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HCHS/SOL Medical/Family History Questionnaire

ID NUMBER:

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

Contact Occasion

SEQ #

Acrostic: _____

ADMINISTRATIVE INFORMATION

0a. Completion Date: //

0b. Staff ID:

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

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

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

No 0
Yes 1

→ **FOR WOMEN: GO TO QUESTION 1a**

1a. Was this during pregnancy only?

No 0
Yes 1

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

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

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

No 0
Yes 1

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

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

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

No 0 → **GO TO QUESTION 3b**
Yes 1

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

Age in years

Has a doctor ever said that these relatives had angina?

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

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

No 0 → **GO TO QUESTION 4b**
Yes 1

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

Age in years

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

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

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

No 0
Yes 1

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

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

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

No 0
Yes 1

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

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

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

No 0
Yes 1

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

No 0
Yes 1

If yes, please specify: _____

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

No 0
Yes 1

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24. Have you ever been told by a doctor that you have a sleep disorder?

No 0 → **GO TO QUESTION 27**

Yes 1

Don't know 9 → **GO TO QUESTION 27**

25. Which sleep disorder(s)? (Mark all that apply)

a. Insomnia

b. Restless legs

c. Narcolepsy

d. Apnea

e. Other

If other, please specify: _____

26. Have you been prescribed a CPAP or BIPAP machine, or a device to wear in your mouth to treat your sleep apnea?

No 0

Yes 1

27. Has a doctor ever said that you have cancer or a malignant tumor?

No 0 → **GO TO QUESTION 27b**

Yes 1

27a. What type? (Mark all that apply)

a. Lung

b. Breast

c. Cervical

d. Blood/lymph glands

e. Testes/scrotum

f. Bone

g. Melanoma

h. Skin (not melanoma)

i. Brain

j. Stomach

k. Colon

l. Uterine

m. Prostate

n. Other

Has a doctor ever said that these relatives had cancer or a malignant tumor?

27b. Mother No or Don't know 0 Yes 1

27c. Father No or Don't know 0 Yes 1

27d. Brother(s) or sister(s) No or Don't know 0 Yes 1

MEN → STOP, END QUESTIONNAIRE

WOMEN → GO TO QUESTION 28

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

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

If other hormone combination, please specify: _____