OMB#: 0925-0216
Exp. 12/2007

Public reporting burden for this collection of information is estimated to average 180 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.

OMB#: 0925-0216
Exp. 12/2007

Keyer:

SECTION A - TRACKING INFORMATION (SELF)

Date this information was collected: ____/____/____ ***Interviewer #:***_____

- **Please circle all printed information (marked with O) if accurate, otherwise correct data with red/blue ink.**
- **Please spell out first, middle, last names, address and all phone numbers to verify.**
- **Please enter "N/A" in all spaces that do not apply.**
- **All shaded areas must be updated on roster.**

1. ID Number: -

O 2. Prefix:

O 3. Name: _____
(First) (MI) (Last)

O 4. Date of Birth:

O 5. Sex:

O 6. Address: _____

_____

_____

O Home Phone Number:

O Work Phone Number:

Cell Phone Number: |___|___|___| - |___|___|___| - |___|___|___|___|

O 9. Email:

O 7. Resides: _____

_____

_____
(City) (State) (Zip Code)

SECTION A - TRACKING INFORMATION (SELF)

O 10. Preferred Method of Contact: Home: _____
Work:
Email:
Cellular:

0	No
1	Yes
2	Never
8	N/A

11. Also Known As: _____

12. Maiden Name: _____

13. 2nd Address:

(City) (State) (Zip Code)

2nd Address Telephone Number: |___|___|___| - |___|___|___| - |___|___|___|___|

14. 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 purposes. Data from this study will be linked with data supplied by the National Center for Health Statistics. This information is collected under the authority of Section 421 (42USC 285b-3) of the Public Health Service Act.

15. Place of Employment: _____

Address: _____
(City) (State) (Zip Code)

Occupation: _____

SECTION B – TRACKING INFORMATION (SPOUSE/PARTNER)
CURRENT SPOUSE/PARTNER

1. In FHS: □ NOT IN STUDY **If Yes, Framingham ID:** |__|__| - |__|__| __|__|

2. Current Spouse/Partner's Name: _____
(Prefix) (First) (MI) (Last)

(Please Circle one)
Status: Spouse / Partner / Divorce

3. Address if different: _____
(Number) (Street) (Apt. #)

_____
(City) (State) (Zip Code)

4. Telephone Number if Different: |___|___|___| - |___|___|___| - |___|___|___|___|

5. Work Telephone Number: |___|___|___| - |___|___|___| - |___|___|___|___|

SPOUSE/PARTNER ON RECORD

1. Spouse/Partner's Name:

(Please Circle one)
Status: Spouse / Partner / Divorce

2. Address: ,
,
3. Telephone:
4. Work Telephone :
5. Framingham ID: -

PREVIOUS SPOUSE/PARTNER

1. In FHS: □ NOT IN STUDY **If Yes, Framingham ID:** |__|__| - |__|__| __|__|

2. Previous Spouse/Partner's Name: _____
(Prefix) (First) (MI) (Last) (Please Circle one)
Status: Spouse / Partner / Divorce

3. Address: _____
(Number) (Street) (Apt. #)

_____
(City) (State) (Zip Code)

4. Home Telephone Number: |___|___|___| - |___|___|___| - |___|___|___|___|

5. Work Telephone Number: |___|___|___| - |___|___|___| - |___|___|___|___|

SECTION D – CONTACTS

RELATIVE AT DIFFERENT ADDRESS

1. In FHS: □ NOT IN STUDY **If Yes, Framingham ID:** |__|__| - |__|__| __|__|

2. Name: _____
(Prefix) (First) (MI) (Last)

3. Relationship: _____

4. Address: _____
(Number) (Street) (Apt. #)

_____
(City) (State) (Zip Code)

5. Telephone number: |___|___|___| - |___|___|___| - |___|___|___|___|

6. Spouse Name: _____
(Prefix) (First) (MI) (Last)

CLOSE FRIEND AT DIFFERENT ADDRESS

1. In FHS: □ NOT IN STUDY **If Yes, Framingham ID:** |__|__| - |__|__| __|__|

2. Name: _____
(Prefix) (First) (MI) (Last)

3. Relationship: _____

4. Address: _____
(Number) (Street) (Apt. #)

_____
(City) (State) (Zip Code)

5. Telephone number: |___|___|___| - |___|___|___| - |___|___|___|___|

6. Spouse Name: _____
(Prefix) (First) (MI) (Last)

SECTION E – PHYSICIAN'S INFORMATION

1. Participant's primary physician's name: _____
(First) (Last) (Suffix)

Address: _____
(Number) (Street) (Apt. #)

_____
(City) (State) (Zip)

Telephone number: |___|___|___| - |___|___|___| - |___|___|___|___|

2. Participant's 2nd physician's name: _____
(First) (Last) (Suffix)

Address: _____
(Number) (Street) (Apt. #)

_____
(City) (State) (Zip)

Telephone number: |___|___|___| - |___|___|___| - |___|___|___|___|

3. Participant's 3rd physician's name: _____
(First) (Last) (Suffix)

Address: _____
(Number) (Street) (Apt. #)

_____
(City) (State) (Zip)

Telephone number: |___|___|___| - |___|___|___| - |___|___|___|___|

Mother:

FramId:

Father:

FramId:

SECTION F – SIBLINGS (BROTHERS AND SISTERS)

List all siblings in birth order. (Oldest to youngest)

Number of Sibling(s) not including yourself: _____
(In other words, how many brothers and sisters do

SIBLING VERIFICATION
To be completed by another tech after time of admitting.

☐ **Yes** ☐ **No** Did all siblings' name and DOB match with those reported by their offspring parents?

Tech ID#: _____

SECTION F – SIBLINGS (BROTHERS AND SISTERS)

1. In FHS: □ NOT IN STUDY **If Yes, Framingham ID:** |__|__| - |__|__| __|__|

Name: _____
(Prefix) (First) (MI) (Last)

Address: _____
(Number) (Street) (Apt. #)

_____
(City) (State) (Zip Code)

Spouse Name: _____
(Prefix) (First) (MI) (Last)

Telephone number: |___|___|___| - |___|___|___| - |___|___|___|___|

(Please Circle one)
Relationship: Full / Half / Step / Adopted n/a

Living: Yes / No

If **NO**, Year of Death: |___|___|___|___| n/a

Cause of Death: _____n/a_____

SECTION F – SIBLINGS (BROTHERS AND SISTERS)

1. In FHS: □ NOT IN STUDY **If Yes, Framingham ID:** |__|__| - |__|__| __|__|

Name: _____
(Prefix) (First) (MI) (Last)

Address: _____
(Number) (Street) (Apt. #)

_____
(City) (State) (Zip Code)

Spouse Name: _____
(Prefix) (First) (MI) (Last)

Telephone number: |___|___|___| - |___|___|___| - |___|___|___|___|

(Please Circle one)
Relationship: Full / Half / Step / Adopted n/a

Living: Yes / No

If **NO**, Year of Death: |___|___|___|___| n/a

Cause of Death: _____n/a_____

SECTION F – SIBLINGS (BROTHERS AND SISTERS)

1. In FHS: □ NOT IN STUDY **If Yes, Framingham ID:** |__|__| - |__|__| __|__|

Name: _____
(Prefix) (First) (MI) (Last)

Address: _____
(Number) (Street) (Apt. #)

_____
(City) (State) (Zip Code)

Spouse Name: _____
(Prefix) (First) (MI) (Last)

Telephone number: |___|___|___| - |___|___|___| - |___|___|___|___|

(Please Circle one)
Relationship: Full / Half / Step / Adopted n/a

Living: Yes / No

If **NO**, Year of Death: |___|___|___|___| n/a

Cause of Death: _____n/a_____

SECTION F – SIBLINGS (BROTHERS AND SISTERS)

1. In FHS: □ NOT IN STUDY **If Yes, Framingham ID:** |__|__| - |__|__| __|__|

Name: _____
(Prefix) (First) (MI) (Last)

Address: _____
(Number) (Street) (Apt. #)

_____
(City) (State) (Zip Code)

Spouse Name: _____
(Prefix) (First) (MI) (Last)

Telephone number: |___|___|___| - |___|___|___| - |___|___|___|___|

(Please Circle one)
Relationship: Full / Half / Step / Adopted n/a

Living: Yes / No

If **NO**, Year of Death: |___|___|___|___| n/a

Cause of Death: _____n/a_____

SECTION F – SIBLINGS (BROTHERS AND SISTERS)

1. In FHS: □ NOT IN STUDY **If Yes, Framingham ID:** |__|__| - |__|__| __|__|

Name: _____
(Prefix) (First) (MI) (Last)

Address: _____
(Number) (Street) (Apt. #)

_____
(City) (State) (Zip Code)

Spouse Name: _____
(Prefix) (First) (MI) (Last)

Telephone number: |___|___|___| - |___|___|___| - |___|___|___|___|

(Please Circle one)
Relationship: Full / Half / Step / Adopted n/a

Living: Yes / No

If **NO**, Year of Death: |___|___|___|___| n/a

Cause of Death: _____n/a_____

SECTION F – SIBLINGS (BROTHERS AND SISTERS)

1. In FHS: □ NOT IN STUDY **If Yes, Framingham ID:** |__|__| - |__|__| __|__|

Name: _____
(Prefix) (First) (MI) (Last)

Address: _____
(Number) (Street) (Apt. #)

_____
(City) (State) (Zip Code)

Spouse Name: _____
(Prefix) (First) (MI) (Last)

Telephone number: |___|___|___| - |___|___|___| - |___|___|___|___|

(Please Circle one)
Relationship: Full / Half / Step / Adopted n/a

Living: Yes / No

If **NO**, Year of Death: |___|___|___|___| n/a

Cause of Death: _____n/a_____

More than 6 siblings? Yes _____ No _____

If YES, attach additional sheets!!!

SECTION G – CHILDREN

Number of Children: _____

1. In FHS: □ NOT IN STUDY **If Yes, Framingham ID:** |__|__| - |__|__| __|__|

Name: _____
(Prefix) (First) (MI) (Last)

Address: _____
(Number) (Street) (Apt. #)

_____
(City) (State) (Zip Code)

Spouse Name: _____
(Prefix) (First) (MI) (Last)

Telephone number: |___|___|___| - |___|___|___| - |___|___|___|___|

(Please Circle one)
Relationship: Full / Half / Step / Adopted n/a

Living: Yes / No

If **NO**, Year of Death: |___|___|___|___| n/a

Cause of Death: _____n/a_____

SECTION G – CHILDREN

2. In FHS: □ NOT IN STUDY **If Yes, Framingham ID:** |__|__| - |__|__| __|__|

Name: _____
(Prefix) (First) (MI) (Last)

Address: _____
(Number) (Street) (Apt. #)

_____
(City) (State) (Zip Code)

Spouse Name: _____
(Prefix) (First) (MI) (Last)

Telephone number: |___|___|___| - |___|___|___| - |___|___|___|___|

(Please Circle one)
Relationship: Full / Half / Step / Adopted n/a

Living: Yes / No

If **NO**, Year of Death: |___|___|___|___| n/a

Cause of Death: _____n/a_____

SECTION G – CHILDREN

3. In FHS: □ NOT IN STUDY **If Yes, Framingham ID:** |__|__| - |__|__| __|__|

Name: _____
(Prefix) (First) (MI) (Last)

Address: _____
(Number) (Street) (Apt. #)

_____
(City) (State) (Zip Code)

Spouse Name: _____
(Prefix) (First) (MI) (Last)

Telephone number: |___|___|___| - |___|___|___| - |___|___|___|___|

(Please Circle one)
Relationship: Full / Half / Step / Adopted n/a

Living: Yes / No

If **NO**, Year of Death: |___|___|___|___| n/a

Cause of Death: _____n/a_____

SECTION G – CHILDREN

4. In FHS: □ NOT IN STUDY **If Yes, Framingham ID:** |__|__| - |__|__| __|__|

Name: _____
(Prefix) (First) (MI) (Last)

Address: _____
(Number) (Street) (Apt. #)

_____
(City) (State) (Zip Code)

Spouse Name: _____
(Prefix) (First) (MI) (Last)

Telephone number: |___|___|___| - |___|___|___| - |___|___|___|___|

(Please Circle one)
Relationship: Full / Half / Step / Adopted n/a

Living: Yes / No

If **NO**, Year of Death: |___|___|___|___| n/a

Cause of Death: _____n/a_____

SECTION G – CHILDREN

5. In FHS: □ NOT IN STUDY **If Yes, Framingham ID:** |__|__| - |__|__| __|__|

Name: _____
(Prefix) (First) (MI) (Last)

Address: _____
(Number) (Street) (Apt. #)

_____
(City) (State) (Zip Code)

Spouse Name: _____
(Prefix) (First) (MI) (Last)

Telephone number: |___|___|___| - |___|___|___| - |___|___|___|___|

(Please Circle one)
Relationship: Full / Half / Step / Adopted n/a

Living: Yes / No

If **NO**, Year of Death: |___|___|___|___| n/a

Cause of Death: _____n/a_____

SECTION G – CHILDREN

6. In FHS: □ NOT IN STUDY **If Yes, Framingham ID:** |__|__| - |__|__| __|__|

Name: _____
(Prefix) (First) (MI) (Last)

Address: _____
(Number) (Street) (Apt. #)

_____
(City) (State) (Zip Code)

Spouse Name: _____
(Prefix) (First) (MI) (Last)

Telephone number: |___|___|___| - |___|___|___| - |___|___|___|___|

(Please Circle one)
Relationship: Full / Half / Step / Adopted n/a

Living: Yes / No

If **NO**, Year of Death: |___|___|___|___| n/a

Cause of Death: _____n/a_____

DRAFT

Numerical Data--Part I

|7|0|2|0|1| FORM NUMBER OMB NO=0925-0216

Basic Information			
|__|__|__|	**Examiner's Number** for weight and height.		
|__|	**Sex of Participant** (1=Male, 2=Female)		
|_|_|-|_|_|-|_|_|_|_|	**Date of Birth** (mo/day/year).	Use 4 digits for year	
|__|__|__|	**Weight** (to nearest pound)	|__| **Protocol modification**	0=No

|__|__|*|__|__|	**Height** (inches, to next lower 1/4 inch)	|__| **Protocol modification**	1=Yes

Regional Anthropometry

(Code boxes below with 9's if not done or unknown)

|__|__|__|	**Examiner's Number** for anthropometry, fasting and hand preference.		
|__|__|*|__|__|	**Waist Girth** (inches, to next lower 1/4 inch	|__| **Protocol modification**	0=No 1=Yes
	__|__|	**Number of Hours Fasting** (99=Don't know)		
|__|__|*|__|__|	**Hip** (inches, to the next lower ¼ inch)		
|__|__|*|__|__|	**Sagittal Abdominal Diameter** (inches to the next lower ¼ inch)		

|__|__|__| **Technician's Number for Blood Pressure** (to nearest 2 mm Hg)

Systolic	Diastolic	BP cuff size	Protocol modification	
|__|__|__|	|__|__|__|	|__| 0=pediatric, 1=regular, 2=large ad., 3=thigh	|__|	0=No, 1=Yes

Comments on **all** protocol modifications:

_____

_____

_____

TECH01

|7|0|2|0|2| FORM NUMBER OMB NO=0925-0216

Exam 2 Procedures Sheet

|__|	**Informed Consent Signed**	
|__|	**Anthropometry**	
|__|	**Sociodemographic Questions**	
|__|	**SF-12 Health Survey**	0=No,
|__|	**CES-D Scale**	
|__|	**Exercise Questionnaire**	1=Yes,
|__|	**Placement of ambulatory blood pressure device and accelerometer**	
|__|	**Urine Specimen**	
|__|	**Blood Draw**	
|__|	**ECG**	
|__|	**Tonometry /Brachial /ECHO**	
|__|	**Spirometry**	
|__|	**Diffusion Capacity**	
|__|__|	**Reason Spirometry not done**	1=Major Surgery, 2=Heart Attack 3=Stroke, 4=Aneurysm, 5=BP>210/110 6=Refused, 7=Test Aborted, 8=Other, 10=equipment problems
|__|__|	**Reason Diffusion not done**	

Exit Interview

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

|__|	Procedure sheet reviewed	
|__|	Referral sheet reviewed	0=No
|__|	Willett dietary questionnaire provided	1=Yes
|__|	Left clinic w/ belongings	
|__|	Coronary Ca CT test brochure given 8=not asked or not eligible	
|__|	Feedback 0=No feedback, 1=Positive feedback, 2=Negative feedback, 3=Other	

Comments_____

_____

_____

_____

TECH02

Respiratory Disease Questionnaire. Technician Administered.

|7|0|2|0|3| FORM NUMBER OMB NO=0925-0216

Respiratory Diagnoses

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

|__| **1. Have you ever had asthma?** 0=No,1=Yes

If yes, fill ▯

|__| Do you still have it?

|__| Was it diagnosed by a doctor or other health professional? 0=No 1=Yes

|__|__| At what age did it start? **(Age in years)**

|__|__| If you no longer have it, at what age did it stop? **(Age in years)** ←88=N/A

|__| Have you received medical treatment for this in the past 12 months?

|__| **2. Have you ever had hay fever** (allergy involving the nose and/or eyes)**?**

|__| **3. Have you ever had bronchitis?** 0=No 1=Yes

|__| **4. Have you ever had pneumonia** (including bronchopneumonia)**?**

5. Have you ever had ….

	Condition?	**Health professional DX?**	**Age condition began**
	(0=No, 1=Yes)		99=Unk
Chronic Bronchitis	|__|	|__|	|__|__|
Emphysema	|__|	|__|	|__|__|
COPD Chronic obstructive pulmonary disease	|__|	|__|	|__|__|
Sleep Apnea	|__|	|__|	|__|__|
Pulmonary Fibrosis	|__|	|__|	|__|__|

6. Have you ever had …

|__| **Any other chest illnesses?** If yes, please specify:_____ 0=No 1=Yes

|__| **Any chest operations?** If yes, please specify:_____

|__| **Any chest injuries?** If yes, please specify:_____

TECH03

Respiratory Disease Questionnaire. Technician Administered.

|7|0|2|0|4| FORM NUMBER OMB NO=0925-0216

Triggered airway symptoms

1. When you are near animals, such as cats, dogs, or horses, near feathers, including pillows, quilts, or in a dusty or moldy part of the house, do you ever

|__| Start to cough?
|__| Start to wheeze?
|__| Get a feeling of tightness in your chest?
|__| Start to feel short of breath?
|__| Get a runny or stuffy nose or start to sneeze?
|__| Get itching or watering eyes?

0=No
1=Yes

2. When you are near trees, grass, or flowers, or when there is a lot of pollen in the air, do you ever

|__| Start to cough?
|__| Start to wheeze?
|__| Get a feeling of tightness in your chest?
|__| Start to feel short of breath?
|__| Get a runny or stuffy nose or start to sneeze?
|__| Get itching or watering eyes?

0=No
1=Yes

3. When you are at your current job, do you ever

|__| Start to cough?
|__| Start to wheeze?
|__| Get a feeling of tightness in your chest?
|__| Start to feel short of breath?
|__| Get a runny or stuffy nose or start to sneeze?
|__| Get itching or watering eyes?

0=No
1=Yes
8=No current job

4. When you are near strong odors such as perfume or bleach, do you ever

|__| Start to cough?
|__| Start to wheeze?
|__| Get a feeling of tightness in your chest?
|__| Start to feel short of breath?

0=No
1=Yes

5. When you exercise or exert yourself or when the air is cold, do you ever

|__| Start to cough?
|__| Start to wheeze?
|__| Get a feeling of tightness in your chest?
|__| Start to feel short of breath?

0=No
1=Yes

|__| **6. Do you currently have a cat, dog, or other furry pets living in your home?**

|__| **7. Have you ever been exposed at work to vapors, gas, dust or fumes?** 0=No,1=Yes 9=Don't know

If yes, fill |__|__| Total years exposed (01=1 year or less) 99=Don't know

TECH04

Sociodemographic questions. Part I Self-administered

|7|0|2|0|7| FORM NUMBER OMB NO=0925-0216

|__| **What is your current marital status?**	
	1=single/never married, 2=married/living as married/living with partner 3=separated 4=divorced 5=widowed 9=prefer not to answer
Which of the following best describes you? (check ALL that apply)	
|__|	Caucasian or white
|__|	Spanish/Hispanic/Latino
|__|	African-American or black
|__|	Asian
|__|	Native Hawaiian or other Pacific Islander
|__|	American Indian or Alaska native
|__|	Other, specify _____
|__|	prefer not to answer
|__| **What is the highest degree or level of school you have completed?** (if currently enrolled, mark the highest grade completed, degree received)	
	0= no schooling 1=grades 1-8 2=grades 9-11 3=completed high school (12th grade) or GED 4=some college but no degree 5=technical school certificate 6=associate degree (Junior college AA, AS) 7=Bachelor's degree (BA, AB, BS) 8=graduate or professional degree (master's, doctorate, MD, etc.) 9=prefer not to answer
|__| **Please choose which of the following best describes your current employment status?**	
	0=homemaker, not working outside the home 1=employed (or self-employed) full time 2=employed (or self-employed) part time 3=employed, but on leave for health reasons 4=employed, but temporarily away from my job 5=unemployed or laid off or full-time student 6=retired from my usual occupation and not working 7= retired from my usual occupation but working for pay 8= retired from my usual occupation but volunteering 9=prefer not to answer 10=unemployed due to disability

SA01

Sociodemographic questions. Part II. Self-administered

|7|0|2|0|8| FORM NUMBER OMB NO=0925-0216

	What is your current occupation? Write in _____
|__||__|	**Using the occupation coding sheet choose the code that best describes your occupation.**
	What is the occupation you have worked in longest? Write in _____
|__||__|	**Using the occupation coding sheet choose the code that best describes the occupation you have worked in longest.**
|__|__|	**Please select which income group best represents your combined family income for the past 12 months.**
	1=under $12,000 2 =$12,000 – $24,999 3 =$25,000 – $49,999 4 =$50,000 – $74,999 5 =$75,000 – $100.000 6 =over $100,000 99=prefer not to answer
|__|__|	**How many people are supported by this income?**

		To help you pay your medical care, do you have Please, circle one on **every line**
YES	**NO**	HMO or other private insurance such as Blue Cross, Aetna, Harvard-Pilgrim, etc
YES	**NO**	Medicare
YES	**NO**	Medicaid
YES	**NO**	Military or Veteran's administration sponsored
YES	**NO**	Other
YES	**NO**	None
YES	**NO**	Prefer not to answer

SA02

SF-12® Health Survey (Standard)
Self-administered

|7|0|2|0|9| FORM NUMBER OMB NO=0925-0216

This questionnaire asks for your views about your health. This information will help you keep track of how you feel and how well you are able to do your usual activities.

Please answer every question by marking one box. If you are unsure about how to answer a question, please give the best answer you can.

1. In general, would you say your health is:

Excellent	Very good	Good	Fair	Poor
☐	☐	☐	☐	☐

The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
2. **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐	☐	☐
3. Climbing **several** flights of stairs	☐	☐	☐

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	Yes	No
4. Accomplished less than you would like	☐	☐
5. Were limited in the **kind** of work or other activities	☐	☐

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	Yes	No
6. Accomplished less than you would like	☐	☐
7. Didn't do work or other activities as **carefully** as usual	☐	☐

SA03

SF-12® Health Survey (Standard)
Self-administered

|7|0|2|1|0| FORM NUMBER OMB NO=0925-0216

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

Not at all	A little bit	Moderately	Quite a bit	Extremely
☐	☐	☐	☐	☐

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks…

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
9. Have you felt calm and peaceful?	☐	☐	☐	☐	☐	☐
10. Did you have a lot of energy?	☐	☐	☐	☐	☐	☐
11. Have you felt downhearted and blue?	☐	☐	☐	☐	☐	☐

12. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐	☐	☐	☐	☐

CES-D Scale (Self-administered)

|7|0|2|1|1| FORM NUMBER OMB NO=0925-0216

Circle the number for each statement which best describes how often you felt or behaved this way DURING THE PAST WEEK.

Circle best answer for each question DURING THE PAST WEEK	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)
1. I was bothered by things that usually don't bother me.	0	1	2	3
2. I did not feel like eating; my appetite was poor.	0	1	2	3
3. I felt that I could not shake off the blues, even with help from my family and friends.	0	1	2	3
4. I felt that I was just as good as other people.	0	1	2	3
5. I had trouble keeping my mind on what I was doing.	0	1	2	3
6.I felt depressed.	0	1	2	3
7. I felt that everything I did was an effort.	0	1	2	3
8. I felt hopeful about the future.	0	1	2	3
9. I thought my life had been a failure.	0	1	2	3
10. I felt fearful.	0	1	2	3
11. My sleep was restless.	0	1	2	3
12. I was happy.	0	1	2	3
13. I talked less than usual.	0	1	2	3
14. I felt lonely.	0	1	2	3
15. People were unfriendly.	0	1	2	3
16. I enjoyed life.	0	1	2	3
17. I had crying spells.	0	1	2	3
18. I felt sad.	0	1	2	3
19. I felt that people disliked me	0	1	2	3
20. I could not "get going"	0	1	2	3

DRAFT

Physical Activity Questionnaire--Framingham Heart Study

Tech-administered

|7|0|2|0|5| FORM NUMBER OMB NO=0925-0216

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

Rest and Activity for a Typical Day (Activities must equal 24 hours)	**Number of hours**
Sleep--Number of hours that you typically sleep?	_____
Sedentary--Number of hours typically sitting?	_____
Slight Activity--Number of hours with activities such as standing, walking?	_____
Moderate Activity--Number of hours with activities such as housework (vacuum, dust, yard chores, climbing stairs; light sports such as bowling, golf)?	_____
Heavy Activity--Number of hours with activities such as heavy household work, heavy yard work such as stacking or chopping wood, exercise such as intensive sports--jogging, swimming etc.?	_____
Total number of hours (should be the total of above items)	**24**

|__|	**What is your normal walking pace outdoors?**
	0 = Unable to walk 1 = Easy, casual, slow (less than 2 miles per hour) 2 = Normal, average (2 to 2.9 miles per hour) 3 = Brisk pace (3 to 3.9 miles per hour) 4 = Very brisk pace (4 to 4.9 miles per hour) 9 = Unknown
|__|	**How many flights of stairs (not steps) do you climb daily?** (10 stairs per flight)
	0 = No flights 1 = 1-2 flights 2 = 3-4 flights 3 = 5-9 flights 4 = 10-14 flights 5 = >15 flights 9 = Unknown

TECH05

Physical Activity Questionnaire--Framingham Heart Study
Tech-administered

|7|0|2|0|6| FORM NUMBER OMB NO=0925-0216

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

DURING THE PAST YEAR, what was your average time PER WEEK spent in each of the following recreational activities?	code 0 Zero	code 1 1-4 min	code 2 5-19 min	code 3 20-59 min	code 4 1 hr	code 5 1-1.5 hr	code 6 2-3 hr	code 7 4-6 hr	code 8 7-10 hr	code 9 11+ hr
Walking for exercise or walking to work	0	1	2	3	4	5	6	7	8	9
Jogging (slower than 10 minute mile)	0	1	2	3	4	5	6	7	8	9
Running (10 minutes/mile or faster)	0	1	2	3	4	5	6	7	8	9
Bicycling (include stationary bike)	0	1	2	3	4	5	6	7	8	9
Tennis, squash, racquetball	0	1	2	3	4	5	6	7	8	9
Lap swimming	0	1	2	3	4	5	6	7	8	9
Other aerobic exercise (aerobic dance, ski or stair machine, etc)	0	1	2	3	4	5	6	7	8	9
Lower intensity exercise (yoga, stretching, toning)	0	1	2	3	4	5	6	7	8	9
Other vigorous exercise (lawn mowing)	0	1	2	3	4	5	6	7	8	9
Weight training including free weights or machines such as nautilus	0	1	2	3	4	5	6	7	8	9

Is there any activity that you do, that is not listed above?
If so, which category would you fit your activity in (from those listed above)

TECH06

Medical History		
HEART PROBLEMS, such as:		
|__|	**Chest pain, angina or angina pectoris**	0=No 1=Yes 2=Don't know
|__|	**Heart attack or myocardial infarction or MI**	
|__|	**Heart failure or congestive heart failure or CHF**	
|__|	**Heart catheterization or cardiac catheterization**	
|__|	**Heart bypass operation or coronary bypass surgery or CABG**	
|__|	**Procedure to unblock vessels to the heart muscle** (PTCA, stent, angioplasty)	
|__|	**Other heart problem** (pacemaker, valve, aorta, etc.)write in_____	
CIRCULATORY PROBLEMS, such as:		
|__|	**Stroke, TIA, sudden paralysis, vision, speech loss**	0=No 1=Yes 2=Don't know
|__|	**Procedure to unblock blood vessels in the neck** (such as carotid endarterectomy)	
|__|	**Poor blood circulation or blockadge to legs/feet**	
|__|	**Amputation of leg or toes, due to poor circulation/gangrene**	
|__|	**Blood clot or embolism in leg or lung**	
|__|	**Other circulation problem** write in_____	
OTHER NEUROLOGICAL PROBLEMS, such as:		
|__|	**Memory problems or dementia**	0=No,1=Yes 2=Don't know
|__|	**Other neurological problems such as Parkinson's**	
|__|	**Have this parent ever had an MRI scan of the head?**	
HAS YOUR PARENT OTHER PROBLEMS		
|__|	**Cancer,** specify site/type_____	0=No,1=Yes 2=Don't know
|__|	**Fracture, broken bone**	
|__|	**Other** write in _____	
|__|	**High blood cholesterol**	0=No,1=Yes 2=Don't know.
|__|	**Hypertension (high blood pressure)**	
|__|	**Diabetes (high blood sugar)**	

TECH08

Vascular Testing

|7|0|2|1|4| FORM NUMBER OMB NO=0925-0216

Exam 2 Framingham Study Vascular Function Participant Worksheet		
	Keyer 1: _____	**Keyer 2: _____**
0 1 9 If yes, ☐discontinue PAT	**Do you have a latex allergy?** (0=No, 1=Yes, 9=Unknown)	
0 1 9 If yes, ☐discontinue brachial	**Do you have active Raynaud's disease, as manifested by daily attacks of Raynaud's currently blue fingers or ischemic finger ulcers?** (0=No, 1=Yes, 9=Unknown)	
0 1 2 3 8 9 If 1(right),☐discontinue brachial If 2(left), ☐**BP on right**	**<u>Women Only</u>: Have you had a radical mastectomy on right side?** A radical mastectomy is the removal of the breast, associated lymph nodes, and underlying musculature. Does NOT include lumpectomy or simple mastectomy. (0=No, 1=Yes, right, 2=Yes, left, 3=Yes, both, 8=Male, 9=Unknown)	
0 1 9 **if yes fill ☐**	**Have you had any caffeinated coffee, caffeinated tea, or other caffeinated drinks in the last 6 hours?** (0=No, 1=Yes, 9=Unknown) |__|__| How many cups? (99=Unkown)	
0 1 9	**Have you eaten anything else this morning?** (0=No, 1=Yes, 9=Unknown)	
0 1 9	**Have you had a fat free cereal bar in clinic?** (0=No, 1=Yes, 9=Unknown)	
0 1 9 **if yes fill ☐**	**Have you smoked cigarettes in the last 6 hours?** (0=No, 1=Yes, 9=Unkn) |__|__|**:**|__|__| If yes, how many hours and minutes since your last cigarette? (99:99=Unknown)	

Tonometry	
|__|__|**/**|__|__|**/**|__|__|	**Date of tonometry scan?** Mo/Day/Yr
|__|__|__|	**Tonometry Sonographer ID**
0 1	**Was tonometry done?** 0= No, test was not attempted or done 1= Yes, test was done, even if all 4 pulses could not be acquired and recorded.

GENERATION 3 EXAM 2 LOG BOOK SHEET FOR TONOMETRY TEST

|7|0|2|1|7| FORM NUMBER OMB NO=0925-0216

Date of Clinic Visit ____ - ____ - _____ **Room #** **108** **106**
Mo Day Yr

TONOMETRY

Test done?	**yes** (test was done, even if all 4 pulses could not be acquired and recorded)	**no** (test was not attempted or done)	**If no , why: Circle all that apply**
30 49 88 740 750 54	**Sonographer ID#**		**1**. Subject refusal **2**. Subject discomfort **3**. Time constraint **4**. Equipment problem, specify _____ **7**. Other, specify _____
|__|__|__|-|__|__|__|	**Video CD#**		
___/____/____	**TONOMETRY test date** if different from Clinic Date above.		

PAT

Test done?	**yes** (test was done) attempted	**yes, partial** (yes, partial test was done but suspect data problems)	**no** (test was not or done)	**If no or partial, why: Circle all that apply**
30 49 88 740 750 54	**Sonographer ID#**			**1**. Subject refusal **2**. Subject discomfort **3**. Time constraint **4**. Equipment problem, specify _____ **5**. test contraindication **7**. Other, specify_____ **8.** Latex allergy
|__|__|__|-|__|__|__|	**Video CD#**			
___/____/____	**PAT test date** if different from Clinic Date above.			

Date of exam

_____/_____/_____

Framingham Heart Study
Gen 3 Exam 2

Summary Sheet to Personal Physician

Blood Pressure	First Reading	Second Reading
Systolic		
Diastolic		

ECG Diagnosis _____

_____

The following tests are done on a routine basis: Blood Glucose, Blood Lipids, Pulmonary Function Test (results enclosed);Echocardiogram findings will be forwarded at a later date **only if <u>abnormal.</u>**

Summary of Findings_____

|__| 1.**No hx or physical exam findings to suggest cardiovascular disease.**
(check box if applicable)

_____

_____

_____

_____

_____

_____

_____

_____
Examining Physician

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

Referral Tracking

|7|0|2|1|5| FORM NUMBER OMB NO=0925-0216

|__| **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
|__|	**Abnormal Urine** result _____
	Write in abnormality
|__|	**ECG abnormality** _____
|__|	**Clinic Physician** _____ **identified medical problem**
|__|	**Other** _____ _____

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

REF01

|7|0|2|1|6| FORM NUMBER OMB NO=0925-0216

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:_____

_____

_____

REF02

Medical History—Hospitalizations, ER Visits, MD Visits

GEN 3 EXAM 2

DATE _____

|7|0|3|0|1| FORM NUMBER OMB NO=0925-0216 (SCREEN 1)

Health Care	
|__|__|__|	**1st Examiner ID** _____ 1st Examiner Name
|__|	**Hospitalization** (not just E.R.**) ever** (0=No; 1=yes, hospitalization, 2=yes, more than 1 hospitalization, 9=Unknown)
|__|	**E.R. Visit ever** (0=No; 1=Yes, 1 or more Emergency Room visit, 9=Unknown)
|__|	**Day Surgery** (0=No, 1=Yes, 9=Unknown)
|__|	**Major illness with visit to doctor** (0=No, 1=Yes, 1 visit; 2=Yes, more than 1 visit; 9=Unk)
|__|	**Check up** by doctor in past 5 years (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

|7|0|3|0|2| FORM NUMBER OMB NO=0925-0216 (SCREEN 2)

|__| **If yes, fill**	**Take aspirin regularly**? (0=No, 1=Yes, 9=Unk)	
	|__|__|	**Number aspirins taken regularly** (99=Unknown)
	|__|	**Frequency per** (1=Day, 2=Week 3=Month, 4=Year, 9=Unk)
	|__|__|__|	**Usual dose (** 081=baby,160=half dose, 325=nl, 500=extra or larger,999=unk)

|__| **If yes, fill**	**Have you ever taken medication for hypertension/high blood pressure?** (0=no, 1=yes,now, 2=yes,not now, 9=unk)	
	|__|__|	At what age did you begin taking medicine for this (99=unk)
|__| **If yes, fill**	**Have you ever taken medication for high blood cholesterol?** (0=no, 1=yes, now, 2=yes,not now, 9=unk)	
	|__|__|	At what age did you begin taking medicine for this (99=unk)
|__| **If yes, fill**	**Have you ever taken medication for high blood sugar or diabetes?** (0=no, 1=yes,now, 2=yes,not now, 9=unk)	
	|__|__|	At what age did you begin taking medicine for this (99=unk)
	|__|	Was insulin your first diabetes medication? (0=no, 1=yes, 9=unk)
	|__|	Did diabetes occur in pregnancy only (0=no, 1=yes, 9=unk)
|__| **If yes, fill**	**Have you ever taken medication for cardiovascular disease**(for example angina/chest pain,heart failure, atrial fibrillation/heart rhythm abnormality, stroke, leg pain when walking? (0=no, 1=yes,now, 2=yes,not now, 9=unk)	
	|__|__|	At what age did you begin taking medicine for this (99=unk)

Medical History – Prescription and Non-Prescription Medications

|7|0|3|0|3| FORM NUMBER OMB NO=0925-0216 (SCREEN 3)

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 bag with meds brought to exam?**	0=No, 1=Yes

*****List medications taken regularly in past month/ongoing medications*****

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	

Continue on the next page

Medical History—Prescription and Non-Prescription Medications
Continue from screen 3.

|7|0|3|0|4| FORM NUMBER OMB NO=0925-0216 (SCREEN 4)

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.

*****List medications taken regularly in past month/ongoing medications*****

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	9
			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	
			D W M	

MD04

Medical History–Female Reproductive History. Part 1.

|7|0|3|0|5| FORM NUMBER OMB NO=0925-0216 (SCREEN 5)

If participant is male, leave questions blank

|__|__|	**1.How old were you when you had your first menstrual period (menses)?** (0=never, 9 or less, 10, 11, 12, 13, 14, 15, 16, 17,or older, 99=unknown)
|__| **If yes, fill**	**2.Have you ever taken or used oral contraceptive pills, shots, or hormone implants for birth control or medical indications (not post menopausal hormone replacement)?** (0=no, 1=yes, now, 2=yes, not now, 9=unknown)
	What is the name of the **current or most recent** oral contraceptive, shot or implant used?
	_____ Name
	_____ Strength
	|__| Form (1=pill, 2=shot, 3=patch, 4=implant)
	____/_____, ____/_____ Duration of use (mo/yr began, mo/yr ended, year – 4 digits) 99/9999=Unknown, **88/8888=current user**
	|__|__| What is the total number of years over your lifetime that you used oral contraceptive pills, shots, or hormone implants? (1=1year or less)
|__| **If yes, fill**	**3,Have you ever been pregnant?** (0=no, 1=yes, 9=Unkn))
	|__|__| Number of pregnancies?
	|__|__| Number of live births?
	|__|__| How old were you at the end of your first term pregnancy? 99=unknown
	|__|__| How old were you at the end of your last term pregnancy? 99=unknown
	|__| During any of these pregnancies, were you told you had hypertension(high blood pressure)? (0=no,1=yes,1st pregnancy only,2=yes,not 1st pregnancy,3=yes,1st & subsequent pregnancy, 9=unknown)
|__| **If yes, fill**	**4.Have you had a hysterectomy (uterus/womb removed)?** (0=no, 1=yes, 9=unknown)
	|__|__| Age at hysterectomy?
	_ _/_ _ _ _ Date of surgery (mo/yr) Use 4 digits for year 99/9999=Unknown
|__| **If yes, fill**	**5.Have you ever had an operation to remove one or both of your ovaries?** (0=no, 1=yes, one ovary removed, 2=yes, two ovaries removed, 3=yes, unknown number of ovaries removed, 4=yes, part of an ovary removed, 9=unknown)
	|__|__| Age when ovaries removed? If more than one surgery, **use age at last surgery**

MD05

Medical History–Female Reproductive History. Part 2.

|7|0|3|0|6| FORM NUMBER OMB NO=0925-0216
(SCREEN 6)

|__|	**6. Have your periods stopped (for one year or more)? (Have you reached menopause?)** (0=not stopped, pregnant, breast feeding, 1=stopped but now have periods induced by hormones, 2=yes stopped>1 year, 3=yes stopped<1 year, 9=unknown)

Please fill in only one of the boxes below, not both!

IF PERIODS NOT STOPPED (!pre-menopausal, pregnant, breast feeding!)

__/__/_ _ _ **When was the first day of your last menstrual period?**(Use 4 digits for year, 99/9999=Unknown

|__|__| **Normally how many days are there between your periods (start to start)?**

|__|__| **How many periods have you had in past 12 months?**

IF PERIODS STOPPED (post-menopausal, post-menopausal on hormone replacement, or peri-menopausal on horm.repl.)

|__|__|	**a) Age when periods stopped** (00=not stopped, 99=unknown) **!** If periods now induced by hormones, code age when periods naturally stopped.
|__|	**b) Was your menopause natural or the result of surgery, chemotherapy, or radiation?** (1=natural, 2=surgical, 3=chemo/radiation, 4=other, 9=unknown)
|__|	**c) Have you ever taken hormone replacement therapy?** (estrogen/progesterone) (0=no, 1=yes, now, 2=yes, not now, 9=unknown)
If yes, fill	|__|__| **What age did you begin hormone replacement therapy?** 99=unknown |__|__| years |__|__| months **For how long did you take hormones?** 99/99=unknown
	|__| **Estrogen use ever?** (0=no, 1=yes, now, 2=yes, not now, 9=unknown) **If yes, fill** _ _____ Name of most recent estrogen preparation _____ Strength |__|__| Number of days per month taken
	|__| **Progesterone use ever?** (0=no, 1=yes, now, 2=yes, not now, 9=unknown) **If yes, fill** _____ Name of most recent progesterone preparation |__|__| . |__|__| Strength |__|__| Number of days per month taken
|__| **If yes, fill**	**d) Have you used Evista (raloxifene) or Nolvadex (tamoxifen) or other selective estrogen receptor Modulator (SERM)?** (0=no, 1=yes, now, 2=yes, not now, 9=unknown)
	|__|__|__| **Number of months used?** |__| **Current use?** (0=no, 1=yes, raloxifene, 2=yes, tamoxifen, 3=yes, other, 9=unknown)
|__| **If yes, fill**	**e) Do you take over-the-counter alternative, herbal, or natural soy-based preparations to treat menopausal symptoms?** (0=no, 1=yes, 9=unknown)
	Specify preparation_____

|7|0|3|0|7| FORM NUMBER OMB NO=0925-0216 (SCREEN 7)

Medical History--Smoking

Cigarettes

|__| **Have you ever smoked cigarettes regularly?** (No means less than 20 packs of cigarettes or 12 oz of tobacco in a lifetime or less than 1 cigarette a day for 1 year.) (0=no, 1=yes, 9=unk)

If yes, fill

|__| Have you smoked cigarettes regularly in the last year?

|__| Do you now smoke cigarettes (as of 1 month ago)?

|__|__| How many cigarettes do you smoke per day now?

|__|__| On the average of the entire time you smoked, how many cigarettes did you smoke per day?

|__|__| How old were you when you first started regular cigarette smoking? (99=Unk.)

|__|__| If you have stopped smoking cigarettes completely, how old were you when you stopped? (Age stopped, 00=not stopped, 99=Unk)

|__| When you were smoking, did you ever stop smoking for >6 months?

If yes, fill

|__|__| For how many years in total did you stop smoking cigarettes (00=never stopped)

Pipes

|__| **Have you ever smoked a pipe regularly?** (Yes means more than 12oz of tobacco in a lifetime.) (0=no, 1=yes, 9=unk)

If yes, fill

|__| Have you smoked a pipe regularly in the last year?

|__| Do you now smoke a pipe (as of 1 month ago)?

|__|__| How much pipe tobacco do you smoke per day now? (oz. Per week)

|__|__| On the average of the entire time you smoked a pipe how much pipe tobacco did you smoke per week? (oz./week, a standard pouch of tobacco contains 1 1/2 oz.)

|__|__| How old were you when you first started to smoke a pipe? (99=Unk.)

|__|__| If you have stopped smoking a pipe completely, how old were you when you stopped? (Age stopped, 00=not stopped, 99=Unk)

|__| When you were smoking a pipe, did you ever stop smoking for >6 months?

If yes, fill

|__|__| For how many years in total did you stop smoking a pipe?(00=never stopped)

MD07

|7|0|3|0|8| FORM NUMBER OMB NO=0925-0216 (SCREEN 8)

Medical History--Smoking

Cigars

|__| **Have you ever smoked cigars regularly?** (Yes means more than 1 cigar/week for a year) (0=no, 1=yes, 9=unk)

If yes, fill

- |__| Have you smoked cigars regularly in the last year?
- |__| Do you now smoke cigars (as of 1 month ago)?
- |__|__| How many cigars do you smoke per week now?
- |__|__| On the average of the entire time you smoked cigars, how many cigars did you smoke per week?
- |__|__| How old were you when you first started to smoke cigars regularly? (99=Unk.)
- |__|__| If you have stopped smoking cigars completely, how old were you when you stopped? (Age stopped, 00=not stopped, 99=Unk)
- |__| When you were smoking cigars, did you ever stop smoking for >6 months?

If yes, fill

- |__|__| For how many years in total did you stop smoking cigars (00=never stopped)

Passive smoking exposure.

|__| **In your childhood, did you live with a regular cigarette smoker who smoked in your home?** (0=no, 1=yes, 9=unk)

If yes, fill

- |__| Mother smoked?
- |__| Father smoked?
- |__| Others in Household smoked?

If yes to OTHERS, fill

- |__|__| How many others?

|__| **As an adult, now or in the past, have you ever lived with a regular cigarette smoker who smoked in your home?** (0=no, 1=yes, 9=unk)

If yes, fill

- |__| Spouse or Partner? |__|__| Years of exposure
- |__| Others in household? |__|__| Years of exposure

|__| **Currently, when you are not at home, do you regularly spend time indoors where there are people smoking cigarettes?** (0=no, 1=yes, 9=unk)

If yes, fill

- |__| At Work? |__|__| Years of exposure
- |__| Other than work? |__|__| Years of exposure

Medical History –Alcohol Consumption.

|7|0|3|0|9| FORM NUMBER OMB NO=0925-0216 (SCREEN 9)

|__| **if yes fill**	**Have you ever consumed alcoholic beverages** (beer, wine, liquor/spirits)? (0=no,1=yes,9=unknown)	
	|__|__|	How old were you when you first started drinking alcoholic beverages? (99=unknown)

Do you drink any of the following beverages at least once a month?

Drink? 0=No, 1=Yes, 9=Ukn	Beverage	If yes, complete for number of drinks in a typical week/month over past year. *Code EITHER per week OR per month as appropriate.*			
			Number of drinks		Usually with meals
			Per week **OR** Per month 999=Unk		0=No, 1=Yes
|__|	Beer	12oz bottle, glass, can	|__|__|__|	|__|__|__|	|__|
|__|	White wine	4oz glass	|__|__|__|	|__|__|__|	|__|
|__|	Red wine	4oz glass	|__|__|__|	|__|__|__|	|__|
|__|	Liquor/ spirits	1 ¼ oz jigger	|__|__|__|	|__|__|__|	|__|
|__|	Other	Specify _____	|__|__|__|	|__|__|__|	|__|

|__|__|	**At what age did you stop drinking alcohol?** (00= not stopped, 99=Unknown)

|__|	**Over the past year, on average on how many days per week did you drink an alcoholic beverage of any type?** (1=1or less, 9=Unknown)
|__|__|	**Over the past year, on a typical day when you drink, how many drinks do you have?** (99=Unknown)
|__|__|	**What was the maximum number of drinks you had in 24 hr. period during the past month?** (99=Unknown)
|__|	**Has there ever been a time in your life when you drank 5 or more alcoholic drinks of any kind almost daily?** (0=no, 1=yes, 9=unknown**)**

MD09

Medical History—Respiratory Symptoms. Part I

|7|0|3|1|0| FORM NUMBER OMB NO=0925-0216 (SCREEN 10)

Cough

|__| **During the past 12 months, have you had a cough apart from colds?** (Count a cough when you first go outdoors or first smoke. Exclude clearing of throat)

|__| **During the past 12 month, have you had a cough 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 on most days (4 or more days/week) for three months or more during the past 12 months?

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

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

# of years

Phlegm

|__| **During the past 12 months, have you brought up phlegm from your chest apart from colds?** (Exclude phlegm from the nose)

|__| **During the past 12 month, have you brought up phlegm from your chest 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 months or more during the past 12 months?

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

|__| **Have you ever had wheezing or whistling in your chest?**

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

if yes, fill all

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

|__| 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

Medical History—Respiratory Symptoms. Part II

|7|0|3|1|1| FORM NUMBER OMB NO=0925-0216 (SCREEN 11)

Sleep Related Symptoms (days/nights)

|__| **In the past 12 months, on average how many nights a week did you snore?**	0=Never 1=Rarely(1-2 nights/week) 2=Occasionally(3-4 nights/week) 3=Frequently(5/more nights/week) 9=Unknown Use coding for nights OR days.
|__| **In the past 12 months, on average how many nights a week do you snort, gasp, or stop breathing while you are asleep?**	
|__| **In the past 12 months, on average how many days a week have you had excessive (too much) daytime sleepiness?**	

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?**		0=No 1=Yes 9=Don't know
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?	
|__| **Do you/have you needed to sleep on two or more pillows to help you breath?** (Orthopnea)		
|__| **Have you ever had swelling in both your ankles (ankle edema)?**		
|__| **Have you been told you had heart failure or congestive heart failure?**		
|__| **Have you been hospitalized for heart failure?**		

Examiner's opinion:

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

Comments_____

Medical History—Chest pain

7|0|3|1|2| FORM NUMBER OMB NO=0925-0216 (SCREEN 12)

|__|	**Any chest discomfort** (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, Use 4 digits for year, 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 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

|__|	**Have you ever been told by a doctor you had a heart attack or myocardial infarction?**	0=No, 1=Yes, 2=Maybe 9=Unknown

CHD First Opinions		
|__|	**Angina pectoris**	(0=No, 1=Yes, 2=Maybe, 9=Unknown)
|__|	**Angina pectoris since revascularization procedure**	
|__|	**Coronary insufficiency**	
|__|	**Myocardial infarct**	

Comments_____

_____

_____

_____

MD12

Medical History—Atrial Fibrillation/Syncope

|7|0|3|1|3| FORM NUMBER (SCREEN 13) OMB NO=0925-0216

|__| **Have you been told you have/had 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 ever fainted or lost consciousness?** 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) 1=1 min or less

|__| **Did you have any injury caused by the event?**(0=No,1=Yes, 2=Maybe,9=Unkn)

|__| **ER/hospitalized or saw M.D.** (0=No, 1=Hosp/ER, 2=Saw M.D., 9=Unkn)

Hospitalized at: _____

M.D. seen: _____

|__| **History of ever having a head injury with loss of consciousness** (0=No, 1=Yes, 2=Maybe, 9=Unknown)

if yes, fill

|__|__|*|__|__|*|__|__|__|__| mm dd yyyy — Date of serious head injury with loss of consciousness (00/00/0000 =none, 99/99/9999=unk, Use 4 digits for year)

|__| **History of a seizure disorder.**.Have you ever had a seizure? (0=No, 1=Yes, 2=Maybe,, 9=Unknown)

if yes, fill

|__|__|*|__|__|*|__|__|__|__| mm dd yyyy — Date of most recent seizure (99/99/9999=unk) code four digit year

|__| — Are you being treated for a seizure disorder? (0=No, 1=Yes, 2=Maybe, 9=Unknown)

Syncope First Opinions

|__| **Syncope** (0=No, 1=Yes, 2=Maybe, 3=Presyncope, 9=Unknown) needs second opinion

|__|	**Cardiac syncope**	(0=No, 1=Yes, 2=Maybe, 9=Unknown)
|__|	**Vasovagal syncope**	
|__|	**Other-Specify: _____**	

Comments:_____

_____

_____

MD13

Medical History—Cerebrovascular Disease

|7|0|3|1|4| FORM NUMBER OMB NO=0925-0216 (SCREEN 14)

Cerebrovascular Episodes

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

|__| **Sudden muscular weakness**

|__| **Sudden speech difficulty**

|__| **Sudden visual defect**

|__| **Sudden double vision**

|__| **Sudden loss of vision in one eye**

|__| **Sudden numbness, tingling**

if yes, fill

|__| Numbness and tingling is positional

|__| **Head CT or MRI scan** (date/place_____)
(0=No, 1=CT, 2=MRI, 3=both, 9=Unknown)

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

Neurology First Opinions

|__| **TIA or stroke took place**
(0=No, 1=Yes, 2=Maybe, 9=Unknown)

if yes or maybe fill

|__|__|*|__|__|__|__| **Date** (mo/yr, Use 4 digits for year, 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 Comments_____

_____

_____

_____

MD14

Medical History--Venous and Peripheral Arterial Disease

|7|0|3|1|5| FORM NUMBER OMB NO=0925-0216 (SCREEN 15)

Venous Disease

|__|	**Have you ever had a Deep Vein Thrombosis (blood clots in legs or arms)**	0=No, 1=Yes, 2=Maybe, 9=Unknown
|__|	**Have you ever had a Pulmonary Embolus** (blood clot in lungs)	

Peripheral Arterial Disease

|__| **Do you have lower limb (leg) discomfort while walking?** (0=No, 1=Yes, 9=Unkn)

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** (Use 4 digits for year ,00=no, 9999=unkn)

Left	Right	**Claudication symptoms (0=No, 1=Yes, 9=Unkn)**
|__|	|__|	Discomfort in calf while walking
|__|	|__|	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 (00=No, 88=N/A, 99=Unknown)

PAD First Opinion

|__| **Intermittent Claudication** (0=No, 1=Yes, 2=Maybe, 9=Unknown)

Comments Peripheral Vascular Disease / Venous Disease_____

_____

_____

_____

MD15

Medical History-- CVD Procedures

|7|0|3|1|6| FORM NUMBER OMB NO=0925-0216 (SCREEN 16)

Coding: 0=No, 1=Yes 2=Maybe, 9=Unkn	**Cardiovascular Procedures (if procedure was repeated code only first and provide narrative) (write 4 digits for year, i.e. 1998, 1999, 2000)**
|__| **if yes fill**	**Heart Valvular Surgery**
	|__|__|__|__| Year done (9999-Unk) Location and description_____
|__| **if yes fill**	**Exercise Tolerance Test**
	|__|__|__|__| Year done (9999-Unk) Location_____
|__| **if yes fill**	**Coronary arteriogram**
	|__|__|__|__| 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_____

Write in other procedures, year done, location if more than one.

Comments:_____

_____

_____

_____

MD16

Cancer Site or Type

|7|0|3|1|7| FORM NUMBER OMB NO=0925-0216 (SCREEN 17)

|__| **Have you ever had cancer or a tumor?**
(0=No and skip to next screen; If 1=Yes, 2=Maybe, 9=Unknown please continue)

Code for table: 0=No, 1=Yes, Cancerous, 2=Maybe, Possible Cancer, 3=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)

_____

_____

_____

_____

_____

Physical Exam--Head, Neck and Respiratory

|7|0|3|1|8| FORM NUMBER OMB NO=0925-0216 (SCREEN 18)

Physician **Blood Pressure** (first reading)			
Systolic	**Diastolic**	**BP cuff size**	**Protocol modification**
|__|__|__| to nearest 2 mm Hg	|__|__|__| to nearest 2 mm Hg	|__| 0=pedi,1=reg.adult, 2=large adult, 3= thigh, 9=unknown	|__| 0=No, 1=Yes, 9=Unknown

Respiratory		
|__|	**Wheezing on auscultation**	0=No, 1=Yes, 2=Maybe, 9=Unknown
|__|	**Rales**	
|__|	**Abnormal breath sounds**	

Comments about Respiratory_____

_____

_____

_____

_____

MD18

Physical Exam—Heart and Abdomen

|7|0|3|1|9| FORM NUMBER OMB NO=0925-0216 (SCREEN 19)

Heart		
|__|	**Left Heart Enlargement**	0=No 1=Yes 9=Unknown
|__|	**Right Heart Enlargement**	
|__|	**S3 Gallop**	
|__|	**S4 Gallop**	
|__|	**Systolic Click**	0=No 1=Yes 2=Maybe 9=Unknown
|__|	**Neck vein distention at 90 degrees** (sitting upright)	
|__|	**Other--Specify** _____	

|__| **if yes, fill out below**	**Systolic murmur(s)** (0=No, 1=Yes, 2=Maybe, 9=Unknown)				
Murmur Location	**Grade** 0=No sound 1 to 6 for grade of sound heard 9=Unknown	**Type** 0=None 1=Ejection 2=Regurgitant 3=Other 9=Unknown	**Radiation** 0=None 1=Axilla 2=Neck 3=Back 4=Rt. chest 9=Unknown	**Valsalva** 0=Nochange 1=Increase 2=Decrease 9=Unknown	**Origin** 0=None, indet. 1=Mitral 2=Aortic 3=Tricuspid 4=Pulm 9=Unknown
Apex	|__|	|__|	|__|	|__|	|__|
Left Sternum	|__|	|__|	|__|	|__|	|__|
Base	|__|	|__|	|__|	|__|	|__|

|__|	**Diastolic murmur(s)** (0=No, 1=Yes, 2=Maybe, 9=Unknown)
if yes, fill	|__| Valve of origin for diastolic murmur(s) (0=No, 1=Mitral, 2=Aortic, 3=Both, 4=Other, 8=N/A, 9=Unk)

Comments_____

_____

_____

Abdominal Abnormalities		
|__|	**Liver enlarged**	0=No 1=Yes 2=Maybe 9=Unknown
|__|	**Surgical scar**	
|__|	**Abdominal aneurysm**	
|__|	**Abdominal bruit**	

Physical Exam--Peripheral Vessels--Part I

|7|0|3|2|0| FORM NUMBER OMB NO=0925-0216 (SCREEN 20)

Left	Right	Varicosities	
|__|	|__|	**Stem varicose veins** (Do not code reticular or spider varicosities)	0=No abnormality 1=Uncomplicated 2=With skin changes 3=With ulcer 9=Unknown
Left	**Right**	**Lower Extremity Abnormalities**	
|__||	|__||	**Ankle edema**	(0=No, 1=Yes, 2=Maybe, 8=absent due to amputation 9=Unknown)
|__|	|__|	**Amputation level**	(0=No, 1=Toes only, 2=Ankle, 3=Knee, 4=Hip, 8=Not applicable, 9=Unknown)

Comments_____

_____

Physical Exam--Peripheral Vessels--Part II

Artery	Pulse		Bruit	
	(0=Normal, 1=Abnormal, 9=Unknown)		(0=Normal, 1=Abnormal, 9=Unknown)	
	Left	Right	Left	Right
Femoral	|__|	|__|	|__|	|__|
Popliteal			|__|	|__|
Post Tibial	|__|	|__|		
Dorsalis Pedis	|__|	|__|		

Comments_____

_____

_____

MD20

Physical Exam--Neurological Diseases and Final Blood Pressure

|7|0|3|2|1| FORM NUMBER OMB NO=0925-0216 (SCREEN 21)

Neurological Exam			
Left	**Right**		
|__|	|__|	**Carotid Bruit**	Coding (0=No, 1=Yes, 2=Maybe, 9=Unknown)
	|__|	**Speech disturbance**	
	|__|	**Disturbance in gait**	
	|__|	**Other neurological abnormalities on exam** Specify_____	

Physician **Blood Pressure** (second reading)			
Systolic	**Diastolic**	**BP cuff size**	**Protocol modification**
|__|__|__| to nearest 2 mm Hg 999=Unknown	|__|__|__| to nearest 2 mm Hg 999=Unknwon	|__| 0=pedi,1=reg.adult, 2=large adult, 3= thigh, 9=Unknown	|__| 0=No, 1=Yes, 9=Unknown

Write in protocol modification_____

_____

_____

_____

MD21

Electrocardiograph--Part I

|7|0|3|2 |2 | FORM NUMBER OMB NO=0925-0216 (SCREEN 22)

|__| **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 (hundreths of a second)** (99=Fully Paced, Atrial Fib, or Unknown)
|__|__|	**QRS interval (hundreths of second)** (99=Fully Paced, Unknown)
|__|__|	**Q-T interval (hundreths 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)

MD22

Electrocardiograph-Part II

|7|0|3|2|3| FORM NUMBER OMB NO=0925-0216 (SCREEN 23)

	Myocardial Infarction Location	
|__|	**Anterior**	**(0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unknown)**
|__|	**Inferior**	
|__|	**True Posterior**	
	Left Ventricular Hypertrophy Criteria	
|__|	**R > 20mm in any limb lead**	**(0=No, 1=Yes, 9=Fully paced, Complete LBBB or Unk)**
|__|	**R > 11mm in AVL**	
|__|	**R in lead I plus S in lead III ≥ 25mm**	
	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	
|__|	**R≥ 25mm**	**(0=No, 1=Yes, 9=Fully paced, Complete LBBB or Unk)**
|__|	**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_____

_____

MD23

Clinical Diagnostic Impression--Part I

|7|0|3|2|4| FORM NUMBER OMB NO=0925-0216 (SCREEN 24)

Heart Diagnoses First Examiner Opinions		
|__|	**Rheumatic Heart Disease**	**0=No, 1=Yes, 2=Maybe, 9=Unknown**
|__|	**Aortic Valve Disease**	
|__|	**Mitral Valve Disease**	
|__|	**Other Heart Disease (includes congenital)**	
|__|	**Arrhythmia**	

Peripheral Vascular Disease First Examiner Opinions		
|__|	**Other Peripheral Vascular Disease**	**0=No, 1=Yes, 2=Maybe, 9=Unknown**
|__|	**Other Vascular Diagnosis**	
	(Specify)_____	

Neurologic Disease First Examiner Opinions		
|__|	**Stroke/ TIA**	**0=No, 1=Yes, 2=Maybe, 9=Unknown**
|__|	**Dementia**	
|__|	**Parkinson's Disease**	
|__|	**Adult Seizure Disorder**	
|__|	**Other Neurological Disease**	
	(Specify)_____	

Comments CDI

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MD24

Clinical Diagnostic Impression--Part II

Non Cardiovascular Diagnoses First Examiner Opinions

|7|0|3|2|5| FORM NUMBER OMB NO=0925-0216 (SCREEN 25)

Endocrine		
|__|	**Thyroid Disease**	**0=No, 1=Yes, 2=Maybe, 9=Unknown**
|__|	**Diabetes Mellitus**	
|__|	**Other endocrine disorders,** specify_____	
GU/GYN		
|__|	**Renal disease,** specify_____	**0=No, 1=Yes, 2=Maybe, 9=Unknown**
|__|	**Prostate disease**	
|__|	**Gynecologic problems,** specify_____	
Pulmonary		
|__|	**Emphysema**	**0=No, 1=Yes, 2=Maybe, 9=Unknown**
|__|	**Pneumonia**	
|__|	**Asthma**	
|__|	**Other pulmonary disease,** specify_____	
Rheumatologic Disorders		
|__|	**Gout**	**0=No, 1=Yes, 2=Maybe, 9=Unknown**
|__|	**Degenerative joint disease**	
|__|	**Rheumatoid arthritis**	
|__|	**Other musculoskeletal or connective tissue disease,**specify_____	
GI		
|__|	**Gallbladder disease**	**0=No, 1=Yes, 2=Maybe, 9=Unknown**
|__|	**GERD/ulcer disease**	
|__|	**Liver disease**	
|__|	**Other GI disease,** specify_____	
Blood		
|__|	**Hematologic disorder**	**0=No, 1=Yes, 2=Maybe, 9=Unk**
|__|	**Bleeding disorder**	
Other		
|__|	**Eye**	**0=No, 1=Yes, 2=Maybe, 9=Unknown**
|__|	**ENT**	
|__|	**Skin**	
|__|	**Other,** specify_____	
Infectious Disease		
|__|	**HIV**	**0=No, 1=Yes, 2=Maybe, 9=Unknown**
|__|	**TB**	
|__|	**Other,** specify_____	
Mental Health		
|__|	**Depression**	**0=No, 1=Yes, 2=Maybe, 9=Unknown**
|__|	**Anxiety**	
|__|	**Psychosis**	
|__|	**Other,** specify_____	

Comments CDI Diagnoses_____

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MD25
Second Examiner Opinions

|7|0|3|2|6| FORM NUMBER OMB NO=0925-0216 (SCREEN 26)

|__|__|__|	**2nd Examiner ID Number**	_____**2nd Examiner Last Name**

Coronary Heart Disease Second Examiner Opinions (Provide initiators, qualities, radiation, severity, timing, presence after procedures done)		
|__|	**Congestive Heart Failure**	0=No, 1=Yes, 2=Maybe, 9=Unknown
|__|	**Cardiac Syncope**	
|__|	**Angina Pectoris**	
|__|	**Coronary Insufficiency**	
|__|	**Myocardial Infarct**	

Comments about chest and heart disease

Intermittent Claudication Second Examiner Opinions (Provide initiators, qualities, radiation, severity, timing, presence after procedures done)		
|__|	**Intermittent Claudication**	0=No, 1=Yes, 2=Maybe, 9=Unknown

Comments about peripheral vascular disease

Cerebrovascular Disease Second Examiner Opinions (Provide initiators, qualities, severity, timing, presence after procedures done)		
|__|	**Stroke**	0=No, 1=Yes, 2=Maybe, 9=Unknown
|__|	**TIA**	

Comments about possible Cerebrovascular Disease

MD26