FORM CODE: PHF Version: A 06/05/07
ARIC ID: <NNNNNNN> CY: < 00 > SEQ: <00>

ARIC Heart Failure Survey

O.M.B 0925-0281
Exp. XX/XXXX

Dear < Dr >,

Your patient, < Ms/Mr. > who is a long time participant in the ARIC Study, has indicated to ARIC study personnel that < s/he > has been diagnosed with heart failure. We have your patient's authorization to ask you to provide this information for our study records. We appreciate your response to the following questions and request that you return this form in the enclosed envelope at your earliest convenience (ideally within 2 weeks).

Thank you.

Sincerely,
< Field center medical director > Date < Date letter is sent >

Patient Name < Ms/Mr. **>** **Patient Date of Birth <** mm/dd/yyyy **>**

1. Has this patient ever had heart failure or cardiomyopathy of any type? ☐ Yes ☐ Unsure ☐ No
(If response is NO, skip to question 3)

2. If the patient has or ever had heart failure or cardiomyopathy:
   (a) Is this patient's condition characterized as predominantly:
   ☐ Systolic dysfunction ☐ Diastolic dysfunction ☐ Mixed ☐ Not determined
   (b) Estimated LVEF (worst): ____%
   (b.1.) If LVEF is not specifically available, estimate LV function:
   ☐ Normal ☐ Decreased mildly ☐ Decreased moderately ☐ Decreased severely
   (c) Estimated date of onset or diagnosis: ___ / _____ (month/year)

3. Has this patient ever had (check all that apply):
   ☐ Atrial fibrillation on an ECG?
   ☐ Pulmonary rales on a physical examination?
   ☐ Rhonchi on a physical examination?
   ☐ Angina pectoris?
   ☐ Previous MI?
   ☐ Other coronary heart disease?
   ☐ None of the above

4. Was s/he prescribed treatment specifically for heart failure during the past year?
   ☐ Yes ☐ No ☐ Not known

5. Was this patient prescribed any of the following during the past year? (check all that apply)
   ☐ ACE inhibitors
   ☐ Alpha blockers
   ☐ Aldosterone blocker
   ☐ Amiodarone / Antiarrhythmics
   ☐ Angiotensin II receptor blockers
   ☐ Anticoagulants
   ☐ Aspirin / Antiplatelets
   ☐ Beta blockers
   ☐ Calcium channel blockers
   ☐ Digitalis
   ☐ Diuretics
   ☐ Hydralazine
   ☐ Lipid-lowering agents
   ☐ Nitrates
   ☐ Other antihypertensives

Form completed by: _____ (Signature or stamp)

Date: _____ (MM/ DD /YY)

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O.M.B 0925-0281
Exp. 05/31/2010