OMB#: 0925-0584 Exp. XX/XXXX

Public reporting burden for this collection of information is estimated to average 30 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 (0925-0584). Do not return the completed form to this address.

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 Oa. Completion Date: / / / / Ob. Staff ID:									
<u>Instructions:</u> 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 DEAT 1. Are you familiar w	TH with the events surroun	iding the decedent's de	eath?						
No 0 Yes 1		and are acceptant as							
2. Did you witness th	ne 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 o	of physician:								
Addres	ss:								

ID NUMBER:								FORM CODE: PQ VERSION: A 10/20/08		Contact Occasion	0	1	SEQ #	
CIRCUMSTANCES SURROUNDING DEATH														
4. What do you believe to be the underlying cause of death?														
Other Cereb Other Emplos Obs Pneu Asthr Other	e Myoc Ischer Forovaso Cardi Tysema tructiv monia Tang Cardio	mic l cular ovas a, chr e pul Dise	Hear Dis cula conic lmor	rt Di ease r Di c bro nary	seas seas onch dise	se se sitis or ease (C			=	specify: 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.														
5 min 1 hou More 1 day	than 5 nutes to ir to 24 than 2 to 3 do than 3	o 1 hou l hou 24 ho ays	our rs urs			0								
6. Was there an acute episode of pain in the chest, left arm or jaw during the last 72 hours prior to death?														
No Yes Unkn	own	0 1 2												
7. Was there an acute episode of shortness of breath during the 72 hours prior to death?														
No Yes Unkn	own	0												
8. Was there an acute episode of wheezing during the 72 hours prior to death?														
No Yes Unkn	own	0												

ID FORM CODE: PQ Contact VERSION: A 10/20/08 Occasion 0 1 #
9. Did the decedent take or was s/he given nitrates or nitroglycerin at the time of the acute episode? No 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 even 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: / / /

ID NUMBER:				FORM CODE: PQ VERSION: A 10/20/08	Contact Occasion 0	1 SEQ #		
11d. Stroke (CVA)?								
	No	0	Skip to 1	1e				
	Yes	1	1					
	Unknown	2	Skip to 1	1e				
	_							
	i. Date of m	iost re	cent CVA:					
11 ₀ '	Transient Isch	emic /	Attack (TIA	12				
110.								
	No Yes	0	Skip to 1	1f				
	r es Unknown	2	Skip to 1	<mark>1f</mark>				
	Charlown	_	omp to 1.					
	i. Date of fi	rst dia	gnosis:	/ /				
11f.]	Intermittent C	laudica	ation or Oth	er Peripheral Arterial I	Disease (PAD)	<mark>?</mark>		
	No	0	Skip to 1	1g				
	Yes	1		0				
	Unknown	2	Skip to 1	<mark>1g</mark>				
11 ~	Loveron Exitnon	siter Dr	mass Angie	onlasty or Amoutation	Cocondowy to 1	DA D2		
11g.	Lower Extrem	шу Бу		oplasty or Amputation	Secondary to i	PADI		
	No	0	Skip to 1	1h				
	Yes	1	Chin to 1	1 L				
	Unknown	2	Skip to 1	<u>IN</u>				
11h.	Coronary Byp	ass Su	rgery?					
	No	0						
	Yes	1						
	Unknown	2						
			1					
11i. (Coronary Ang	ioplast	y?					
	No	0						
	Yes	1						
	Unknown	2						
11i]	Emphysema o	hronic	bronchitis	or Chronic Obstruction	n Pulmonary I	Disease (COPD)?		
<u> J</u> • - 1					in a difficulty 1	License (GOLD).		
	No Yes	0	Skip to 1	IK				
	y es Unknown	1	Skip to 1	1 <mark>k</mark>				
	O I I I I I I I I I I I I I I I I I I I		Jimp to 1.					

ID FORM CODE: PQ Contact VERSION: A 10/20/08 Occasion 0 1 #	
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 recenvisit:	t
12a. Date of visit: / / / / / / / / / / / / / / / / / / /	
12b. Chief Complaint:	
12c. Primary Diagnosis:	
12d. Changes in Medical Management:	
Form completed by: Date:	