



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):

<input type="checkbox"/> Atrial fibrillation on an ECG?	<input type="checkbox"/> Angina pectoris?
<input type="checkbox"/> Pulmonary rales on a physical examination?	<input type="checkbox"/> Previous MI?
<input type="checkbox"/> Rhonchi on a physical examination?	<input type="checkbox"/> Other coronary heart disease?
	<input type="checkbox"/> 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)

<input type="checkbox"/> ACE inhibitors	<input type="checkbox"/> Beta blockers
<input type="checkbox"/> Alpha blockers	<input type="checkbox"/> Calcium channel blockers
<input type="checkbox"/> Aldosterone blocker	<input type="checkbox"/> Digitalis
<input type="checkbox"/> Amiodarone / Antiarrhythmics	<input type="checkbox"/> Diuretics
<input type="checkbox"/> Angiotensin II receptor blockers	<input type="checkbox"/> Hydralazine
<input type="checkbox"/> Anticoagulants	<input type="checkbox"/> Lipid-lowering agents
<input type="checkbox"/> Aspirin / Antiplatelets	<input type="checkbox"/> Nitrates
	<input type="checkbox"/> Other antihypertensives

Form completed by:

Date:

(Signature or stamp)

(MM/ DD /YY)



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

Public reporting burden for this collection of information is estimated to average 4 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 (0925-0281)**. Do not return the completed form to this address.