Breslau, Nagi, IADL**	
|__|	**Leisure Time Cognitive and Physical Activities**	
|__|	**Healthcare Preference Questions** 8=not eligible due to cognitive status	
|__|	**Height** 8=not done due to offsite visit	
|__|	**Weight**	
|__|	**Socio-demographic, Nursing (Community) Services Use**	

Exit Interview

|__|__|__| **Examiner ID**

|__|	**Procedure Sheet Review**	
|__|	**Referral Sheet Review**	
|__|	**Left Clinic with all belongings** 8=n/a, offsite	0=No
|__|	**Feedback** 0=No feedback, 1=Positive feedback, 2=Negative feedback, 3=Other	1=Yes

Comments_____

_____

_____

_____

TECH02

Observed performance.

OMB No=0925-0216 12/31/2007

|__|__|__|	**Examiner's Number**

HAND GRIP TEST Measured to the nearest kilogram

Right hand

Trial 1 99=Unknown |__|__|

Trial 2 99=Unknown |__|__|

Trial 3 99=Unknown |__|__|

Left hand

Trial 1 99=Unknown |__|__|

Trial 2 99=Unknown |__|__|

Trial 3 99=Unknown |__|__|

Was this test completed? (0=No, 1=Yes, 8=Not attempted, 9=Unknown) |__|

If not attempted or completed, why not?
1=Physical limitation 3=Other _____write in |__|
2=Refused 9=Unknown

PHYSICAL FUNCTION TEST 10 seconds stand

Side by Side

Was this test completed? Held for 10 seconds (0=No, 1=Yes, 8=N/A, 9=Unknown) |__|

If not attempted or completed, why not? |__|
1=Physical limitation 3=Other _____write in
2=Refused 9=Unknown

Number of seconds held if less than 10 99.99=Unknown |__|__|*|__|__|

Semi-Tandem

Was this test completed? Held for 10 seconds (0=No, 1=Yes, 8=N/A, 9=Unknown) |__|

If not attempted or completed, why not? |__|
1=Physical limitation 3=Other _____write in
2=Refused 9=Unknown

Number of seconds held if less than 10 99.99=Unknown |__|__|*|__|__|

Tandem

Was this test completed? Held for 10 seconds (0=No, 1=Yes, 8=N/A, 9=Unknown) |__|

If not attempted or completed, why not? |__|
1=Physical limitation 3=Other _____write in
2=Refused 9=Unknown

Number of seconds held if less than 10 99.99=Unknown |__|__|*|__|__|

Observed performance.

OMB No=0925-0216 12/31/2007

|__|__|__|	**Examiner's Number**

REPEATED CHAIR STANDS

Was this test completed? (0=No, 1=Yes, 8=Not attempted, 9=Unknown) |__|

If not attempted or completed, why not?

1=Physical limitation 3=Other _____write in |__|

2=Refused 4=Test stopped at 60 sec 9=Unknown

IF OFFSITE visit, Chair height (in inches, 99.99=Unknown) |__|__|*|__|__|

Time to complete five stands in seconds (If not completed in 60 sec – STOP)(99.99=Unk) |__|__|*|__|__|

If less than five stands, enter the number (9=Unk) |__|

Post-Repeated chair stand 30 second heart rate (999=Unknown) |__|__|__|

MEASURED WALKS

Walking aid used: 0=No aid, 1=Cane, 2=Walker, 3=Other, 9=Unknown |__|

First Walk

Was this test completed? (0=No, 1=Yes, 8=Not attempted, 9=Unknown) |__|

If not attempted or completed, why not?

1=Physical limitation 3=Other _____write in |__|

2=Refused 9=Unknown

Walk time (in seconds, 99.99=Unknown) |__|__|*|__|__|

Laser walk time (in seconds, 99.99=Unknown) |__|__|*|__|__|

Second Walk

Was this test completed? (0=No, 1=Yes, 8=Not attempted, 9=Unknown) |__|

If not attempted or completed, why not?

1=Physical limitation 3=Other _____write in |__|

2=Refused 9=Unknown

Walk time (in seconds, 99.99=Unknown) |__|__|*|__|__|

Laser walk time (in seconds, 99.99=Unknown) |__|__|*|__|__|

Quick Walk

Was this test completed? (0=No, 1=Yes, 8=Not attempted, 9=Unknown) |__|

If not attempted or completed, why not?

1=Physical limitation 3=Other _____write in |__|

2=Refused 9=Unknown

Walk time (in seconds, 99.99=Unknown) |__|__|*|__|__|

Laser walk time (in seconds, 99.99=Unknown)	|__|__|*****|__|__|

TECH04

Mini-mental State Exam

I'm going to ask some questions that require concentration and memory. Some questions are more difficult than others and some will be asked more than one time.

OMB No=0925-0216 12/31/2007

|__|__|__|	**Examiner's Number** for Cognitive Function -- MMSE

SCORE CORRECT No Try=6, Unknown=9	**Write all responses on exam form** (score 1 point for each correct response)
0 1 2 3 6 9	**What Is the Date Today?** (Month, day, year, correct score=3)
0 1 6 9	**What Is the Season?**
0 1 6 9	**What Day of the Week Is it?**
0 1 2 3 6 9	**What Town, County and State Are We in?**
0 1 6 9	**What Is the Name of this Place?** (any appropriate answer all right, for instance my home, nursing home, street address, heart study...max score=1)
0 1 6 9	**What Floor of the Building Are We on?**
0 1 2 3 6 9	**I am going to name 3 objects. After I have said them I want you to repeat them back to me. Remember what they are because I will ask you to name them again in a few minutes: Apple, Table, Penny**
|__|__|__|__|__|	**Now I am going to spell a word forward and I want you to spell it backwards. The word is world. W-O-R-L-D. Please Spell it in Reverse Order. Write in Letters, _____** (Letters Are Entered and Scored Later) Score as: 66666=Not administered for reason unrelated to cognitive status 00000=Administered, but couldn't do 99999=Unknown
0 1 2 3 6 9	**What are the 3 objects I asked you to remember a few moments ago?**

Mini-mental **State Exam**

OMB No=0925-0216 12/31/2007

SCORE CORRECT No Try=6, Unknown=9	**Write all responses on exam form.** (score 1 point for each correct answer)
0 1 6 9	**What Is this Called?** (Watch)
0 1 6 9	**What Is this Called?** (Pencil)
0 1 6 9	**Please Repeat the Following: "No Ifs, Ands, or Buts."** (Perfect=1)
0 1 6 9	**Please Read the Following & Do What it Says** (performed=1, code 6 if low vision)
0 1 6 9	**Please Write a Sentence** (code 6 if low vision)
0 1 6 9	**Please Copy this Drawing** (code 6 if low vision)
0 1 2 3 6 9	**Take this piece of paper in your right hand, fold it in half with both hands, and put in your lap** (score 1 for each correctly performed act, code 6 if low vision)

No Yes Maybe Unk (coding for below)	**Factor Potentially Affecting Mental State Testing**
0 1 2 9	Illiterate or low education
0 1 2 9	Not fluent in English
0 1 2 9	Poor eyesight
0 1 2 9	Poor hearing
0 1 2 9	Depression / possible depression
0 1 2 9	Aphasia
0 1 2 9	Coma
0 1 2 9	Parkinsonism or neurologically impaired
0 1 2 9	Other

TECH06

Socio-demographics

OMB No=0925-0216 12/31/2007

|__|__|__|	**Examiner's Number** for Socio-demographics

Socio-demographics			
|___|	**Where do you live?** (0=Private residence, 1=Nursing home, 2=Other institution, such as: assisted living or retirement community, 9=Unknown)		
|___|	**Does anyone live with you?** (0=No, 1=Yes, 9=Unknown) Code Nursing Home Residents as NO to these questions		
If Yes ▯ If 0 or 9, skip down	|___|	Spouse	0=No 1=Yes, less than 3 months per year 2=Yes, at least 3 months per year 9=Unknown
	|___|	Significant Other	
	|___|	Children	
	|___|	Friends	
	|___|	Relatives	
	|___|	Pets	
|___|	**Are you Currently working at a paying job or doing unpaid volunteer or community work?** (0=No,1=Yes, full time(>=32 hrs/week), 2=Yes, part time (<32 hrs/week), 9 =Unknown)		
|___|___|___|	**During the past 6 months (180 days) how many days were you so sick that you were unable to carry out your usual activities?** (999=Unknown)		

** Proxy may NOT be used to help complete this section **	
|___|	**In general, how is your health now**: (1=Excellent, 2=Good, 3=Fair, 4=Poor, 9=Unkn)
|___|	**Compare your health to most people your own age:** (1=Better, 2=About the same, 3=Worse than most people your own age, 9=Unknown)

Instrumental Activities of Daily Living (Lawton IADL)

(Not administered to nursing home residents)

OMB No=0925-0216 12/31/2007

Instructions: *Use the prompt cards when asking these questions.* ***If code=2 –*** write in definition of "some help"

|__|__|	**1. Can you use the phone:**	
	01	completely unable to use the phone
	02	with some help
	03	without help (operates phone on own initiative, looks up, dials number, etc.)
|__|__|	**2. Can you get to places out of walking distance:**	
	01	completely unable to travel unless special arrangements are made (taxi or car with human assistance)
	02	with some help (when assisted or accompanied by another)
	03	without help (travels independently: drives car, public transportation or use of taxi)
|__|__|	**3. Can you go shopping for groceries :**	
	01	completely unable to do any shopping
	02	with some help (needs to be accompanied on any shopping trip)
	03	without help
	88	resides in assisted living facility, does not do
|__|__|	**4. Can you prepare your own meals:**	
	01	completely unable to prepare meals (needs meals prepared and served)
	02	with some help (heat and serve prepared meals)
	03	without help (plans, prepares, serves meals)
	88	resides in assisted living facility, does not do
|__|__|	**5. Can you do your own housework :**	
	01	completely unable to do any housework
	02	with some help
	03	without help (performs light daily tasks – dishwashing, bed making, etc).
	88	resides in assisted living facility, does not do
|__|__|	**6. Can you do your own handyman work:**	
	01	completely unable to do any handyman work
	02	with some help
	03	without help
	88	resides in assisted living facility, does not do
|__|__|	**7. Can you do your own laundry:**	
	01	completely unable to use the laundry
	02	with some help (such as using laundry service)
	03	without help (does personal laundry completely)
	88	resides in assisted living facility, does not do
|__|__|	**8. A. Do you take medicines or use any medications?**	
	01	Yes *Go to question* **8B**
	02	No *Go to question* **8C**
|__|__|	**8. B. Do you take your own medicines:**	
	01	completely unable to take own medicine
	02	with some help (if someone prepares it or reminds you)
	03	without help (in the right doses at the right time)
|__|__|	**8. C. If you had to take medicine, could you do it:**	
	01	completely unable to take own medicine
	02	with some help (if someone prepares it or reminds you)
	03	without help (in the right doses at the right time)
|__|__|	**9. Can you manage your own money:**	
	01	completely unable to manage own money
	02	with some help (manages day-to-day purchases, needs help with banking, major purchases)
	03	without help

Self-Reported Physical Function.

OMB No=0925-0216 12/31/2007

|__|__|__|	**Examiner's Number** for Rosow-Breslau and Nagi Quest.

Nagi Questions

For each thing tell me whether you have
(0) No Difficulty
(1) A Little Difficulty
(2) Some Difficulty
(3) A Lot Of Difficulty
(4) Unable To Do
(5) Don't Do On MD Orders or Institutional Orders
(6) Unable to Assess Difficulty Because Not Done as Part of Daily Activities
(9) Unknown

|__|	**Pulling or pushing large objects like a living room chair**
|__|	**Either stooping, crouching, or kneeling**
|__|	**Reaching or extending arms below shoulder level**
|__|	**Reaching or extending arms above shoulder level**
|__|	**Either writing, or handling or fingering small objects**
|__|	**Standing in one place for long periods, say 15 minutes**
|__|	**Sitting for long periods, say 1 hour**
|__|	**Lifting or carrying weights under 10 pounds (like a bag of potatoes)**
|__|	**Lifting or carrying weights over 10 pounds (like a very heavy bag of groceries)**

Rosow-Breslau Questions

|__|	**Are you able to do heavy work around the house, like shoveling snow or washing windows, walls, or floors without help?**	0=No, unable to do 1=Yes, independent 2=Does not do 9=Unknown
|__|	**Are you able to walk half a mile without help? (About 4-6 blocks)**	
|__|	**If you had to, could you do all the housekeeping yourself?** (like washing clothes and cleaning)	
|__|	**Do you drive now?**	0=No 1=Yes, currently 2=Yes, not now 9=Unknown
if no then	|__| **Reason for not driving now** (1=Health, 2=Other non-health reason, 3=never licensed, 8=N/A, current driver, 9=Unknown)	

TECH09

Self-Reported Physical Function.

OMB No=0925-0216 12/31/2007

|__|__|__|	**Examiner's Number** for Physical Function

Katz: Activities of Daily Living

During the Course of a Normal Day, Can you do the following activities independently or do you need human assistance or the use of a device? Coding: 0=No help needed, independent, 1=Uses device, independent, 2=Human assistance needed, minimally dependent, 3=Dependent, 4=Do not do during a normal day, 9=Unknown

|__|	**Dressing** (undressing and redressing) Devices such as: velcro, elastic laces;
|__|	**Bathing** (including getting in and out of tub or shower) Devices such as: bath chair, long handled sponge, hand held shower, safety bars;
|__|	**Eating** Devices such as: rocking knife, spork, long straw, plate guard.
|__|	**Transferring**(getting in and out of a chair) Devices such as: sliding board, grab bars, special seat;
|__|	**Toileting Activities** (using bathroom facilities and handle clothing) Devices such as: special toilet seat, commode;
|__|	**Bladder Continence** (ask if person has "accidents") (code=5 if use special products) Devices such as: external catheter, drainage bags, ileal appliance, protective devices;
|__|	**Bowel Continence** (ask if person has "accidents") (code=5 if use special products) Devices such as: suppositories, bedpan, regular enemas, colostomy;
|__|	**Walking on Level Surface about 50 Yards** Devices such as: cane, crutches, or walker;
|__|	**Walking up and down One Flight Stairs** Devices such as: handrail, cane.

Compensatory Strategies for Walking in the Home

(Do not administer to Nursing home residents)

|__|__|	**Is there a step to go into your home (entry way step)?**	
|__|__|	**In your home, are the bedroom, bathroom, and kitchen all on the same floor (multilevel living)?**	
|__|	**When you walk, do you use a cane at home?**	0=No 1=Yes 8=Refused 88=n/a,reside in assisted living 9=Don't know
|__|	**When you walk, do you use a walker at home?**	
|__|	**Do you use a wheelchair at home?**	
|__|	**When you walk, do you reach out for or hold on to the furniture or walls at home?**	
|__|	**When you walk, do you hold on to another person at home?**	
|__|	**When you walk in the dark, do you hold on to the furniture or walls?**	
|__|	**When you walk in the dark, do you hold on to another person?**	

Activities Questions.

OMB No=0925-0216 12/31/2007

|__|__|__|	**Examiner's Number** for Activities Questions.

Use of Nursing and Community Services

|__| **Have you been admitted to a nursing home (or skilled facility) since your last exam or medical history update?**
(0=No, 1=Yes, 9=Unknown)

|__| **Since your last exam, have you been visited by a nursing service, or used home, community, or outpatient programs?**
(0=No, 1=Yes, 9=Unknown)

if yes, continue and below

Currently	Since last exam	# months used
0=No **At least once per**: 1=Day 2=Week 3=Month 4=Other(write in)_____ 9=Unknown		0=None 1=One month or less 2-98=Put in actual number of months used 99=Unknown

Currently	Since Last Exam	# Months Used Since Last Exam	
|__| |__| |__|__|	**Home health aides**
|__| |__| |__|__|	**Homemaker visits**
|__| |__| |__|__|	**Visiting Nurses**
|__| |__| |__|__|	**Other** (write in)_____

|__| **Are you in bed or a chair for most or all of the day (on the average)?**
Note: this is a lifestyle question, not related to poor health. (0=No, 1=Yes, 9=Unknown)

|__| **Do you need a special aid (wheelchair, cane, walker) to get around?**
(0=No, 1=Yes, 9=Unknown)

if yes then

If yes, which of the following equipment do you use?

|__|	**Cane or walking stick**
|__|	**Wheelchair**
|__|	**Walker**
|__|	**Other** (Write in)_____

0=No
1=Yes, always
2=Yes, sometimes
9=Unknown

Falls and Fractures

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|__|__|__|	**Examiner's Number** for Falls and Fractures
|__| **if yes, fill ▯**	**Since your last exam have you accidentally fallen and hit the floor or ground?** **(code as no if during sports activity) (0=No, 1=Yes, 2=Maybe, 9=Unk)**
	|__|__| **How many times did you fall in the past year? (99=Unknown)**
|__| **If 1 or 2, fill ▯**	**Since your last exam or medical history update have you broken any bones? (Code: 0=No, 1=Yes, 2=Maybe, 9=Unknown)**
	|__|__| **Location of 1st fracture**
	|__|__| **Location of 2nd fracture**
	|__|__| **Location of 3rd fracture**

Location Fracture Code
1. Clavicle (collar bone)
2. Upper arm (humerus) or elbow
3. Forearm or wrist
4. Hand
5. Back (If disc disease only, code as no)
6. Pelvis
7. Hip
8. Leg
9. Foot
10. Other (specify)_____

TECH12

Health Care Preferences Questionnaire.

OMB No=0925-0216 12/31/2007

|__|__|__|	**Examiner's Number** for Health Care Preferences

***Intro**: People have many ideas about health and health care. Understanding these ideas is crucial to improving care. We are interested in learning what you believe to be the most important considerations at this point in your life. There are no right or wrong answers. We are simply interested in your opinions.*
We understand that this is a sensitive topic. Your participation is voluntary and you may choose to stop answering questions at any time.

|__|	**Would you like to proceed?** (0=No, 1=Yes, 8=not done due to cognitive status)

I would like to ask about the kinds of preparation you may have made in case you become too sick to make your own medical decisions.

|__|	**1. Have you talked about your wishes for medical care toward the end of your life with anyone since your last exam?**	**0=no 1=yes 8= prefer not to answer 9=don't know**
If yes, ask for each one ▯	|__|	Spouse (if applicable), child, grandchild	
	|__|	Other family member	
	|__|	Physician or other health care professional	
	|__|	Clergy	
	|__|	Attorney	
	|__|	Friends	
	|__|	Other, write in _____	

If question 1 = 0, 8, or 9, go to question 2a; if question 1 = 1, go to 2b.

2a. Who would you want to initiate a conversation with you regarding end of life issues?			
ask for each one ▯	|__|	Spouse (if applicable), child, grandchild	**0=no 1=yes 8= prefer not to answer 9=don't know**
	|__|	Other family member	
	|__|	Primary care physician	
	|__|	Physician specialists (such as cardiologist, oncologist)	
	|__|	Clergy	
	|__|	Attorney	
	|__|	Friends	
	|__|	Other, write in _____	
	|__|	No one	
2b. Who else would you want to initiate a conversation with you regarding end of life issues?			
ask for each one ▯	|__|	Spouse (if applicable), child, grandchild	**0=no 1=yes 7=had past conversation 8= prefer not to answer 9=don't know**
	|__|	Other family member	
	|__|	Primary care physician	
	|__|	Physician specialists (such as cardiologist, oncologist)	
	|__|	Clergy	
	|__|	Attorney	
	|__|	Friends	
	|__|	Other, write in _____	
	|__|	No one	

Health Care Preferences Questionnaire.

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|__|	**3. Since your last exam, have you and your doctor discussed any particular wishes you have about the care you would want to receive if you were dying?** (0=no, 1=yes, 8= prefer not to answer, 9=don't know)
if no, ▯	|__| **Do you want your doctor to initiate a conversation with you about your wishes for care if you were dying?** (0=no, 1=yes, 8= prefer not to answer, 9=don't know)
|__|	**4. How comfortable are you with talking about death?** 1=very comfortable, 2=somewhat comfortable, 3=not very comfortable, 4=not at all comfortable, 8= prefer not to answer, 9=don't know
|__|	**5. Have you filled out a Health Care Proxy form naming someone who could make decisions about your medical treatment if you could not speak for yourself?** (0=no, 1=yes, 2=completed advanced directive not sure which form (i.e. HCP form vs. living will) , 8= prefer not to answer, 9=don't know)
if yes, ▯	|__| **Who is your health care proxy?** (1=spouse, 2=child, 3=sibling, 4=other relative, 5=friend, 6=attorney, 7=other, write in_____, 9=don't know)
|__|	**6. Have you filled out a living will giving directions for the kind of medical treatment you would want if ever you could not speak for yourself?** (0=no, 1=yes, 2=completed advanced directive not sure which form (i.e. HCP form vs. living will) , 8= prefer not to answer, 9=don't know)
|__|	**7. If you were seriously ill, would you prefer care 0) to extend your life, even if it meant more pain and discomfort, or 1) to relieve pain and discomfort, even if it meant not living as long.** 0= Extend life as much as possible, 1= Relieve pain or discomfort as much as possible 8= prefer not to answer 9=Don't know

Health Care Preferences Questionnaire.

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I'm going to read some statements that describe situations that sometimes happen to people particularly at the end of their life. We are asking these questions of everyone regardless of how well or sick they are now. For each statement please tell me if you would be very willing, somewhat willing, somewhat unwilling, very unwilling or would rather die than put up with the situation. Please think about the situation as if you would be living this way for the rest of your life.

	Very willing	Some what willing	Some what unwilling	Very unwilling	Rather die	Prefer not to answer	Don't know
8. Being in a great deal of pain unrelieved by medicines?	1	2	3	4	5	8	9
9. Being attached to a ventilator or respirator all the time?	1	2	3	4	5	8	9
10. Being fed through a tube all the time?	1	2	3	4	5	8	9
11. Being unconscious or in coma all the time?	1	2	3	4	5	8	9
12. Forgetting or being confused all the time?	1	2	3	4	5	8	9

|__| **13. Where would you prefer to die?**
1=home, 2=hospital, 3=nursing home 4=hospice, 5= other, 8= prefer not to answer 9=don't know

|__| **14. What are the chances that you will be able to take care of yourself 12 months from now?**
1= 90% or better, 2= about 75% 3= about 50-50, 4= about 25% 5= 10% or less, 8= prefer not to answer 9=don't know

|__| **15. What do you think the chances are that you would live 12 months or more?**
1= 90% or better, 2= about 75% 3= about 50-50, 4= about 25% 5= 10% or less, 8= prefer not to answer 9=don't know

Now I am going to ask a question about how your religious/spiritual beliefs might influence your medical care.

|__| **16. To what extent do your religious beliefs help you cope with or handle serious illness?**
0=not at all, 1=to a small extent, 2= to a moderate extent, 3=to a large extent, 4=it's the most important thing that keeps you going, 8= prefer not to answer, 9=don't know

Thank you very much for you willingness to share this information. This form has been completed for research purposes and does not serve as a legal document. For more information on how to obtain legal forms please speak to your physician.

Interviewer Feedback: Health Care Preferences Questionnaire

OMB No=0925-0216 12/31/2007

|__|__|__| **Examiner's Number**

|__| **1. Did the participant choose to stop before completing all 16 questions? (0=No, 1=Yes, 9=Unknown)**

if yes,

|__| **Why did they stop? (0=no reason given, 1=refused to continue, 2=too upsetting, 3=other:_____ _____)**

|__||__| **What question did they stop at? (write in number)**

Additional Comments: _____ _____ _____ _____ _____

|__| **2. Did the participant seem upset or bothered by any of the questions that were asked? (0=No, 1=Yes, 9=Unknown)**

if yes,

|__||__| |__||__| | __||__| |__||__| |__||__| **Which questions? (write in number(s))**

Additional Comments: _____ _____ _____ _____ _____

|__| **3. Were there any questions that the participant had particular difficulty understanding? (0=No, 1=Yes, 9=Unknown)**

if yes,

|__||__| |__||__| | __||__| |__||__| |__||__| **Which questions? (write in number(s))**

Additional Comments: _____ _____ _____ _____ _____

Berkman Social Network Questionnaire. Tech-administered

OMB No=0925-0216 12/31/2007

The next questions ask about your social support. Please tell me the response that most closely describes your <u>current</u> situation.

|__|__|__|	**Examiner's Number** for Berkman Questionnaire.

For each question please circle one answer						
Coding scheme	**None**	**1 or 2**	**3 to 5**	**6 to 9**	**10 or more**	**Unknown**
1. How many *close friends* do you have, people that you feel at ease with, can talk to about private matters?	**0**	**1**	**2**	**3**	**4**	**9**
2. How many of these *close friends* do you see at least once a month?	**0**	**1**	**2**	**3**	**4**	**9**
3. How many *relatives* do you have, people, that you feel at ease with, can talk to about private matters?	**0**	**1**	**2**	**3**	**4**	**9**
4. How many of these *relatives* do you see at least once a month?	**0**	**1**	**2**	**3**	**4**	**9**

5. Do you participate in any groups such as a senior center, social or work group, religious connected group, self-help group, or charity, public service or community group?

Circle one answer		
No (Code=0)	**Yes** (Code=1)	**Unknown** (Code=9)

6. About how often do you go to religious meetings or services?

Circle one answer						
Never or almost never **0**	**Once or twice a year** **1**	**Every few months** **2**	**Once or twice a month** **3**	**Once a week** **4**	**More than once a week** **5**	**Unknown** **9**

Berkman Social Network Questionnaire. Tech- Administered

OMB No=0925-0216 12/31/2007

7. **Do you have health insurance other than Medicare or Medicaid?**		
Circle one answer		
No (Code=0)	**Yes** (Code=1)	**Unknown** (Code=9)

For each question please circle one answer						
Coding Scheme	**None of the time**	**A little of the time**	**Some of the time**	**Most of the time**	**All of the time**	**Unknown**
8. Is there someone available to you whom you can count on to listen to you when you need to talk?	**0**	**1**	**2**	**3**	**4**	**9**
9. Is there someone available to give you good advice about a problem?	**0**	**1**	**2**	**3**	**4**	**9**
10. Is there someone available to you who shows you love and affection?	**0**	**1**	**2**	**3**	**4**	**9**
11. Can you count on anyone to provide you with emotional support (talking over problems or helping you make a difficult decision)?	**0**	**1**	**2**	**3**	**4**	**9**
12. Do you have as much contact as you would like with someone you feel close to, someone in whom you can trust and confide?	**0**	**1**	**2**	**3**	**4**	**9**

TECH18

Leisure Time Cognitive and Physical Activities.

OMB No=0925-0216 12/31/2007

|__|__|__|	**Examiner's Number** for Leisure time activities.

During the past year, how often have you participated in the following leisure time activities?

Questions to be answered **Circle best answer for each question**	**Never**	**Daily** (7 days per week)	**Several days per week** (2-6 days per week)	**Once weekly** (1 day per week)	**Monthly** (once a month)	**Occa-sionally** (< once a month)
1. Reading books/newspapers	**0**	**1**	**2**	**3**	**4**	**5**
2. Writing for pleasure	**0**	**1**	**2**	**3**	**4**	**5**
3. Doing crossword puzzles	**0**	**1**	**2**	**3**	**4**	**5**
4. Playing board games or cards	**0**	**1**	**2**	**3**	**4**	**5**
5. Participating in organized group discussions	**0**	**1**	**2**	**3**	**4**	**5**
6. Group exercises	**0**	**1**	**2**	**3**	**4**	**5**
7. Housework	**0**	**1**	**2**	**3**	**4**	**5**
8. Playing musical instruments	**0**	**1**	**2**	**3**	**4**	**5**

CES-D Scale

OMB No=0925-0216 12/31/2007

|__|__|__|	**Examiner's Number** for CES-D Scale

The next questions ask about your feelings. For each of the following statements, please say if you felt that way during the past week.

Questions to be answered Circle best answer for each question	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or moderate amount of time (3-4 days)	Most or all of the time (5-7 days)	Unknown
1. I was bothered by things that usually don't bother me.	0	1	2	3	9
2. I did not feel like eating, my appetite was poor.	0	1	2	3	9
3. I felt that I could not shake off the blues, even with help from my family and friends.	0	1	2	3	9
4. I felt that I was just as good as other people.	0	1	2	3	9
5. I had trouble keeping my mind on what I was doing.	0	1	2	3	9
6. I felt depressed.	0	1	2	3	9
7. I felt that everything I did was an effort.	0	1	2	3	9
8. I felt hopeful about the future.	0	1	2	3	9
9. I thought my life had been a failure.	0	1	2	3	9
10. I felt fearful.	0	1	2	3	9
11. My sleep was restless.	0	1	2	3	9
12. I was happy.	0	1	2	3	9
13. I talked less than usual.	0	1	2	3	9
14. I felt lonely.	0	1	2	3	9
15. People were unfriendly.	0	1	2	3	9
16. I enjoyed life.	0	1	2	3	9
17. I had crying spells.	0	1	2	3	9
18. I felt sad.	0	1	2	3	9
19. I felt that people disliked me	0	1	2	3	9
20. I could not "get going"	0	1	2	3	9

Proxy form

OMB No=0925-0216 12/31/2007

|__|	**Proxy used to complete this exam (**0=No, 1=Yes, 1 proxy, 2=Yes, more than 1 proxy, 9=Unk)
if yes, fill ▯	**Proxy Name** _____
|__|	**Relationship** (1=1st Degree Relative(spouse, child), 2=Other Relative, 3=Friend, 4=Health Care Professional, 5=Other, 9=Unknown
|__|__|*****|__|__|	**How long have you known the participant?** (Years, months; 99.99=Unk) example: 3m=00*03
|__|	**Are you currently living in the same household with the participant?** (0=No, 1=Yes, 9=Unk)
|__|	**How often did you talk with the participant during the prior 11 months?** (1=Almost every day, 2=Several times a week, 3=Once a week, 4=1 to 3 times per month, 5=Less than once a month, 9=Unknown)
	Proxy Name _____
|__|	**Relationship** (1=1st Degree Relative(spouse, child), 2=Other Relative, 3=Friend, 4=Health Care Professional, 5=Other, 9=Unknown
|__|__|*****|__|__|	**How long have you known the participant?** (Years, months; 99.99=Unk) example: 3 m=00*03
|__|	**Are you currently living in the same household with the participant?** (0=No, 1=Yes, 9=Unk)
|__|	**How often did you talk with the participant during the prior 11 months?** (1=Almost every day, 2=Several times a week, 3=Once a week, 4=1 to 3 times per month, 5=Less than once a month, 9=Unknown)

TECH21

Mini-mental State Exam

Sentence and Design Handout for Participant

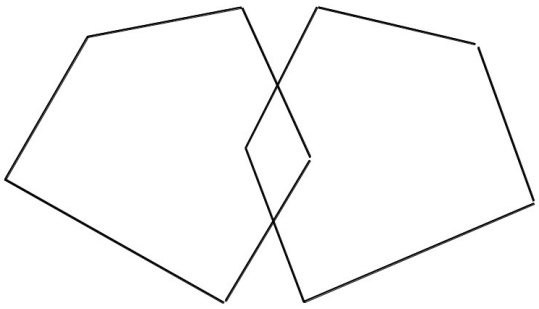
PLEASE WRITE A SENTENCE

_____

_____

_____

PLEASE COPY THIS DESIGN



OMB No=0925-0216 12/31/2007

Date of exam

_____/_____/_____

Framingham Heart Study
Cohort Exam 30

Summary Sheet to Personal Physician

Blood Pressure	First Reading	Second Reading
Systolic		
Diastolic		

ECG Diagnosis _____

_____

Summary of Findings_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Examining Physician

The Heart Study examination is not comprehensive and does not take the place of a routine physical examination.

Referral Tracking

OMB No=0925-0216 12/31/2007

|__||__||__|	**Physician ID#**
|__| **if yes fill below**	Was further medical evaluation recommended for this participant? 0=No, 1=Yes, 9=Unknown
RESULT	**Reason for further evaluation:** 0=No, 1=Yes, 9=Unknown
|__|	**Blood Pressure** result ____/_____ mmHg Phone call > 200/110 Expedite ≥ 180/100 Elevated > 140/90
	Write in abnormality
|__|	**ECG abnormality** _____
|__|	**Clinic Physician** _____ **identified medical problem**
|__|	**Other** _____ _____

|__|__|__|	**Technician ID#**
|__|	**Was there an adverse event in clinic/offsite exam that does not require further medical evaluation?** (0=No, 1=Yes, 9=Unknown) **Comments:**_____ _____ _____

|__|__|__|	**Technician ID#** (for offsite visit only)
|__|	**Was a FHS physician contacted during the examination due to adverse exam findings?** (0=No, 1=Yes, 9=Unknown) **Comments:**_____ _____ _____

TECH22

OMB No=0925-0216 12/31/2007

Method used to inform participant of need for further medical evaluation (circle ALL that apply)	
1	**Face-to-face in clinic**
2	**Phone call**
3	**Result letter**
4	**Other**

Method used to inform participant's personal physician of need for further medical evaluation (circle ALL that apply)	
1	**Phone call**
2	**Result letter mailed**
3	**Result letter FAX'd**
4	**Other**

Date referral made: __ _ -- _ _ -- _ _ _ _ Use 4 digits for year

ID number of person completing the referral: _____

Notes documenting conversation with participant or participant's personal physician:_____

_____

_____

COHORT EXAM 30

DATE _____

Medical History--Hospitalizations

OMB No=0925-0216 12/31/2007

Health Care. Since last Exam or Health Update.	
|__|	**Examiner prefix** (0=MD, 1=Tech)
|__|__|__|	**Examiner ID** _____ Examiner Name
|__|	**Hospitalization** (not just E.R.) since last exam or medical history update (0=No; 1=yes, hospitalization, 2=yes, more than 1 hospitalization, 9=Unknown)
|__|	**E.R. Visit since last exam or medical history update** (0=No; 1=Yes, 1 or more Emergency Room visit, 9=Unknown)
|__|	**Day Surgery** (0=No, 1=Yes, 9=Unknown)
|__|	**Illness with visit to doctor** (0=No, 1=Yes, 1 visit; 2=Yes, more than 1 visit; 9=Unk)
|__|	**Have you had a fever or infection in past two weeks** (0=No, 1=Yes, 9=Unknown)
|__|	**Check up** in interim by doctor (0=No, 1=Yes, 9=Unknown)
_____ MM DD YYYY	**Date** of this FHS exam (Today's date - See above)

Medical Encounter	Month/Year (of last visit)	Site of Hospital or Office	Doctor

MD01

Medical History—Medications

OMB No=0925-0216 12/31/2007

Hypertension

|__|	**Since your last exam have you taken medication for the treatment of hypertension? (high blood pressure)** **(0=No, 1=Yes, now, 2=Yes, not now, 9=Unk)**

Aspirin use

|__| **If yes,** **fill**	**Take aspirin regularly**? (0=No, 1=Yes, 9=Unk)	
	|__|__|	**Number aspirins taken regularly** (99=Unknown)
	|__|	**Aspirin frequency**- number taken regularly (0=Never, 1=Day, 2=Week 3=Month, 4=Year, 9=Unk)
	|__|__|__|	**Usual aspirin dose for above** 081=baby,160=half dose, 325=nl, 500=extra or larger,999=unk

Medical History – Prescription and Non-Prescription Medications

OMB NO=0925-0216 12/31/2007

Copy the name of medicine, the strength including units, and the total number of doses per day/week/month. Include pills, skin patches, eye drops, creams, salves, injections. Include herbal alternative, and soy-based preparations.

Medication Name (Print first 20 letters)	**Strength** (include mg, IU, etc)	**Number per** (day/week/month) (circle one)	**Prn** (0=no, 1=yes, 9=unkn)
EXAMPLE: S A M P L E D R U G N A M E	100 mg	1	D W M	0
			D W M	
			D W M	
			D W M	
			D W M	
			D W M	
			D W M	
			D W M	
			D W M	
			D W M	
			D W M	
			D W M	
			D W M	
			D W M	
			D W M	

To continue with more medications, please use next page.

MD03

Continue from screen 3

Medical History— Prescription and Non-Prescription Medications

OMB NO=0925-0216 12/31/2007

Copy the name of medicine, the strength including units, and the total number of doses per day/week/month. Include pills, skin patches, eye drops, creams, salves, injections. Include herbal, alternative, and soy-based preparations.

Medication Name (Print first 20 letters)	**Strength** (include mg, IU, etc)	**Number per** (day/week/month) (circle one)		**Prn** (0=no, 1=yes, 9=unkn)
EXAMPLE: SAMPLE DRUG NAME	100 mg	1	D W M	0
			D W M	
			D W M	
			D W M	
			D W M	
			D W M	
			D W M	
			D W M	
			D W M	
			D W M	
			D W M	
			D W M	

Blood Pressure

(first reading)

For clinic and offsite visits Examiner ID# equals Examiner ID# in Health Care section.

Systolic	**Diastolic**	**BP cuff size**	**Protocol modification**
|__|__|__|	|__|__|__|	|__|	|__|
to nearest 2 mm Hg 999=Unknown	to nearest 2 mm Hg 999=Unknown	0=pedi,1=reg.adult, 2=large adult, 3= thigh, 9=unknown	0=No, 1=Yes, 9=Unknown write in _____

MD04

Medical History–Prostate and Thyroid Disease, Smoking

OMB No=0925-0216 12/31/2007

Prostate Disease		
|__|	**Prostate trouble since your last exam**	0=No, 1=Yes, 2=Maybe, 8=Woman, 9=Unknown
|__|	**Prostate surgery since your last exam**	

Thyroid		
|__|	**Since your last exam have you had a diagnosis of a thyroid condition?** Comments_____ _____	0=No, 1=Yes, 9=Unknown

Smoking		
|__|	**Have you smoked cigarettes regularly since your last exam?**	0=No, 1=Yes, now, 2=Yes, not now, 9=Unknown
if yes fill ▯		
	|__|__|	How many cigarettes do/did you smoke a day? (01=one or less, 99=unknown)	

MD05

Medical History –Alcohol Consumption.

OMB NO=0925-0216 12/31/2007

Do you drink any of the following beverages at least once a month? (0=no, 1=yes, 9=unknown)	
|__|	Beer
|__|	Wine
|__|	Liquor/spirits
|__|	Other

What is your average number of servings in a typical week or month since your last exam ?
(999=Unknown)
Code alcohol intake as EITHER weekly OR monthly as appropriate.

Beverage	Per week	Per month
Beer (12oz bottle, glass, can)	|__|__|__|	|__|__|__|
Wine (red or white, 4oz glass)	|__|__|__|	|__|__|__|
Liquor/spirits (1oz cocktail/highball)	|__|__|__|	|__|__|__|
Other	|__|__|__|	|__|__|__|

MD06

Medical History—Respiratory Symptoms. Part I

OMB No=0925-0216 12/31/2007

Cough

|__| **Do you usually have a cough?** (Exclude clearing the throat)

|__| **Do you usually have a cough at all on getting up or first thing in the morning?**

0=No
1=Yes
9=Don't know

If **YES** to **either** question above **answer** the following:

|__| Do you cough like this on most days for three consecutive months or more during the past year?

0=No
1=Yes
9=Don't know

|__|__| How many years have you had this cough? (99=Unk.)

# of years

Phlegm

|__| **Do you usually bring up phlegm from your chest apart from colds?**

|__| **Do you usually bring up phlegm at all on getting up or first thing in the morning?**

0=No
1=Yes
9=Don't know

If **YES** to **either** question above **answer** the following:

|__| Do you bring up phlegm from your chest on most days (4 or more days/week) for three consecutive months or more during the past year?

0=No
1=Yes
9=Don't know

|__|__| How many years have you brought phlegm up from your chest on most days? (99=Unk.)

# of years

Wheeze

|__| **In the last 12 months, have you had wheezing or whistling in your chest at any time?**

0=No
1=Yes
9=Don't know

if yes, fill all

|__| **In the last 12 months, how often have you had this wheezing or whistling?**

0=Not at all
1=Most days or nights
2=A few days or nights a week
3=A few days or nights a month
4=A few days or nights a year
9=Unknown

|__| **In the past 12 months, have you had this wheezing or whistling in the chest when you did NOT HAVE A COLD?**

|__| **In the last 12 months, have you had an attack of wheezing or whistling in the chest that had made you feel short of breath?**

0=No
1=Yes
9=Don't know

MD07

Medical History—Respiratory Symptoms. Part II

OMB No=0925-0216 12/31/2007

Nocturnal chest symptoms

|__| **In the last 12 months, have you been awakened by shortness of breath?**	0=No 1=Yes 9=Don't know
|__| **In the last 12 months, have you been awakened by a wheezing/whistling in your chest?**	
|__| **In the last 12 months, have you been awakened by coughing?**	
if yes, fill all |__| In the last 12 months, how often have you been awakened by coughing?	0=Not at all 9=Unknown 1=Most days or nights 2=A few days or nights a week 3=A few days or nights a month 4=A few days or nights a year

Shortness of breath

|__| **Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill?**	
if yes, fill all |__| Do you have to walk slower than people of your age on level ground because of shortness of breath?	
|__| Do you ever have to stop for breath when walking at your own pace on level ground?	
|__| Do you ever have to stop for breath after walking 100 yards (or after a few minutes) on level ground?	0=No 1=Yes 9=Don't know
|__| **Do you/have you needed to sleep on two or more pillows to help you breathe?** (Orthopnea)	
|__| **Have you since your last exam had swelling in both your ankles (ankle edema)?**	
|__| **Have you since your last exam been told you had heart failure or congestive heart failure?**	
|__| **Have you since your last exam been hospitalized for heart failure?**	

Examiner's opinion:

|__| **First examiner believes CHF**	0=No,1=Yes 2=Maybe, 9=Unkn

Comments_____

_____

_____

MD08

Medical History-- Heart

OMB No=0925-0216 12/31/2007

|__| **Any chest discomfort since last exam or medical history update?** (0=No, 1=Yes, 2=Maybe, 9=Unknown)
(please provide narrative comments in addition to checking the appropriate boxes)

if yes, fill and below

|__| Chest discomfort with exertion or excitement (0=No, 1=Yes, 2=Maybe, 9=Unknown)

|__| Chest discomfort when quiet or resting

Chest Discomfort Characteristics (must have checked box at top of table)

|__|__|*|__|__|__|__|	Date of onset	mo/yr, 99/9999=Unknown)
|__|__|__|	Usual duration	(minutes: 1=1 min or less, 900=15 hrs or more, 999=Unknown)
|__|__|__|	Longest duration	(minutes: 1=1 min or less, 900=15 hrs or more, 999=Unknown)
|__|	Location	(0=No, 1=Central sternum and upper chest, 2=L up per Quadrant, 3=L lower ribcage, 4=R chest, 5=Other, 6=Combination, 9=Unknown)
|__|	Radiation	(0=No, 1=Left shoulder or L arm, 2=Neck, 3=R shoulder or arm, 4=Back, 5=Abdomen, 6=Other, 7=Combination, 9=Unknown)
|__|__|__|	Frequency (number in past month)	999=Unknown
|__|__|__|	Frequency (number in past year)	999=Unknown
|__|	Type	(1=Pressure, heavy, vise, 2=Sharp, 3=Dull, 4=Other, 9=Unk)
|__|	Relief by Nitroglycerine in <15 minutes	0=No
|__|	Relief by Rest in <15 minutes	1=Yes,
|__|	Relief Spontaneously in <15 minutes	8=Not tried
|__|	Relief by Other cause in <15 minutes	9=Unknown

|__| **Since your last exam, have you been told by a doctor you had a heart attack?** 0=No, 1=Yes, 2=Maybe, 9=Unknown

CHD First Opinions

|__| **Angina pectoris in interim**

|__| **Angina pectoris since revascularization procedure**

|__| **Coronary insufficiency in interim**

|__| **Myocardial infarct in interim**

0=No, 1=Yes, 2=Maybe, 9=Unknown

Comments_____

_____

_____

_____

MD09

Medical History—Atrial Fibrillation/Syncope

OMB No=0925-0216 12/31/2007

|__|	**Have you been told you have/had a heart rhythm problem called atrial fibrillation?** (0=No, 1=Yes, 2=Maybe,, 9=Unknown)	
if yes, fill	|__|__|*|__|__|*|__|__|__|__| mm dd yyyy	Date of first episode (99/99/9999=unk) code year as 4 digits, example: Year 1999=1999
	|__|	ER/hospitalized or saw M.D. (0=No, 1=Hosp/ER, 2=Saw M.D., 9=Unkn)
		Hospitalized at:_____ M.D. seen: _____

|__|	**Have you fainted or lost consciousness since your last exam?** (If due to stroke skip to screen 11) If event immediately preceded by head injury, or accident code 0=No		Code: 0=No, 1=Yes, 2=Maybe, 9=Unknown
if yes, fill all	|__|__|__|	Number of episodes in the past two years	(999=Unknown)
	|__|__|*|__|__|__|__|	Date of first episode (use 4 digits for year, i.e. 1998)	(mo/yr, 99/9999=Unknown)
	|__|__|__|	Usual duration of loss of consciousness	(minutes, 999=Unkn)
	|__|	Did you have any injury caused by the event? (0=No, 1=Yes, 2=Maybe, 9=Unkn)	
if yes, fill	|__|	ER/hospitalized or saw M.D. (0=No, 1=ER/Hosp., 2=Saw M.D., 9=Unkn)	
		Hospitalized at: _____	
		M.D. seen: _____	

	Syncope First Opinions		
|__|	**Syncope** (0=No, 1=Yes, 2=Maybe, 3=Presyncope, 9=Unknown)		
	|__|	**Cardiac syncope**	0=No, 1=Yes, 2=Maybe, 9=Unknown
	|__|	**Vasovagal syncope**	
	|__|	**Other-Specify: _____**	
|__|	**Seizure Disorder** (0=No, 1=Yes, 2=Maybe,, 9=Unknown)		

Comments _____

_____

_____

_____

_____

MD10

Medical History—Cerebrovascular Disease

OMB No=0925-0216 12/31/2007

Cerebrovascular Episodes in Interim

|__| **Sudden muscular weakness**

|__| **Sudden speech difficulty**

|__| **Sudden visual defect**

|__| **Double vision**

|__| **Loss of vision in one eye**

|__| **Unconsciousness**

|__| **Numbness, tingling**

if yes, fill

|__| Numbness and tingling is positional

0=No, 1=Yes, 2=Maybe, 9=Unknown

|__| **Head CT or MRI scan since last exam other than for the FHS** (date/place_____) | 0=No, 1=CT,2=MRI, 3=both, 9=Unk

|__| **Seen by neurologist**(write in who and when below)

_____

|__| **Have you been told by a doctor you had a stroke or TIA (transient ischemic attack, mini-stroke)?**

|__| **Have you been told by a doctor you have Parkinson Disease?**

|__| **Have you been told by a doctor you have memory problems, dementia or Alzheimer's disease?**

|__| **Do you feel or do other people think that you have memory problems that prevent you from doing things you've done in the past?**

0=No, 1=Yes, 2=Maybe, 9=Unknown

Details for "Serious" Cerebrovascular Event in Interim

|__| **Examiner's opinion that TIA or stroke took place in interim** (0=No, 1=Yes, 2=Maybe, 9=Unknown)

if yes or maybe

fill all to

|__|__|*|__|__|__|__| **Date** (mo/yr, 99/9999=Unkn)
Observed by_____

|__|__|*|__|__|*|__|__| **Duration** (use format days/hours/mins, 99/99/99=Unknown)

|__| **Hospitalized or saw M.D.** (0=No, 1=Hosp.2=Saw M.D, 9=Unk)
Name_____Address_____

Neurology First Opinions

|__| **Stroke in Interim**

|__| **TIA**

|__| **Dementia**

|__| **Parkinson Disease**

|__| **Other-- Specify: _____**

0=No, 1=Yes, 2=Maybe, 9=Unknown

Neurology Comments_____

_____

Medical History--Peripheral Arterial Disease

OMB No=0925-0216 12/31/2007

|__|			**Can you walk 50 feet without help?** (0=Able to walk 50 feet without help, 1=Needs help, 2=Can't walk, 9=Unknown)	
|__|			**Do you have lower limb discomfort while walking?** (0=No, 1=Yes, 2=Can't walk, 9=Unknown)	
if yes fill ▯	|__|__|		**If walking on level ground, how many city blocks until symptoms develop** (00=no, 99=unknown) where 10 blocks=1 mile, code as no if more than 98 blocks required to develop symptoms	
	|__|__|__|__|		**Year symptoms started** (9999=unknown)	
if yes fill in below	**Left**	**Right**	**Vascular symptoms**	
	|__|	|__|	Discomfort in calf while walking	0=No, 1=Yes, 9=Unknown
	|__|	|__|	Discomfort in lower extremity (not calf) while walking	
	|__|		Occurs with first steps (code worse leg)	
	|__|		After walking a while (code worse leg)	
	|__|		Related to rapidity of walking or steepness	
	|__|		Forced to stop walking	
	|__|__|		Time for discomfort to be relieved by stopping (minutes) (00=No relief with stopping, 88=Not Applicable, 99=Unknown)	
	|__|__|		Number of days/month of lower limb discomfort (88=N/A, 99=Unknown)	

|__|		**Have you ever been told by a doctor you have intermittent claudication or peripheral arterial disease ?**	0=No, 1=Yes, 9=Unknown
|__|		**Has a doctor ever told you you had spinal stenosis?**	
if yes, fill ▯	|__|	**Have you had a CT or MRI of your spine? Date__-__-____ Location _____**	

PAD First Opinions		
|__|	**Intermittent Claudication**	0=No, 1=Yes, 2=Maybe, 9=Unknown

Comments_____

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MD12

Venous Disease and Second Blood Pressure

OMB No=0925-0216 12/31/2007

Venous Disease		
|__|	**Since your last exam have you had a Deep Vein Thrombosis (blood clots in legs or arms)**	0=No, 1=Yes, 9=Unknown
|__|	**Since your last exam have you had a Pulmonary Embolus (blood clots in lungs)**	

Second Blood Pressure (second reading)			
For clinic and offsite visits Examiner ID# equals Examiner ID# in Health Care section			
Systolic	**Diastolic**	**BP cuff size**	**Protocol modification**
|__|__|__| to nearest 2 mm Hg 999=Unknown	|__|__|__| to nearest 2 mm Hg 999=Unknown	|__| 0=pedi,1=reg.adult, 2=large adult, 3= thigh, 9=unknown	|__| 0=No, 1=Yes, 9=Unknown

Comments on Protocol modification

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MD13

Medical History-- CVD Procedures

OMB No=0925-0216 12/31/2007

Coding: 0=No, 1=Yes 2=Maybe, 9=Unkn	**Cardiovascular Procedures in Interim (if procedure was repeated code only first in interim and provide narrative) (write 4 digits for year, i.e. 1998, 1999, 2000)**
|__| **if yes fill**	**Heart Valvular Surgery (most recent only)**
	|__|__|__|__| Year done (9999=Unk) Location and description_____
|__| **if yes fill**	**Exercise Tolerance Test (most recent only)**
	|__|__|__|__| Year done (9999=Unk) Location_____
|__| **if yes fill**	**Coronary arteriogram (most recent only)**
	|__|__|__|__| Year done (9999=Unk)
|__| **if yes fill**	**Coronary artery angioplasty**
	|__|__|__|__| Year done (9999=Unk)
	|__| Type of procedure (0=none, 1=balloon, 2=stent, 3=other, 9=unkn)
|__| **if yes fill**	**Coronary bypass surgery**
	|__|__|__|__| Year done (9999=Unk)
|__| **if yes fill**	**Permanent pacemaker insertion**
	|__|__|__|__| Year done (9999=Unk)
|__| **if yes fill**	**Carotid artery surgery**
	|__|__|__|__| Year done (9999=Unk)
|__| **if yes fill**	**Thoracic aorta surgery**
	|__|__|__|__| Year done (9999=Unk)
|__| **if yes fill**	**Abdominal aorta surgery**
	|__|__|__|__| Year done (9999=Unk)
|__| **if yes fill**	**Femoral or lower extremity surgery**
	|__|__|__|__| Year done (9999=Unk)
|__| **if yes fill**	**Lower extremity amputation**
	|__|__|__|__| Year done (9999=Unk)
|__| **if yes fill**	**Other Cardiovascular Procedure (write in below)**
	|__|__|__|__| Year done (9999=Unk) Description_____

Comments:_____

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MD14

Cancer Site or Type

OMB No=0925-0216 12/31/2007

|__| **Have you, since your last clinic visit or medical history update, had a cancer or a tumor?**
0=No - skip to next screen
1=Yes, fill in table below, using the following code:
Code each "site", putting "0" for all sites having no interim tumor.
1= Definite cancer
2=Tumor, nature unknown
3=Definitely benign
9=Unknown

Code	Site of Cancer or Tumor	Year First Diagnosed	Name Diagnosing M.D.	City of M.D.
|__|	**Esophagus**			
|__|	**Stomach**			
|__|	**Colon**			
|__|	**Rectum**			
|__|	**Pancreas**			
|__|	**Larynx**			
|__|	**Trachea/Bronchus/Lung**			
|__|	**Leukemia**			
|__|	**Skin**			
|__|	**Breast**			
|__|	**Cervix/Uterus**			
|__|	**Ovary**			
|__|	**Prostate**			
|__|	**Bladder**			
|__|	**Kidney**			
|__|	**Brain**			
|__|	**Lymphoma**			
|__|	**Other/Unknown** _____			

Comment (If participant has more details concerning tissue diagnosis, other hospitalization, procedures, treatments)

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MD15

Electrocardiograph--Part I

OMB No=0925-0216 12/31/2007

|__|__|__|	**Examiner ID Number** _____ **Examiner Last Name**
|__| **if Yes, fill out rest of form**	**ECG done (0=No, 1=Yes)**
	Rates and Intervals
|__|__|__|	**Ventricular rate per minute** (999=Unknown)
|__|__|	**P-R Interval (hundredths of a second)** (99=Fully Paced, Atrial Fib, or Unknown)
|__|__|	**QRS interval (hundredths of second)** (99=Fully Paced, Unknown)
|__|__|	**Q-T interval (hundredths of second)** (99=Fully Paced, Unknown)
|__|__|__|__|	**QRS angle (put plus or minus as needed)** (e.g. -045 for minus 45 degrees, +090 for plus 90, 9999=Fully paced or Unknown)
	Rhythm--predominant
|__|	**0 or 1 = Normal sinus,** (including s.tach, s.brady, s arrhy, 1 degree AV block) **3 = 2nd degree AV block, Mobitz I (Wenckebach)** **4 = 2nd degree AV block, Mobitz II** **5 = 3rd degree AV block / AV dissociation** **6 = Atrial fibrillation / atrial flutter** **7 = Nodal** **8 = Paced** **9 = Other or combination of above (list)**_____
	Ventricular conduction abnormalities
|__|	**IV Block** (0=No, 1=Yes, 9=Fully paced or Unknown)
if yes, fill	|__| **Pattern** (1=Left, 2=Right, 3=Indeterminate, 9=Unknown)
	|__| **Complete (QRS interval=.12 sec or greater)**(0=No, 1=Yes, 9=Unknown)
	|__| **Incomplete (QRS interval = .10 or .11 sec)** (0=No, 1=Yes, 9=Unknown)
|__|	**Hemiblock** (0=No, 1=Left Ant, 2=Left Post, 9=Fully paced or Unknown)
|__|	**WPW Syndrome** (0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unknown)
	Arrhythmias
|__|	**Atrial premature beats** (0=No, 1=Atr, 2=Atr Aber, 9=Unknown)
|__|	**Ventricular premature beats** (0=No, 1=Simple, 2=Multifoc, 3=Pairs, 4=Run, 5=R on T, 9=Unk)
|__|__|	**Number of ventricular premature beats in 10 seconds** (see 10 second rhythm strip, 99=Unknown)

MD16

Electrocardiograph-Part II

OMB No=0925-0216 12/31/2007

Myocardial Infarction Location

(0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unknown)

|__| **Anterior**

|__| **Inferior**

|__| **True Posterior**

Left Ventricular Hypertrophy Criteria

(0=No, 1=Yes, 9=Fully paced, Complete LBBB or Unk)

|__| **R > 20mm in any limb lead**

|__| **R > 11mm in AVL**

|__| **R in lead I plus S ≥ 25mm in lead III**

Measured Voltage

*|__|__| **R AVL in mm** (at 1 mv = 10 mm standard) Be sure to code these voltages

*|__|__| **S V3 in mm** (at 1 mv = 10 mm standard) Be sure to code these voltages

R in V5 or V6-----S in V1 or V2

(0=No, 1=Yes, 9=Fully paced, Complete LBBB or Unk)

|__| **R≥ 25mm**

|__| **S≥ 25mm**

|__| **R or S ≥ 30mm**

|__| **R + S ≥ 35mm**

|__| **Intrinsicoid deflection ≥ .05 sec**

|__| **S-T depression (strain pattern)**

Hypertrophy, enlargement, and other ECG Diagnoses

|__| **Nonspecific S-T segment abnormality (0=No, 1=S-T depression, 2=S-T flattening, 3=Other, 9=Fully paced or unknown)**

|__| **Nonspecific T-wave abnormality (0=No, 1=T inversion, 2=T flattening, 3=Other, 9=Fully paced or unknown)**

|__| **U-wave present (0=No, 1=Yes, 2=Maybe, 9=Paced or Unknown)**

|__| **Atrial enlargement (0=None, 1=Left, 2=Right, 3=Both, 9=Atrial fib. or Unknown)**

|__| **RVH (0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unknown; If complete RBBB present, RVH=9)**

|__| **LVH (0=No, 1=LVH with strain, 2=LVH with mild S-T Segment Abn, 3=LVH by voltage only, 9=Fully paced or Unkn, If complete LBBB present, LVH=9)**

Comments and Diagnosis_____

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MD17

Clinical Diagnostic Impression.

OMB No=0925-0216 12/31/2007

Non Cardiovascular Diagnoses First Examiner Opinions		
|__|	**Diabetes Mellitus**	
|__|	**Prostate disease**	
|__|	**Renal disease (specify)_____**	**0=No,**
|__|	**Emphysema**	**1=Yes,**
|__|	**Chronic bronchitis**	**2=Maybe,**
|__|	**Pneumonia**	**9=Unknown**
|__|	**Asthma**	
|__|	**Other pulmonary disease**	
|__|	**Gout**	
|__|	**Degenerative joint disease**	
|__|	**Rheumatoid arthritis**	
|__|	**Gallbladder disease**	
|__|	**Other non C-V diagnosis (for cancer, see special screen)**	

Comments CDI Other Diagnoses_____

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MD18

Version #3	**09-04-2007 GM**