OMB #0925-0493 Exp: XX/XXXX

Multi-Ethnic Study of Atherosclerosis

Physician Questionnaire: Cardiac/PVD

Participant ID: 8000028 02

Sequence Num: ☐☐ ***(For MESA Field Center use only)***

Participant Name: _____ **Date-of-Birth:** _____/_____/_____

Please complete only this page if participant has not had any condition listed in Question 2 below, OR if you are not familiar with participant's medical history.

Please fill in the appropriate bubbles and write responses in the blanks provided.

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

○ Yes ○ No →

Please complete Question 2 below.

Are you aware of another physician who could provide information regarding this participant?

○ Yes ○ No

Please sign and date the form at the bottom of page 4 and return form.

Please fill in the physician's name and address, ***sign and date the form at the bottom of page 4 and return form.***

_____

_____

_____

2. In your opinion, has the participant had any of the conditions below? (Please check any that apply.)

○	MI	*Please complete section A on page 2.*
○	Angina	*Please complete section B on page 2.*
○	CHF	*Please complete section C on page 2.*
○	PAD/AA*	*Please complete section D on page 2.*
○	None	***Please sign and date at the bottom of page 4 and return form.***

→ ***If participant has had any of the conditions listed, we would appreciate copies of pertinent office notes, including physical exams, reports of stress tests, caths and EKGs.***

* Peripheral Arterial Disease/Aortic Aneurysm.

A. Myocardial Infarction

Has the participant ever been diagnosed with a myocardial infarction?

○ Yes ○ No ○ Unknown

If "Yes," when was the most recent event of this type?

Month / Day / Year

Was the participant hospitalized?

○ Yes ○ No ○ Unknown

If "Yes," where was the participant hospitalized?

Name of Hospital: _____

City, State: _____

The certainty of the diagnosis is:

○ Definite ○ Probable

Go to next relevant section or, if none, skip to Question 3.

B. Angina

Has the participant ever been diagnosed with angina pectoris or coronary insufficiency?

○ Yes ○ No ○ Unknown

If "Yes," did s/he have chest pain or equivalent, or was the diagnosis only the result of diagnostic tests?

○ Pain or pain equivalent

○ No pain; diagnostic testing only

If pain (or pain equivalent), when was the most recent episode of this type?

Month / Day / Year

Was the participant hospitalized for angina/coronary insufficiency?

○ Yes ○ No ○ Unknown

If "Yes," where was the participant hospitalized?

Name of Hospital: _____

City, State: _____

The certainty of the diagnosis is:

○ Definite ○ Probable

Go to next relevant section or, if none, skip to Question 3.

C. CHF

Has the participant ever been diagnosed with congestive heart failure or congestive cardiomyopathy?

○ Yes ○ No ○ Unknown

If "Yes," when was the most recent episode of this type?

Month / Day / Year

Was the participant hospitalized?

○ Yes ○ No ○ Unknown

If "Yes," where was the participant hospitalized?

Name of Hospital: _____

City, State: _____

The certainty of the diagnosis is:

○ Definite ○ Probable

Go to next relevant section or, if none, skip to Question 3.

D. PAD

Has the participant ever been diagnosed with claudication, peripheral artery disease, or abdominal aortic aneurysm?

○ Yes ○ No ○ Unknown

If "Yes," when was the most recent episode of this type?

Month / Day / Year

Was the participant hospitalized?

○ Yes ○ No ○ Unknown

If "Yes," where was the participant hospitalized?

Name of Hospital: _____

City, State: _____

The certainty of the diagnosis is:

○ Definite ○ Probable

Go to next relevant section or, if none, skip to Question 3.

3. Please complete the following sections for the most recent event.

If participant has been diagnosed with MI, Angina or CHF, please complete all sections on pages 3 and 4.

If participant has been diagnosed with PAD only, complete only relevant items in sections a and b.

Section a.

Which (if any) of the following diagnostic tests did the participant have? (Please attach copy of report.)

	Yes	No	Unknown
Electrocardiogram	○	○	○
Trial of Nitroglycerin	○	○	○
Excercise Tolerance Test	○	○	○
---With Thallium?	○	○	○
Cardiac Enzymes	○	○	○
Echocardiogram	○	○	○
Angiography	○	○	○
Chest X-Ray	○	○	○
Other	○	○	○

If Other, please specify: _____

Pertinent Results: _____

_____

_____

_____

Section b.

Which (if any) of the following procedures were done?
When were they performed?

Cardiac Catheterization — Yes ○ No ○ Unknown ○

Date: __ __ / __ __ / __ __ __ __
Month / Day / Year

Angioplasty or Stent Placement — Yes ○ No ○ Unknown ○

Date: __ __ / __ __ / __ __ __ __
Month / Day / Year

CABG (Coronary Artery Bypass Graft) — Yes ○ No ○ Unknown ○

Date: __ __ / __ __ / __ __ __ __
Month / Day / Year

Intravenous or Intracoronary Thrombolytic Therapy (TPA, Streptokinase) — Yes ○ No ○ Unknown ○

Date: __ __ / __ __ / __ __ __ __
Month / Day / Year

Leg angioplasty or other leg revascularization — Yes ○ No ○ Unknown ○

Date: __ __ / __ __ / __ __ __ __
Month / Day / Year

Section c.

Which (if any) of the following medications were prescribed as a therapy?

	Yes	No	Unknown
Nitroglycerin	○	○	○
Beta-Blockers	○	○	○
Calcium Channel Blockers	○	○	○
Aspirin	○	○	○
Diuretics	○	○	○
Ace Inhibitors	○	○	○
Digitalis	○	○	○
Oxygen	○	○	○
Other Vasodilators	○	○	○
Other	○	○	○

If other, please specify: _____

Section d.

Were any of the following present?

	Yes	No	Unknown
Chest pain	○	○	○
Jugular Venous Distention	○	○	○
Cartoid Bruit	○	○	○
Basilar Rales or Crackles Only	○	○	○
Rales or Crackles Above Bases	○	○	○
Wheezing	○	○	○
S-3 Gallop	○	○	○
Cardiac Murmur	○	○	○
Hepatojugular Reflex	○	○	○
Hepatomegaly	○	○	○
Peripheral/Ankle Edema	○	○	○

Thank you very much for your contribution to MESA. Please sign and date this questionnaire and return it to us in the self-addressed, stamped envelope with copies of pertinent office notes or tests. If you do not have the envelope, the address is:

Notes: _____

_____

_____

_____

Form completed by: _____ Date: _____

For MESA Field Center Use Only:

[ ][ ] / [ ][ ] / [ ][ ][ ][ ] Reviewer ID: [ ][ ][ ] Data Entry ID: [ ][ ][ ]

OMB #0925-0493 Exp: XX/XXXX

Multi-Ethnic Study of Atherosclerosis

Physician Questionnaire: Cardiovascular Death

Participant ID: 8000028 02

Hospital Code: ☐☐☐☐

Sequence Num: ☐☐

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. Thank you for your contribution to MESA.

Details of Death

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

○ Yes ○ No

2. Did you witness the death?

○ Yes ○ No

If you answered "Yes" to both or either of Questions 1 and 2, please skip to Question 4.

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

○ Yes ○ No

If "No," please sign and date the form at the bottom of page 2.

If "Yes," please provide the physician's name and address, then sign and date the form at the bottom of page 2.

Name of physician:_____

Address:_____

_____

_____

Circumstances Surrounding Death

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

- ○ Acute Myocardial Infarction
- ○ Other Ischemic Heart Disease
- ○ Cerebrovascular Disease
- ○ Other Cardiovascular Disease
- ○ Non-Cardio/Cerebrovascular *(Please 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
- ○ 5 minutes to 1 hour
- ○ 1 hour to 24 hours
- ○ More than 24 hours
- ○ Unknown

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

○ Yes ○ No ○ Unknown

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

○ Yes ○ No ○ Unknown

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

○ Yes ○ No ○ Unknown

Medical History

9. Are you familiar with the decendent's medical history?

○ Yes ○ No

If you answered "No," please skip to the bottom of the page

10. Did the decendent have a medical history of any of the following conditions or medications prior to the acute event which led to death?

Myocardial Infarction (MI)

○ Yes ○ No ○ Unknown

If "Yes," date of most recent MI:

__ __ / __ __ / __ __ __ __

Month Day Year

Angina Pectoris, Coronary Insufficiency or Other Chronic Ischemic Heart Disease

○ Yes ○ No ○ Unknown

If "Yes," date of first diagnosis:

__ __ / __ __ / __ __ __ __

Month Day Year

Congestive Heart Failure (CHF) or Congestive Cardiomyopathy

○ Yes ○ No ○ Unknown

Stroke (CVA)

○ Yes ○ No ○ Unknown

If "Yes," date of most recent CVA:

__ __ / __ __ / __ __ __ __

Month Day Year

Continued next column

Transient Ischemic Attack (TIA)

○ Yes ○ No ○ Unknown

If "Yes," date of first diagnosis:

__ __ / __ __ / __ __ __ __

Month Day Year

Intermittent Claudication or Other Peripheral Vascular Disease (PVD)

○ Yes ○ No ○ Unknown

Lower Extremity Bypass, Angioplasty or Amputation Secondary to PVD

○ Yes ○ No ○ Unknown

Coronary Bypass Surgery

○ Yes ○ No ○ Unknown

Coronary Angioplasty

○ Yes ○ No ○ Unknown

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

Date of Visit:

__ __ / __ __ / __ __ __ __

Month Day Year

Chief Complaint: _____

_____

Primary Diagnosis: _____

_____

Changes in Medical Management: _____

_____

_____

Form completed by: _____ Date: _____

For MESA Field Center Use Only:

__ __ / __ __ / __ __ __ __ Reviewer ID: __ __ __ Data Entry ID: __ __ __

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OMB #0925-0493 Exp: XX/XXXX

Multi-Ethnic Study of Atherosclerosis

Physician Questionnaire:
Stroke/TIA

Participant ID: 8000028 12

Sequence Num: ☐☐ ***(For MESA Field Center use only)***

Participant Name: _____ **Date-of-Birth:** _____/_____/_____

Please complete only this page if you are not familiar with this participant's medical history.

Please fill in the appropriate bubbles and write responses in the blanks provided.

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

○ Yes ○ No →

Please continue to Question 2 on page 2

Are you aware of another physician who could provide information regarding this participant?

○ Yes ○ No

Please sign and date the form at the bottom of page 3 and return form.

Please fill in the physician's name and address, ***sign and date the form at the bottom of page 3 and return form****.*

_____

_____

_____

2. When did you last see the patient?

Month / Day / Year

3. In your opinion, has the patient ever had a cerebrovascular event such as a stroke, TIA or amaurosis fugax?

○ Yes ○ No ○ Unsure

If "No," skip to the end of the form, sign and date at the bottom of page 3 and return form..

4. When was the **most recent** event of this type?

Month / Day / Year

4a. This most recent event was a(n):

- ○ Subarachnoid hemorrhage
- ○ Intraparenchymal hemorrhage
- ○ Brain infarction
- ○ TIA
- ○ Stroke, uncertain type
- ○ Not a stroke or TIA

If not a stroke or TIA, what was the diagnosis?

4b. The certainty of the diagnosis is:

- ○ Definite
- ○ Probable
- ○ Possible

4c. Was the patient hospitalized?

○ Yes ○ No → *If "No," skip to Question 5.*

Name of Hospital: _____

City/State: _____

5. The symptoms were in the distribution of which vessel?

- ○ Right carotid
- ○ Left carotid
- ○ Vertebral/Basilar
- ○ Unknown

6. Which (if any) of the following diagnostic tests did the patient have?

	Yes	No	Unknown
CT of the head	○	○	○
MRI of the brain	○	○	○
Carotid ultrasound	○	○	○
Electrocardiogram	○	○	○
Echocardiogram	○	○	○
Hypercoagulation work-up	○	○	○
Other	○	○	○

If other, Please specify: _____

7. Which (if any) of the following symptoms or physical findings were present in the most recent event?

	Yes	No	Unknown
Severe headache	○	○	○
Diminished level of conciousness	○	○	○
Loss of conciousness	○	○	○
Language deficit/aphasia	○	○	○
Hemineglect	○	○	○
Dysarthria	○	○	○
Visual field deficit	○	○	○
Weakness or drift	○	○	○
Hemiplegia	○	○	○
Ataxia	○	○	○
Sensory deficit	○	○	○
Asymmetry of reflexes	○	○	○
Babinski	○	○	○
Abnormal gait	○	○	○
Other	○	○	○

If other, please specify: _____

8. Did any neurological findings persist longer than 24 hours from onset?

○ Yes ○ No

↓

Please specify:

9. Which (if any) of the following medications were prescribed as therapy?

	Yes	No	Unknown
Aspirin	○	○	○
Dipyridamole	○	○	○
Anti-coagulants	○	○	○
Ticlopidine or Clopidogrel	○	○	○
Extended Release Dipyridamole	○	○	○
Other	○	○	○

If other, please specify:

If there has been more than one event of this type, please continue to Question 10.

If not, please skip to the end of the form, sign and date, and return the form to the MESA clinic.

10. When was the **first** event of this type?

☐☐ / ☐☐ / ☐☐☐☐

Month Day Year

10a. This first event was a(n):

- ○ Subarachnoid hemorrhage
- ○ Intraparenchymal hemorrhage
- ○ Brain infarction
- ○ TIA
- ○ Stroke, uncertain type
- ○ Not a stroke or TIA

If not a stroke or TIA, what was the diagnosis?

10b. The certainty of the diagnosis

- ○ Definite
- ○ Probable
- ○ Possible

10c. Was the patient hospitalized?

○ Yes ○ No

If "No," skip to Question 5.

Name of hospital: _____

City/State: _____

Thank you very much for your contribution to MESA. Please sign and date this questionnaire and return it to us in the self-addressed, stamped envelope. If you do not have the envelope, the address is:

Form completed by: _____ Date: _____

For MESA Field Center Use Only:

☐☐ / ☐☐ / ☐☐☐☐ Reviewer ID: ☐☐☐ Data Entry ID: ☐☐☐

E.2.2 HOSPCOV (Cover letter to hospital to obtain medical records)

[date]

[hospital name]

[hospital street address]

[hospital city, state zip]

Dear Correspondence Clerk:

I am writing on behalf of the Multi-Ethnic Study of Atherosclerosis (MESA), an epidemiologic project of the **[institution],** along with five other centers in the United States.

[participant] (date of birth **[date of birth]**), a participant in our study, was a patient at **[hospital name]** during **[year].** Enclosed you will find a release of medical information signed by **[next of kin name].** We are needing medical records involving that hospitalization including ER report, History and Physical, Discharge ICD-9 codes, Discharge Summary, Progress Notes, ECGs and Enzyme reports, and all other test and procedure results.

If you have any questions, please feel free to call **NAME**, our local Surveillance Supervisor, at **PHONE NUMBER**.

This information will be used for statistical purposes only, and will remain strictly confidential. Thank you very much in advance for your help in this important study.

Sincerely,

NAME

Principal Investigator

Enclosure: Release Form

E.2.4 PHYSCOV (Cover letter to physician/clinic to obtain medical records)

[date]

[doctor's office or clinic name]

[doctor's office or clinic street address]

[doctor's office or clinic city, state zip]

Dear Correspondence Clerk:

I am writing on behalf of the Multi-Ethnic Study of Atherosclerosis (MESA), an epidemiologic project of the **[institution],** along with five other centers in the United States.

[participant] (date of birth **[date of birth]**), a participant in our study and your patient, reported being under your care during **[year].** Enclosed you will find a release of medical information signed by **[next of kin name].** We are needing medical records involving diagnoses and procedures including History and Physical, Discharge ICD-9 codes, Discharge Summary, Progress Notes, ECGs and Enzyme reports, and all other test and procedure results.

If you have any questions, please feel free to call **NAME**, our local Surveillance Supervisor, at **PHONE NUMBER**.

This information will be used for statistical purposes only, and will remain strictly confidential. Thank you very much in advance for your help in this important study.

Sincerely,

NAME

Principal Investigator

Enclosure: Release Form

E.2.7 MECOV (Cover letter to medical examiner (ME) to obtain ME/coroner reports)

[date]

[medical examiner name]
[street address]
[city, state zip]

Dear **[medical examiner name]**:

I am writing on behalf of the Multi-Ethnic Study of Atherosclerosis (MESA), an epidemiologic project of the **[institution]** along with five other centers in the United States.

We are needing information on **[participant]**, who died on **[date of death]**, and whose death was listed as a Medical Examiner case. MESA requests a copy of the Medical Examiner's report. A consent form signed by his/her next of kin is enclosed.

This information will be used for statistical purposes only, and will remain strictly confidential. If you have any questions, please feel free to call **NAME**, our local Surveillance Supervisor, at **PHONE NUMBER**. Thank you very much in advance for your kind assistance and consideration of this request.

Sincerely,

NAME
Principal Investigator

Enclosure: Release Form

E.2.8 PQCERT (PQ cover letter to physician signing death certificate)

[date]

[physician name]
[street address]
[city, state zip]

Dear **[physician name]**:

I am writing on behalf of the Multi-Ethnic Study of Atherosclerosis (MESA), an epidemiologic project of the **[institution]** along with five other centers in the United States.

We are needing information on **[participant]**, who died on **[date of death]**, and whose death certificate you signed on **[date].** The information is needed to supplement the death certificate in assigning a cause of death. Could you or your nurse take a few moments to provide from your records the answers to the questions on the enclosed form?

This information will be used for statistical purposes only, and will remain strictly confidential. Of course, your participation is entirely voluntary, and, if you choose to not complete and return this form, it will in no way affect any relationship you may have with this institution. If you have any questions, please feel free to call me collect, at **PHONE NUMBER**, or our local Surveillance Supervisor, **NAME**, at **PHONE NUMBER**. Thank you very much in advance for your kind assistance and consideration of this request.

Sincerely,

NAME
Principal Investigator

Enclosure: Physician Questionnaire

E.2.9 PQATND (PQ cover letter to attending physician of decedent)

[date]

[physician name]
[street address]
[city, state zip]

Dear **[physician name]**:

I am writing on behalf of the Multi-Ethnic Study of Atherosclerosis (MESA), an epidemiologic project of the **[institution]** along with five other centers in the United States.

We are needing information on **[participant]**, who died on **[date of death],** and who, according to the family, was your patient. The information is needed to supplement the death certificate in assigning a cause of death. Could you or your nurse take a few moments to provide from your records the answers to the questions on the enclosed?

This information will be used for statistical purposes only, and will remain strictly confidential. Of course, your participation is entirely voluntary, and, if you choose to not complete and return this form, it will in no way affect any relationship you may have with this institution. If you have any questions, please feel free to call me collect, at **PHONE NUMBER**, or our local Surveillance Supervisor, **NAME**, at **PHONE NUMBER**. Thank you very much in advance for your kind assistance and consideration of this request.

Sincerely,

NAME
Principal Investigator

Enclosure: Physician Questionnaire

E.2.10 PQCLIN (PQ cover letter to medical clinic of decedent)

[date]

[doctor's office or clinic name]
[doctor's office or clinic street address]
[doctor's office or clinic city, state zip]

Dear **[physician name]**:

I am writing on behalf of the Multi-Ethnic Study of Atherosclerosis (MESA), an epidemiologic project of the **[institution]** along with five other centers in the United States.

We are needing information on **[participant],** who died on **[date of death],** and who, according to the family, was a patient at **[doctor's office or clinic name].** The information is needed to supplement the death certificate in assigning a cause of death. Could you or your nurse take a few moments to provide from your records the answers to the questions on the enclosed form?

This information will be used for statistical purposes only, and will remain strictly confidential. Of course, your participation is entirely voluntary, and, if you choose to not complete and return this form, it will in no way affect any relationship you may have with this institution. If you have any questions, please feel free to call me collect, at **PHONE NUMBER**, or our local Surveillance Supervisor, **NAME**, at **PHONE NUMBER**. Thank you very much in advance for your kind assistance and consideration of this request.

Sincerely,

NAME
Principal Investigator

Enclosure: Physician Questionnaire