

OMB#: 0925-0216
Exp. 12/2007

Public reporting burden for this collection of information is estimated to average 10 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 (0925-0216). Do not return the completed form to this address.

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Dear _____,

We thank you for participating in the Framingham Heart Study. Your clinic appointment is scheduled for _____ at _____ A.M.

The Framingham Heart Study's **new** address is 73 Mt. Wayte Avenue, in the **Perini Building**. The Framingham Heart Study offices are **located in the wing at the Franklin Street side** of the Building. **There is reserved parking for participants behind the Franklin Street wing**. Please see the enclosed map. The building is handicap accessible.

You should bring slippers and if you choose, bring your own robe. In order to perform certain tests, we ask that you **DO NOT** eat after 8:00 P.M. the previous evening. You may have **water, decaffeinated black coffee or tea (no creamer, milk or sugar) that evening and again in the morning** before your appointment. A urine sample will be collected when you arrive.

Please **take any prescription medications**, as you normally would.

Using the enclosed **MEDICATION BAG**, please bring all prescription and nonprescription medications you currently take or have taken in the past month **in their original containers. They will be returned to you before you leave.**

ON THE BACK OF THIS SHEET, please list information regarding hospitalizations and major illnesses you have experienced in the past. **PLEASE BRING THIS LETTER WITH YOU TO THE CLINIC.** If you need help completing this form, Clinic staff can assist you at the time of your appointment.

If you have any questions, please call Maureen Valentino, Project Coordinator at **(508) 935-3417** locally and for long distance at **(800) 854-7582 ext 417**.

Welcome to the Framingham Heart Study!

Sincerely yours,



Daniel Levy, MD
Director
Framingham Heart Study

OVER →

Social Security Number: |__|__|__| - |__|__| - |__|__|__|__|

DISCLOSURE STATEMENT FOR SOCIAL SECURITY NUMBER: provision of the social security number is voluntary and unwillingness to do so will not have any effect upon the receipt of any benefits or programs of the United States Government. The information we receive will be used only for statistical purpose. Data from this study will be linked with data supplied by the National Center for Health Services. This information is collected under the authority of Section 421 (42USC 285b-3) of the Public Health Service Act.

Doctor(s)/Health Care Provider you want your report sent to:

Name	Address	Telephone
_____	_____	
_____	_____	
_____	_____	
_____	_____	

Hospitalizations, Emergency Room Visits, or Day Surgeries

Date	Reason	Hospital Name & Address	Doctor's Name
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Doctor's Office Visits

Date	Reason	Doctor's Name
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____