OMB#: 0925-0584
Exp. XX/XXXX

OMB#: 0925-0584
Exp. X/XX/XXXX

HCHS/SOL Physician Questionnaire

ID NUMBER:									FORM CODE: PQE VERSION: A 10/20/2008	Contact Occasion		SEQ #	

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ 0b. Staff ID: ☐☐☐

Instructions: Please complete the following questions to the best of your ability by filling in the appropriate bubbles or writing the answer in the blank provided. Please return completed forms in the self addressed stamped envelope provided.

DETAILS OF DEATH

1. Are you familiar with the events surrounding the decedent's death?

No 0 ☐
Yes 1 ☐

2. Did you witness the death?

No 0 ☐
Yes 1 ☐

If informant answered "Yes" to one or both of Items 1 and 2, please skip to Item 4.

3. If you answered "No" to both Questions, are you aware of another physician who could provide information regarding the death?

No 0 ☐ Please sign and date the bottom of this form
Yes 1 ☐

3a. Provide contact information. Please then sign and date the bottom of this form.

Name of physician: _____

Address: _____

_____

_____

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CIRCUMSTANCES SURROUNDING DEATH

4. What do you believe to be the underlying cause of death?

Acute Myocardial Infarction	0	☐	
Other Ischemic Heart Disease	1	☐	
Cerebrovascular Disease	2	☐	
Other Cardiovascular Disease	3	☐	
Emphysema, chronic bronchitis or chronic obstructive pulmonary disease (COPD)	4	☐	
Pneumonia	5	☐	
Asthma	6	☐	
Other Lung Disease	7	☐	specify: _____
Non Cardio - Pulmonary Disease	8	☐	specify: _____

5. Please specify the time between the onset of the acute episode of symptoms and death. (We are defining death as the point where spontaneous breathing ceased and the patient never recovered.) Please check the appropriate time period.

Less than 5 minutes	0	☐
5 minutes to 1 hour	1	☐
1 hour to 24 hours	2	☐
More than 24 hours	3	☐
1 day to 3 days	4	☐
More than 3 days	5	☐
Unknown	6	☐

6. Was there an acute episode of pain in the chest, left arm or jaw during the last 72 hours prior to death?

No	0	☐
Yes	1	☐
Unknown	2	☐

7. Was there an acute episode of shortness of breath during the 72 hours prior to death?

No	0	☐
Yes	1	☐
Unknown	2	☐

8. Was there an acute episode of wheezing during the 72 hours prior to death?

No	0	☐
Yes	1	☐
Unknown	2	☐

9. Did the decedent take or was s/he given nitrates or nitroglycerin at the time of the acute episode?

No	0	☐
Yes	1	☐
Unknown	2	☐

MEDICAL HISTORY

10. Are you familiar with the decedent's medical history?

No	0	☐ End questionnaire
Yes	1	☐

11. Did the decedent have a medical history of any of the following conditions prior to the acute event which led to death?

11a. Myocardial Infarction (MI)?

No	0	☐ Skip to 11b
Yes	1	☐
Unknown	2	☐ Skip to 11b

i. Date of most recent MI: ☐☐/☐☐/☐☐☐☐

11b. Angina Pectoris, Coronary Insufficiency or Other Chronic Ischemic Heart Disease?

No	0	☐ Skip to 11c
Yes	1	☐
Unknown	2	☐ Skip to 11c

i. Date of first diagnosis: ☐☐/☐☐/☐☐☐☐

11c. Congestive Heart Failure (CHF) or Congestive Cardiomyopathy?

No	0	☐ Skip to 11d
Yes	1	☐
Unknown	2	☐ Skip to 11d

i. Date of first exacerbation: ☐☐/☐☐/☐☐☐☐

11d. Stroke (CVA)?

No	0 ☐	Skip to 11e
Yes	1 ☐	
Unknown	2 ☐	Skip to 11e

i. Date of most recent CVA: ☐☐/☐☐/☐☐☐☐

11e. Transient Ischemic Attack (TIA)?

No	0 ☐	Skip to 11f
Yes	1 ☐	
Unknown	2 ☐	Skip to 11f

i. Date of first diagnosis: ☐☐/☐☐/☐☐☐☐

11f. Intermittent Claudication or Other Peripheral Arterial Disease (PAD)?

No	0 ☐	Skip to 11g
Yes	1 ☐	
Unknown	2 ☐	Skip to 11g

11g. Lower Extremity Bypass, Angioplasty or Amputation Secondary to PAD?

No	0 ☐	Skip to 11h
Yes	1 ☐	
Unknown	2 ☐	Skip to 11h

11h. Coronary Bypass Surgery?

No	0 ☐	
Yes	1 ☐	
Unknown	2 ☐	

11i. Coronary Angioplasty?

No	0 ☐	
Yes	1 ☐	
Unknown	2 ☐	

11j. Emphysema, chronic bronchitis, or Chronic Obstruction Pulmonary Disease (COPD)?

No	0 ☐	Skip to 11k
Yes	1 ☐	
Unknown	2 ☐	Skip to 11k

i. Date of first exacerbation (or onset): ☐☐/☐☐/☐☐☐☐

11k. Asthma?

No	0	☐
Yes	1	☐
Unknown	2	☐

i. Approximate age asthma first started: ☐☐

12. If you saw the participant within one month of death, please fill out the following for the most recent visit:

12a. Date of visit: ☐☐/☐☐/☐☐☐☐

12b. Chief Complaint:_____

_____

12c. Primary Diagnosis:_____

_____

12d. Changes in Medical Management:_____

_____

_____

Form completed by: _____ Date: _____