

Multi-Ethnic Study of Atherosclerosis



Physician Questionnaire:
Cardiac/PVD

Participant ID: 8000028 02

Sequence Num: (For MESA Field Center use only)

Public reporting burden for this collection of information is estimated to average 10 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 0925-0493. Do not return the completed form to this address.

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trial of Nitroglycerin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Excercise Tolerance Test	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
---With Thallium?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cardiac Enzymes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Echocardiogram	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Angiography	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chest X-Ray	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Beta-Blockers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Calcium Channel Blockers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Aspirin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diuretics	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ace Inhibitors	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Digitalis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Oxygen	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other Vasodilators	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If other, please specify:

Section d.

Were any of the following present?

	Yes	No	Unknown
Chest pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Jugular Venous Distention	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Carotid Bruit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Basilar Rales or Crackles Only	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rales or Crackles Above Bases	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wheezing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
S-3 Gallop	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cardiac Murmur	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hepatojugular Reflex	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hepatomegaly	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Peripheral/Ankle Edema	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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:					

Multi-Ethnic Study of Atherosclerosis



**Physician Questionnaire:
Cardiovascular Death**

Participant ID: 8000028 02

Hospital Code:

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Sequence Num:

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Public reporting burden for this collection of information is estimated to average 10 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- . Do not return the completed form to this address.

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 decedent'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)

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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 decedent take or was s/he given nitrates or nitroglycerin at the time of the acute episode?

- Yes No Unknown

8000028 02

Medical History

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

- Yes No

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

10. Did the decedent 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:

Multi-Ethnic Study of Atherosclerosis



Physician Questionnaire:
Stroke/TIA

Participant ID: 8000028 12

Sequence Num:

Two empty boxes for sequence number

(For MESA Field Center use only)

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Participant Name: _____

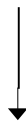
Date-of-Birth: ____/____/____

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.

Three horizontal lines for writing the physician's name and address

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
MRI of the brain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Carotid ultrasound	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Electrocardiogram	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Echocardiogram	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hypercoagulation work-up	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diminished level of consciousness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Loss of consciousness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Language deficit/aphasia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hemineglect	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dysarthria	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Visual field deficit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Weakness or drift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hemiplegia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ataxia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sensory deficit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Asymmetry of reflexes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Babinski	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Abnormal gait	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dipyridamole	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anti-coagulants	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ticlopidine or Clopidogrel	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Extended Release Dipyridamole	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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