



Physician Questionnaire Form

ID NUMBER:

CONTACT YEAR:

FORM CODE: PHQ
VERSION C: 05/22/2007

LAST NAME:

INITIALS:

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Decedent's Name: _____ Age:

Date of Birth: / /
month day year

Date of Death: / /
month day year

Event ID: Sequence Number:

Physician's name: _____

Please complete the following and return in the enclosed envelope.

A. Medical History

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

Yes

If No, Skip to Item 5 on Page 3 No

2. When did you last see the decedent?

/
month year

3. Did the decedent have a history of any of the following?

- | | <u>Yes</u> | <u>No</u> | <u>Uncertain</u> |
|---|--------------------------|--------------------------|--------------------------|
| a. Angina pectoris or coronary insufficiency..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Valvular disease or cardiomyopathy..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Coronary bypass surgery..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Coronary angioplasty..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Hypertension..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Myocardial infarction..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If MI **yes**, date of most recent event: /
month year

- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| h. Other chronic ischemic heart disease..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Stroke (CVA)..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

j. **If yes**, date of most recent event: /
month year

- | | <u>Yes</u> | <u>No</u> | <u>Uncertain</u> |
|---|--------------------------|--------------------------|--------------------------|
| k. Any non-cardiac condition that might have contributed to this death..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If yes, specify: _____

- | | <u>Yes</u> | <u>No</u> | <u>Uncertain</u> |
|---------------------------|--------------------------|--------------------------|--------------------------|
| l. Diabetes..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Cigarette smoking..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

4. Was the decedent taking any of the following medications within four weeks prior to death?

	<u>Yes</u>	<u>No</u>	<u>Uncertain</u>
a. Nitrates.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Calcium channel blockers.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Digitalis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Beta-blockers.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.1. Aspirin.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.2. ACE or Angiotensin II inhibitors.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Other cardiovascular drugs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, specify: _____

B. Details of Death

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

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

6. Did you witness the death?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

If you answered **No** to both 5 and 6 skip to Item 14. Otherwise, continue with Item 7.

7. Was there any pain in the chest, left arm, shoulder or jaw within 72 hours of death?

Yes	No	Uncertain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If **No** or **Uncertain** go to item 8.

b. Did the pain include the chest?

Yes	No	Uncertain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

c. Did you think this pain was of a cardiac origin?

Yes	No	Uncertain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If No, specify what you think was the cause:

8. Did the decedent take (or was he/she given) nitrates at the time of the acute episode?

Yes	No	Uncertain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. Was coronary reperfusion (intravenous or intracoronary streptokinase or TPA, angioplasty, etc.) attempted during the acute episode?

Yes	No	Uncertain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. Was CPR and/or cardioversion performed within 24 hours of death?

Yes	No	Uncertain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. Please give time between onset of acute symptoms to death. (We are defining death as the point where spontaneous breathing ceased and the patient never recovered)

<input type="checkbox"/> More than 3 days (A)	<input type="checkbox"/> At least 1 hour, (F) but less than 4 hours
<input type="checkbox"/> 2-3 days (B)	<input type="checkbox"/> Less than 1 hour (G)
<input type="checkbox"/> 1 day (C)	<input type="checkbox"/> Death instantaneous, (H) no symptoms
<input type="checkbox"/> At least 12 hours, but less than 24 hours (D)	<input type="checkbox"/> Unknown (I)
<input type="checkbox"/> At least 4 hours, but less than 12 hours (E)	

12. Would you classify the decedent's cause of death as due to CHD?

Yes	No	Uncertain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. If no, what do you believe to be the cause of death?

	<u>Yes</u>	<u>No</u>	<u>Uncertain</u>
13a. Pulmonary embolism.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13b. Acute pulmonary edema.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13c. Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13d. Pneumonia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13e. Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13f. Other.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13g. Specify: _____

C. Signature

14. Form completed by: _____
Signature

15. Date: / /
month day year

Thank you very much for your help. Please return this questionnaire in the enclosed self-addressed envelope.

Office use only: 23. Self (A) _____ Interview(B) _____ ER. records(C) _____