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Check here if whole page is blank. Reason why \_\_\_\_\_

### Exam 9 Procedures Sheet

0=No, 1=Yes, 8=Offsite visit

<input type="checkbox"/>	<b>Type of Exam</b>	1=Complete exam, 2=Split exam(exam completed in 2 visits), 3=short exam (incomplete exam)
<input type="checkbox"/>	<b>Informed Consent Signed</b>	0=No, 1=Yes, 2=Consent by substituted judgment
<input type="checkbox"/>	<b>Urine Specimen</b>	
<input type="checkbox"/>	<b>Blood Draw</b>	
<input type="checkbox"/>	<b>Mini-Mental Status Exam</b>	
<input type="checkbox"/>	<b>Anthropometry</b>	
<input type="checkbox"/>	<b>Sociodemographic Questions</b>	
<input type="checkbox"/>	<b>SF-12 Health Survey</b>	
<input type="checkbox"/>	<b>CES-D Scale</b>	
<input type="checkbox"/>	<b>Exercise Questionnaire</b>	
<input type="checkbox"/>	<b>ECG</b>	
<input type="checkbox"/>	<b>Observed performance (Fast walk, hand grip, chair stands)</b>	
<input type="checkbox"/>	<b>Tonometry</b>	
<input type="checkbox"/>	<b>Ankle-brachial blood pressure by Doppler. (Participants ≥ 40 years)</b>	
<input type="checkbox"/>	<b>Spirometry</b>	0=Not Done, 1=Done, 2=Test attempted but not finished, 8=Offsite
<input type="checkbox"/>	<b>Reason Spirometry not done</b>	1=Major Surgery, 2=Heart Attack 3=Stroke, 4=Aneurysm, 5=BP>210/110, 6=Refused, 7=Test Aborted by tech, 8=Other, 10=equipment problems
<input type="checkbox"/>	<b>Post albuterol Spirometry (sub-sample)</b>	0=Not Done, 1=Done, 2=Test attempted but not finished, 8=Offsite
<input type="checkbox"/>	<b>Reason post bronchodilator test not done</b>	1=Major Surgery, 2=Heart Attack 3=Stroke, 4=Aneurysm, 5=BP>210/110, 6=Refused, 7=Test Aborted by tech, 8=Other, 10=equipment problems, 11=didn't qualify for test
<input type="checkbox"/>	<b>Diffusion Capacity</b>	0=Not Done, 1=Done, 2=Test attempted but not finished, 8=Offsite
<input type="checkbox"/>	<b>Reason Diffusion not done</b>	1=Major Surgery, 2=Heart Attack 3=Stroke, 4=Aneurysm, 5=BP>210/110, 6=Refused, 7=Test Aborted by tech, 8=Other, 10=equipment problems

TECH02 CL

## For Participants Who Wish to Complete Their Exam on a Second Visit (Split Exam)

<input type="text"/> * <input type="text"/> * <input type="text"/>	<b>Second Exam Date</b> <i>(If participant returns to finish their clinic exam on a date other than the original exam date, then fill in the date they return here. Otherwise leave entire page completely blank)</i>
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**Keys:** if Second Exam Date is not filled and page is blank' then leave the page all blank.

Fill in with 1=yes if procedure **was done** on the **Second** Exam Date and 0=no if procedure **was not done** on the **Second** Exam Date. Note that informed consent from first visit will cover the second visit.

<b>Exam 9 Procedures Sheet</b>		
0=No, 1=Yes, 8=Offsite visit		
<input type="checkbox"/>	<b>Type of Exam</b>	1=Complete exam, 2=Split exam(exam completed in 2 visits), 3=short exam (incomplete exam)
<input type="checkbox"/>	<b>Informed Consent Signed</b>	0=No, 1=Yes, 2=Consent by substituted judgment
<input type="checkbox"/>	<b>Urine Specimen</b>	
<input type="checkbox"/>	<b>Blood Draw</b>	
<input type="checkbox"/>	<b>Mini-Mental Status Exam</b>	
<input type="checkbox"/>	<b>Anthropometry</b>	
<input type="checkbox"/>	<b>Sociodemographic Questions</b>	
<input type="checkbox"/>	<b>SF-12 Health Survey</b>	
<input type="checkbox"/>	<b>CES-D Scale</b>	
<input type="checkbox"/>	<b>Exercise Questionnaire</b>	
<input type="checkbox"/>	<b>ECG</b>	
<input type="checkbox"/>	<b>Observed performance (Fast walk, hand grip, chair stands)</b>	
<input type="checkbox"/>	<b>Tonometry</b>	
<input type="checkbox"/>	<b>Ankle-brachial blood pressure by Doppler. (Participants ≥ 40 years)</b>	
<input type="checkbox"/>	<b>Spirometry</b>	0=Not Done, 1=Done, 2=Test attempted but not finished, 8=Offsite
<input type="checkbox"/>	<b>Reason Spirometry not done</b>	1=Major Surgery, 2=Heart Attack 3=Stroke, 4=Aneurysm, 5=BP>210/110, 6=Refused, 7=Test Aborted by tech, 8=Other, 10=equipment problems
<input type="checkbox"/>	<b>Post albuterol Spirometry (sub-sample)</b>	0=Not Done, 1=Done, 2=Test attempted but not finished, 8=Offsite
<input type="checkbox"/>	<b>Reason post bronchodilator test not done</b>	1=Major Surgery, 2=Heart Attack 3=Stroke, 4=Aneurysm, 5=BP>210/110, 6=Refused, 7=Test Aborted by tech, 8=Other, 10=equipment problems, 11=didn't qualify for test
<input type="checkbox"/>	<b>Diffusion Capacity</b>	0=Not Done, 1=Done, 2=Test attempted but not finished, 8=Offsite
<input type="checkbox"/>	<b>Reason Diffusion not done</b>	1=Major Surgery, 2=Heart Attack 3=Stroke, 4=Aneurysm, 5=BP>210/110, 6=Refused, 7=Test Aborted by tech, 8=Other, 10=equipment problems

**TECH0? CL**

## Numerical Data/Anthropometry

<input type="checkbox"/>	Check here if whole page is blank.	Reason why _____
_ _ _	<b>Technician Number.</b> (for basic information)	

<b>Basic Information</b>	
_	<b>Sex of Participant</b> 1=Male, 2=Female
_	<b>Site of Exam</b> (0=Heart Study, 1=Nursing home, 2=Residence, 3=Other).
_ _	<b>Age of Participant</b> (number of years)
_ _	<b>What state do you reside in?</b> (If reside outside the USA, code ZZ, if plans to wear accelerometer while visiting USA code state of visit) Code: AL, AK, AS, etc.

<b>Anthropometry</b>	
<i>Check <b>Protocol Modification</b> ONLY if there was one and document it in Comment section</i>	
88*88=Refused, 99*99=Not done or Unk	
_ _ _	<b>Weight</b> (to nearest pound) (400=400 or more. 888=refused, 999=Unk.)
<input type="checkbox"/> <b>Protocol modification.</b>	
_	<b>In the past year, have you lost more than 10 pounds?</b> 0=No, 1= Yes, unintentionally, NOT due to dieting or exercise 2= Yes, intentionally, due to dieting or exercise
_ _ * _ _	<b>Height</b> (inches, to next lower 1/4 inch)
<input type="checkbox"/> <b>Protocol modification.</b>	
_ _ _	<b>Technician Number.</b> (for anthropometry)
_ _ * _ _	<b>Neck Circumference</b> (inches, to next lower 1/4 inch)
<input type="checkbox"/> <b>Protocol modification.</b>	
_ _ * _ _	<b>Waist Girth at umbilicus</b> (inches, to next lower 1/4 inch).
<input type="checkbox"/> <b>Protocol modification.</b>	
_ _ * _ _	<b>Hip Girth</b> (inches, to next lower 1/4 inch)
<input type="checkbox"/> <b>Protocol modification</b>	
_ _ * _ _	<b>Thigh Girth</b> (inches, to next lower 1/4 inch)
<input type="checkbox"/> <b>Protocol modification.</b>	

**Comments for ALL Protocol Modification** (specify measurement)

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**TECH01**



Check here if whole page is blank. Reason why \_\_\_\_\_

<b>Exit Interview</b>	
_ _ _	<b>Technician Number</b>
_	<b>Procedure sheet reviewed</b>
_	<b>Referral sheet reviewed</b> <span style="float: right;">0=No</span>
_	<b>Dietary questionnaire provided</b> (if not completed in clinic) <span style="float: right;">1=Yes</span>
_	<b>Left clinic with accelerometer</b> <span style="float: right;">9=Unk.</span>
_	<b>Left clinic w/ belongings</b>
_	<b>Feedback</b> 0=No feedback, 1=Positive feedback, 2=Negative feedback, 3=Other, 9=Unk.
Comments _____	
_____	
_____	

_ _ _	<b>Technician Number</b>												
_	<b>Was there an adverse event in clinic that does not require further medical evaluation?</b> (0=No, 1=Yes, 9=Unk.)												
Comments: _____													
<i>OFFSITE only if yes fill</i>	<table style="width: 100%;"> <tr> <td style="width: 15%; text-align: center;"> _ _ _ </td> <td><b>Technician number</b></td> <td style="text-align: right;"><i>(OFFSITE visit only)</i></td> </tr> <tr> <td style="text-align: center;"> _ </td> <td><b>Was a FHS physician contacted during the examination due to adverse exam finding?</b> (0=No, 1=Yes, (=Unk.)</td> <td></td> </tr> <tr> <td colspan="3">Comments: _____</td> </tr> <tr> <td colspan="3">_____</td> </tr> </table>	_ _ _	<b>Technician number</b>	<i>(OFFSITE visit only)</i>	_	<b>Was a FHS physician contacted during the examination due to adverse exam finding?</b> (0=No, 1=Yes, (=Unk.)		Comments: _____			_____		
_ _ _	<b>Technician number</b>	<i>(OFFSITE visit only)</i>											
_	<b>Was a FHS physician contacted during the examination due to adverse exam finding?</b> (0=No, 1=Yes, (=Unk.)												
Comments: _____													
_____													

_ _ _	<b>Technician who reviewed TECH portion of exam</b>
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Your exam today was for research purposes only and is not designed to make a medical diagnosis. The exam cannot identify all serious heart and health issues. It is important that you continue regular follow-up with your physician or health care provider.

**TECH0? CL**



## Socio-demographic Questionnaire. (Tech-administered)

Check here if whole page is blank. Reason why \_\_\_\_\_

\_\_\_\_ Technician Number

### Socio-demographics

**Where do you live?** (0=Private residence, 1=Nursing home, 2=Other institution, such as: assisted living, retirement community, 9=Unk.)

**Does anyone live with you?** (0=No, 1=Yes, 9=Unk.)  
*Code Nursing Home Residents as NO*

If Yes, fill

Spouse 0=No

Significant Other 1=Yes, less than 3 months per year

If 0 or 9,  
skip to next  
table

Children 2=Yes, more than 3 months per year

Friends 9=Unk.

Relatives

### Use of Nursing and Community Services

**Have you been admitted to a nursing home (or skilled facility) in the past year)** 0=No

**In the past year, have you been visited by a nursing service, or used home, community, or outpatient programs?** 1=Yes  
9=Unk.

TECH03 CL.

**Nagi Questions.**  
**(Tech-administered)**

Check here if whole page is blank. Reason why \_\_\_\_\_

||\_||\_||\_

**Technician Number**

**Nagi Questions**

For each thing tell me whether you have:

- (0) No Difficulty
- (1) A Little Difficulty
- (2) Some Difficulty
- (3) A Lot Of Difficulty
- (4) Unable To Do
- (5) Don't Do On MD Orders
- (6) Unable to Assess Difficulty Because not Done as Part of Daily Activities
- (9) Unk.

**Pulling or pushing large objects like a living room chair**

**Either stooping, crouching, or kneeling**

**Reaching or extending arms below shoulder level**

**Reaching or extending arms above shoulder level**

**Either writing, or handling, or fingering small objects**

**Standing in one place for long periods, say 15 minutes**

**Sitting for long periods, say 1 hour**

**Lifting or carrying weights under 10 pounds** *(like a bag of potatoes)*

**Lifting or carrying weights over 10 pounds** *(like a very heavy bag of groceries)*

**TECH04      CL**

## Rosow-Breslau Scales and Katz Activities of Daily Living (Tech-administered)

Check here if whole page is blank. Reason why \_\_\_\_\_

\_\_\_\_ Technician Number

### Rosow-Breslau Questions

- |                          |   |        |
|--------------------------|---|--------|
| <input type="checkbox"/> | <b>Are you able to do heavy work around the house, like shoveling snow or washing windows, walls, or floors without help?</b> | 0=No   |
| <input type="checkbox"/> | <b>Are you able to walk half a mile without help? (About 4-6 blocks)</b>  | 1=Yes  |
| <input type="checkbox"/> | <b>Are you able to walk up and down one flight of stairs without help?</b>  | 9=Unk. |

During the Course of a Normal Day, can you do the following activities independently or do you need human assistance or the use of a device.

- 0=No help needed, independent,
- 1=Uses device, independent,
- 2=Human assistance needed, minimally dependent,
- 3=Dependent,
- 4=Do not do during a normal day,
- 9=Unk.

- |                          |  |
|--------------------------|--|
| <input type="checkbox"/> | <b>Dressing</b> (undressing and redressing)<br><i>Devices such as: velcro, elastic laces</i>   |
| <input type="checkbox"/> | <b>Bathing</b> (including getting in and out of tub or shower)<br><i>Devices such as: bath chair, long handled sponge, hand held shower, safety bars</i> |
| <input type="checkbox"/> | <b>Eating</b><br><i>Devices such as: rocking knife, spork, long straw, plate guard.</i>  |
| <input type="checkbox"/> | <b>Transferring</b> ( getting in and out of a chair)<br><i>Devices such as: sliding board, grab bars, special seat</i>                                   |
| <input type="checkbox"/> | <b>Toileting Activities</b> (using bathroom facilities and handle clothing)<br><i>Devices such as: special toilet seat, commode</i>                      |

**TECH04      CL**

## CES-D Scale

### Tech-administered

Check here if whole page is blank. Reason why \_\_\_\_\_

\_\_\_\_ Technician Number

The questions below ask about your feelings. For each statement, please say how often you felt that way during the past week.

DURING THE PAST WEEK	Circle best answer for each question			
	<b>Rarely</b> or none of the time (less than 1 day)	<b>Some</b> or a little of the time (1-2 days)	<b>Occasionally</b> or moderate amount of time (3-4 days)	<b>Most</b> or all of the time (5-7 days)
<b>*I was bothered by things that usually don't bother me.</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
<b>I did not feel like eating; my appetite was poor.</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
<b>I felt that I could not shake off the blues, even with help from my family and friends.</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
<b>I felt that I was just as good as other people.</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
<b>I had trouble keeping my mind on what I was doing.</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
<b>*I felt depressed.</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
<b>I felt that everything I did was an effort.</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
<b>I felt hopeful about the future.</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
<b>I thought my life had been a failure.</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
<b>I felt fearful.</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
<b>*My sleep was restless.</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
<b>I was happy.</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
<b>I talked less than usual.</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
<b>I felt lonely.</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
<b>People were unfriendly.</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
<b>I enjoyed life.</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
<b>I had crying spells.</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
<b>I felt sad.</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
<b>I felt that people disliked me</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
<b>I could not "get going"</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>

\* Indicates that the technician should preface the statement with "During the past week"

**TECH13**

**Physical Activity Questionnaire--Framingham Heart Study  
Tech-administered**

Check here if whole page is blank. Reason why \_\_\_\_\_

\_\_\_\_ Technician Number

<b>Rest and Activity for a Typical Day</b> <i>(Activities must equal 24 hours)</i>	<b>Number of hours</b>
<b>Sleep</b> - Number of hours that you typically sleep?	_____
<b>Sedentary</b> - Number of hours typically sitting?	_____
<b>Slight Activity</b> - Number of hours with activities such as standing, walking?	_____
<b>Moderate Activity</b> - Number of hours with activities such as housework (vacuum, dust, yard chores, climbing stairs; light sports such as bowling, golf)?	_____
<b>Heavy Activity</b> - Number of hours with activities such as heavy household work, heavy yard work such as stacking or chopping wood, exercise such as intensive sports--jogging, swimming etc.?	_____
<b>Total number of hours</b> <i>(should be the total of above items)</i>	<b>24</b>

**What is your normal walking pace outdoors?**

- 0 = Unable to walk (code 0 mean unable to walk outdoors or unable to walk at all)
- 1 = Easy, casual, slow (less than 2 miles per hour)
- 2 = Normal, average (2 to 2.9 miles per hour)
- 3 = Brisk pace (3 to 3.9 miles per hour)
- 4 = Very brisk pace (4 to 4.9 miles per hour)
- 9 = Unk.

**How many flights of stairs (not steps) do you climb daily? (10 stairs per flight)**

- 0 = No flights
- 1 = 1-2 flights
- 2 = 3-4 flights
- 3 = 5-9 flights
- 4 = 10-14 flights
- 5 = >15 flights
- 9 = Unk.

ECH05 CL

## Physical Activity Questionnaire--Framingham Heart Study Tech-administered

Check here if whole page is blank. Reason why \_\_\_\_\_

I am going to read a list of activities. Please tell me which activities you have done in the past year.

\_\_\_\_ Technician Number

During past year did you do? 0=No, 1=Yes, 8=Refused, 9=Unk.	In a typical 2 week period of time, how often do you ( <i>name of activity</i> )	Average time/session		Number months/year 0-12
		hours	minutes	
<input type="checkbox"/> <b>Walking for exercise</b>	____	____	____	____
<input type="checkbox"/> <b>Calisthenics/general exercise</b>	____	____	____	____
<input type="checkbox"/> <b>Moderate strenuous household chores</b>	____	____	____	____
<input type="checkbox"/> <b>Mowing the lawn</b>	____	____	____	____
<input type="checkbox"/> <b>Gardening</b>	____	____	____	____
<input type="checkbox"/> <b>Hiking</b>	____	____	____	____
<input type="checkbox"/> <b>Jogging</b>	____	____	____	____
<input type="checkbox"/> <b>Biking</b>	____	____	____	____
<input type="checkbox"/> <b>Exercise cycle, ski or stair machine</b>	____	____	____	____
<input type="checkbox"/> <b>Dancing</b>	____	____	____	____
<input type="checkbox"/> <b>Aerobics</b>	____	____	____	____
<input type="checkbox"/> <b>Golf</b>	____	____	____	____
<input type="checkbox"/> <b>Swimming</b>	____	____	____	____
<input type="checkbox"/> <b>Weight training (<i>free weights, machines</i>)</b>	____	____	____	____
<input type="checkbox"/> <b>Other, write in _____</b> _____	____	____	____	____
<input type="checkbox"/> <b>Other, write in _____</b> _____	____	____	____	____

**TECH06 CL**

## Fractures

<input type="checkbox"/>	Check here if whole page is blank.	Reason why _____
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_ _ _	Technician Number
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<b>Fractures</b>	
_	<b>Since Your Last Clinic Visit Have You Broken Any Bones?</b> (0=No, 1=Yes, 2=Maybe, 9=Unk.)
<b>If Yes, fill</b>  _ _	<b>Location of fracture:</b>
_ _	<b>Location of second fracture</b> (if more than one):
_ _	<b>Location of third fracture</b> (if more than two):
<b>Code for Location</b> ( <i>code Unk. as 99</i> )	
1= Clavicle (collar bone)	
2=Upper arm (humerus) or elbow	
3=Forearm or wrist	
4=Hand	
5=Back ( <i>If disc disease only, code as no</i> )	
6=Pelvis	
7=Hip	
8=Leg	
9=Foot	
10=Other, specify _____	

**TECH08**

**CL**

### Cognitive Function--Part I

<input type="checkbox"/>	Check here if whole page is blank.	Reason why _____
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I'm going to start by asking questions that require concentration and memory. Some questions are more difficult than others and some will be asked more than one time.

_ _ _	<b>Technician Number</b>
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SCORE CORRECT No Try=6 Unk.=9	<i>Write all responses on exam form (score 1 point for each correct response)</i>
0 1 2 3 6 9	<b>What Is the Date Today?</b> (Month, day, year, correct score=3)
0 1 6 9	<b>What Is the Season?</b>
0 1 6 9	<b>What Day of the Week Is it?</b>
0 1 2 3 6 9	<b>What Town, County and State Are We in?</b>
0 1 6 9	<b>What Is the Name of this Place?</b> <i>(any appropriate answer all right, for instance my home, street address, heart study..max score=1)</i>
0 1 6 9	<b>What Floor of the Building Are We on?</b>
0 1 2 3 6 9	<b>I am going to name 3 objects. After I have said them I want you to repeat them back to me. Remember what they are because I will ask you to name them again in a few minutes: Apple, Table, Penny</b>
_ _ _ _ _	<b>Now I am going to spell a word forward and I want you to spell it backwards. The word is world. W-O-R-L-D. Please Spell it in Reverse Order.</b> <i>(Letters Are Entered and Scored Later)</i>
Score as	66666=Not administered for reason unrelated to cognitive status 00000=Administered, but couldn't do 99999=Unk.
0 1 2 3 6 9	<b>What are the 3 objects I asked you to remember a few moments ago?</b>

**TECH09 CL**



## Cognitive Function --Part II

Check here if whole page is blank. Reason why \_\_\_\_\_

SCORE CORRECT No Try=6 Unk.=9	<i>Write all responses on exam form.</i>
0 1 6 9	<b>What Is this Called? (Watch)</b>
0 1 6 9	<b>What Is this Called? (Pencil)</b>
0 1 6 9	<b>Please Repeat the Following: "No Ifs, Ands, or Buts." (Perfect=1)</b>
0 1 6 9	<b>Please Read the Following &amp; Do What it Says</b> ( <i>performed=1, code 6 if low vision</i> )
0 1 6 9	<b>Please Write a Sentence</b> ( <i>code 6 if low vision</i> )
0 1 6 9	<b>Please Copy this Drawing</b> ( <i>code 6 if low vision</i> )
0 1 2 3 6 9	<b>Take this piece of paper in your right hand, fold it in half with both hands, and put in your lap</b> ( <i>score 1 for each correctly performed act, code 6 if low vision</i> )

No Yes Maybe Unk (coding for below)	Factor Potentially Affecting Mental Status Testing
0 1 2 9	<b>Illiterate or low education</b>
0 1 2 9	<b>Not fluent in English</b>
0 1 2 9	<b>Poor eyesight</b>
0 1 2 9	<b>Poor hearing</b>
0 1 2 9	<b>Depression / possible depression</b>
0 1 2 9	<b>Other, write in _____</b>

**TECH10 CL**



<input type="checkbox"/> Check here if whole page is blank. Reason why _____
--

### Sentence and Design Handout for Participant

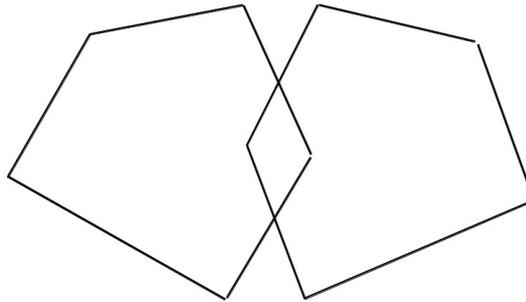
PLEASE WRITE A SENTENCE

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PLEASE COPY THIS DESIGN





### Observed performance. Part 1 Technician Administered

Check here if whole page is blank. Reason why \_\_\_\_\_

_ _ _	<b>Technician Number</b>
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<b>HAND GRIP TEST</b> <i>Measured to the nearest kilogram</i>		
<b>Right hand</b>		
<b>Trial 1</b>	99=Unk.	_ _
<b>Trial 2</b>	99=Unk.	_ _
<b>Trial 3</b>	99=Unk.	_ _
<b>Left hand</b>		
<b>Trial 1</b>	99=Unk.	_ _
<b>Trial 2</b>	99=Unk.	_ _
<b>Trial 3</b>	99=Unk.	_ _

**Check if this test not completed or not attempted.**

|\_| **If not attempted or completed, why not?**  
 1=Physical limitation, 2=Refused, 3=Other \_\_\_\_\_ write in, 9=Unk.

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**TECH11 CL**

## Observed performance. Part 2

### Technician Administered

<input type="checkbox"/> Check here if whole page is blank.	Reason why _____
---	------------------

<b>Measured Walks</b>	
<b>Walking aid used:</b> 0=No aid, 1=Cane, 2=Walker, 3=Wheelchair, 4=Other, 9=Unk.	_
<b>First Walk</b>	
<b>Walk time</b> (in seconds, 99.99=Unk.)	_ _ * _ _
<b>Laser walk time</b> (in seconds, 99.99=Unk.)	_ _ * _ _
<input type="checkbox"/> <b>Check if this test not completed or not attempted.</b>	
<input type="checkbox"/> <b>If not attempted or completed, why not?</b> (1=Physical limitation, 2=Refused, 3=Other _____ write in, 9=Unk.)	
<b>Second Walk</b>	
<b>Walk time</b> (in seconds, 99.99=Unk.)	_ _ * _ _
<b>Laser walk time</b> (in seconds, 99.99=Unk.)	_ _ * _ _
<input type="checkbox"/> <b>Check if this test not completed or not attempted.</b>	
<input type="checkbox"/> <b>If not attempted or completed, why not?</b> (1=Physical limitation, 2=Refused, 3=Other _____ write in, 9=Unk.)	
<b>Quick Walk</b>	
<b>Walk time</b> (in seconds, 99.99=Unk.)	_ _ * _ _
<b>Laser walk time</b> (in seconds, 99.99=Unk.)	_ _ * _ _
<input type="checkbox"/> <b>Check if this test not completed or not attempted.</b>	
<input type="checkbox"/> <b>If not attempted or completed, why not?</b> (1=Physical limitation, 2=Refused, 3=Other _____ write in, 9=Unk.)	

TECH12

CL

**Ankle Brachial Blood Pressure Measurements. Participants ≥40 years**

SYSTOLIC BLOOD PRESSURES BY DOPPLER (to be taken in the following order with participant supine after 5 minutes of rest)

<input type="checkbox"/> Page blank and Participant <40	<input type="checkbox"/> Page blank and Participant ≥40; fill	Reason why _____
_ _ _	<b>Technician Number</b> for Doppler Ankle Brachial Blood Pressure.	
_	<b>Cuff size, arm</b>	0= pediatric, 1= regular adult
_	<b>Cuff size, ankle</b>	2= large adult, 3= thigh

_ _ _	<b>Right arm</b>	
_ _ _	<b>Right ankle</b>	300=≥300 mmHg
_ _ _	<b>Left ankle</b>	888= Not Done
_ _ _	<b>Left arm</b>	999= Unk.

REPEAT SYSTOLIC BLOOD PRESSURE MEASUREMENTS (reverse order)

_ _ _	<b>Left arm</b>	
_ _ _	<b>Left ankle</b>	300=≥300 mmHg
_ _ _	<b>Right ankle</b>	888= Not Done
_ _ _	<b>Right arm</b>	999= Unk.

THIRD SYSTOLIC BLOOD PRESSURE MEASUREMENT (order as in repeat SBP). To be obtained if initial and repeat SBP at any site differ by more than 10 mmHg. For site that differs.

_ _ _	<b>Right arm</b>	
_ _ _	<b>Right ankle</b>	300=≥300 mmHg
_ _ _	<b>Left ankle</b>	888= Not Done
_ _ _	<b>Left arm</b>	999= Unk.

_	<b>Right Ankle blood pressure site</b>	0= posterior tibial (ankle)
_	<b>Left Ankle blood pressure site</b>	1= dorsalis pedis (foot)

EXCLUSIONS:

Enter exclusion **ONLY** if there is an 888 above.

Right	Left	
_	_	<b>Lower Extremity Exclusions</b> 1= venous stasis ulceration, 2= amputation, 3= other _____
_	_	<b>Upper Extremity Exclusions</b> 1=Mastectomy, 3= Other _____
<input type="checkbox"/> <b>Check if Protocol modification</b> , write in _____		
<b>Comments</b> _____		

**TECH04**



**Respiratory Disease Questionnaire, Part 1**

Technician Administered.

 Check here if whole page is blank. Reason why \_\_\_\_\_
**Respiratory Diagnoses**
    Technician Number

 Have you ever had asthma? (0=No, 1=Yes, 9=Unk.)
If yes,  
fill 
 Do you still have it?

 Was it diagnosed by a doctor or other health care professional?

  At what age did it start? (Age in years 88=N/A, 99=Unk.)

  If you no longer have it, at what age did it stop? (Age in years) 88=still have it, 99=Unk.

 Have you received medical treatment for this in the past 12 months?

 Have you ever had hay fever (allergy involving the nose and/or eyes)? (0=No, 1=Yes, 9=Unk.)
If yes,  
fill 
 Do you still have it? (0=No, 1=Yes, 9=Unk.)

**Have you ever had any of the following conditions diagnosed by a doctor or other health care professional? (0=No, 1=Yes, 9=Unk.)**
 Chronic Bronchitis

 Emphysema

 COPD (Chronic obstructive pulmonary disease)

 Sleep Apnea

 Pulmonary Fibrosis
**Inhaler Use** (0=No, 1=Yes)
 Do you take inhalers or bronchodilators?
If yes,  
fill 
 Do you take any of the inhaled medications?- albuterol, ProAir, Proventil, Ventolin, pirbuterol, Maxair, levalbuterol, Xopenex, metaproterenol, Alupent, or ipratropium, Atrovent, Combivent
If yes,  
fill 
  How many hours ago did you last use the medication, either by inhaler or nebulizer? if last used >48 hrs ago code 88, 99= Unk.
Time in  
hours 1-48
 Do you take any of the following inhaled medications? salmeterol, Serevent, Advair, formoterol, Foradil, Symbicort, arformoterol, Brovana, tiotropium, or Spiriva,
If yes,  
fill 
  How many hours ago did you last use the medication, either by inhaler or nebulizer? if last used >48 hrs ago code 88, 99=Unk.
Time in  
hours 1-48

TECH14

CL

## Respiratory Disease Questionnaire, Part 2. Technician Administered.

Check here if whole page is blank. Reason why \_\_\_\_\_

### Acute Respiratory Illnesses Since Last Exam

#### Since your last exam or medical history update

Have you been hospitalized because of breathing trouble or wheezing? (0=No, 1=Yes, 9=Unk.)

If yes, fill  How many times has this occurred?

Were any of these hospitalizations due to a lung or bronchial problem, for example COPD, asthma, bronchitis, emphysema, or pneumonia? (0=No, 1=Yes, 9=Unk.)

Have you required an emergency room visit or an unscheduled visit to a doctor's office or clinic because of breathing trouble or wheezing? (0=No, 1=Yes, 9=Unk.)

If yes, fill  How many times has this occurred?

Were any of these emergency room or unscheduled visits due to a lung or bronchial problem, for example COPD, asthma, bronchitis, emphysema, or pneumonia? (0=No, 1=Yes, 9=Unk.)

Have you had pneumonia (including bronchopneumonia)? (0=No, 1=Yes, 9=Unk.)

If yes, fill  How many times have you had pneumonia?

The following questions are about problems which occur when you **DO NOT** have a cold or the flu. Please list problems that occurred IN THE PAST 12 MONTH only

Have you had a problem with sneezing or a runny or blocked nose when you **DID NOT** have a cold or the flu? (0=No, 1=Yes, 9=Unk.)

If yes, fill  Has this nose problem been accompanied by itchy-watery eyes? (0=No, 1=Yes, 9=Unk.)

In which of the months did this nose problem occur? (0=No, 1=Yes) Fill in ALL months.

January

July

February

August

March

September

April

October

May

November

June

December

TECH15 CL

## Proxy form

Check here if whole page is blank. Reason why \_\_\_\_\_

**Proxy used to complete this exam** (0=No, 1=Yes, 1 proxy, 2=Yes, more than 1 proxy, 9=Unk)

**if yes,  
fill**

**Proxy Name** \_\_\_\_\_

**Relationship** (1=1<sup>st</sup> Degree Relative(spouse, child), 2=Other Relative, 3=Friend, 4=Health Care Professional, 5=Other, 9=Unk.)

**How long have you known the participant?**  
(Years, months; 99.99=Unk) example: 3m=00\*03

**Are you currently living in the same household with the participant?**  
(0=No, 1=Yes, 9=Unk)

**How often did you talk with the participant during the prior 11 months?** (1=Almost every day, 2=Several times a week, 3=Once a week, 4=1 to 3 times per month, 5=Less than once a month, 9=Unk.)

**Proxy Name** \_\_\_\_\_

**Relationship** (1=1<sup>st</sup> Degree Relative(spouse, child), 2=Other Relative, 3=Friend, 4=Health Care Professional, 5=Other, 9=Unk.)

**How long have you known the participant?**  
(Years, months; 99.99=Unk) example: 3 m=00\*03

**Are you currently living in the same household with the participant?**  
(0=No, 1=Yes, 9=Unk)

**How often did you talk with the participant during the prior 11 months?** (1=Almost every day, 2=Several times a week, 3=Once a week, 4=1 to 3 times per month, 5=Less than once a month, 9=Unk.)

TECH016

CL



**Sociodemographic questions. Part I**  
**Self-administered. Offsite - tech-administered.**

**What is your current marital status? (check ONE)**

- 1 single/never married
- 2 married/living as married/living with partner
- 3 separated
- 4 divorced
- 5 widowed
- 9 prefer not to answer

**Please choose which of the following best describes your current employment status? (check ONE)**

- 0 homemaker, not working outside the home
- 1 employed (or self-employed) full time
- 2 employed (or self-employed) part time
- 3 employed, but on leave for health reasons
- 4 employed, but temporarily away from my job
- 5 unemployed or laid off
- 6 retired from my usual occupation and not working
- 7 retired from my usual occupation but working for pay
- 8 retired from my usual occupation but volunteering
- 9 prefer not to answer
- 10 unemployed due to disability
- 11 full-time student

**What is your current occupation?**

Write in \_\_\_\_\_

||\_|\_|

**Using the occupation coding sheet choose the code that best describes your occupation.**

YES       NO      Do you have some form of health insurance?

YES       NO      Do you have prescription drug coverage?

**TECH17 CL**



**SF-12® Health Survey (Standard)  
Self-administered**

This questionnaire asks for your views about your health. This information will help you keep track of how you feel and how well you are able to do your usual activities.

Please answer every question by marking one box. If you are unsure about how to answer a question, please give the best answer you can.

1. In general, would you say your health is:

Excellent	Very good	Good	Fair	Poor
<input type="checkbox"/>				

The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
2. <b>Moderate activities</b> , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Climbing <b>several</b> flights of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	Yes	No
4. <b>Accomplished less</b> than you would like	<input type="checkbox"/>	<input type="checkbox"/>
5. Were limited in the <b>kind</b> of work or other activities	<input type="checkbox"/>	<input type="checkbox"/>

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	Yes	No
6. <b>Accomplished less</b> than you would like	<input type="checkbox"/>	<input type="checkbox"/>
7. Didn't do work or other activities as <b>carefully</b> as usual	<input type="checkbox"/>	<input type="checkbox"/>

**TECH19 CL**

**SF-12® Health Survey (Standard)  
Self-administered**

. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

<b>Not at all</b>	<b>A little bit</b>	<b>Moderately</b>	<b>Quite a bit</b>	<b>Extremely</b>
<input type="checkbox"/>				

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

**How much of the time during the past 4 weeks...**

	<b>All of the time</b>	<b>Most of the time</b>	<b>A good bit of the time</b>	<b>Some of the time</b>	<b>A little of the time</b>	<b>None of the time</b>
<b>9.</b> Have you felt calm and peaceful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>10.</b> Did you have a lot of energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>11.</b> Have you felt downhearted and blue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**12.** During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

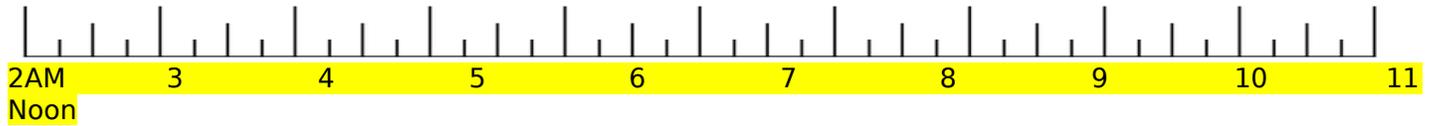
<b>All of the time</b>	<b>Most of the time</b>	<b>Some of the time</b>	<b>A little of the time</b>	<b>None of the time</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TECH20 CL

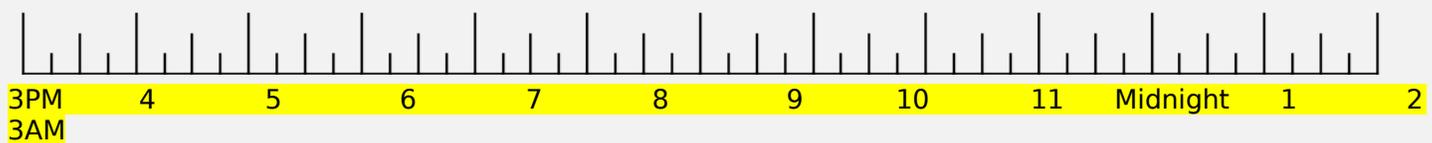
## Sleep Questionnaire. Part 1

### Self-administered

Considering only your “feeling best” rhythm, **at what time would you get up if you were entirely free to plan your day?** (Place a cross at the appropriate point along the scale.)



Considering only your “feeling best” rhythm, **at what time would you go to bed if you were entirely free to plan your evening?** (Place a cross at the appropriate point along the scale.)



**What is the chance that you would doze off or fall asleep (not just “feel tired”) in each of the following situations?** (Circle one response for each situation. If you are never or rarely in the situation, please give your best guess for that situation)

	None	Slight	Moderate	High
Sitting and reading	0	1	2	3
Watching TV.	0	1	2	3
Sitting inactive in a public place (such as theater or a meeting)	0	1	2	3
Riding as a passenger in a car for an hour without a break.	0	1	2	3
Lying down to rest in the afternoon when circumstances permit.	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol.	0	1	2	3
In a car, while stopped in traffic for a few minutes.	0	1	2	3

TECH??

CL

## Sleep Questionnaire. Part 2

### Self-administered

#### During the past month...

when have you usually gone to bed at night?

:    
hours : min AM PM

how long has it usually taken you to fall asleep each night?

:  
hours : min

when have you usually gotten up in the morning?

:    
hours : min AM PM

how much *actual sleep* did you get at night?

:  
hours : min

#### When you experience the following situations, how likely is it for you to have difficulty sleeping?

Circle an answer even if you have not experienced these situations recently.

	Not likely	Somewhat likely	Moderately likely	Very likely
Before an important meeting the next day	0	1	2	3
After a stressful experience during the day	0	1	2	3
After a stressful experience in the evening	0	1	2	3
After getting bad news during the day	0	1	2	3
After watching a frightening movie or TV show	0	1	2	3
After having a bad day at work	0	1	2	3
After an argument	0	1	2	3
Before having to speak in public	0	1	2	3
Before going on vacation the next day	0	1	2	3

On average over the past year, how often do you snore?

On average over the past year, how often do you have times when you stop breathing while you are asleep?

0= Never  
1= Less than 1 night per week  
2= 1-2 nights per week  
3= 3-5 nights per week  
4= 6-7 nights per week  
9= Don't know

TECH21

CL

### Sleep Questionnaire. Part 3

#### Self-administered

One hears about “morning” and “evening” types of people. Which ONE of these types do you consider yourself to be? Please check ONE box below

- Definitely a “morning” type
- Rather more a “morning” than an “evening” type
- Neither a “morning” nor an “evening” type
- Rather more an “evening” than a “morning” type
- Definitely an “evening” type

Have you ever been told by a doctor or other health professional that you have any of the following?

(Circle one response for each item)	No	Yes	Don't know
Sleep apnea or obstructive sleep apnea.	0	1	9
if yes, fill <input type="checkbox"/> Do you wear a mask (“CPAP”) or other device at night to treat sleep apnea?	0	1	9
Insomnia.	0	1	9
Restless legs.	0	1	9

TECH?? CL



**Date of exam**

\_\_\_\_/\_\_\_\_/\_\_\_\_

**Framingham Heart Study  
Offspring EXAM 9**

**Summary Sheet to Personal Physician**

<b>Blood Pressure</b>	<b>First Reading</b>	<b>Second Reading</b>
<b>Systolic</b>		
<b>Diastolic</b>		

ECG Diagnosis \_\_\_\_\_  
\_\_\_\_\_

The following tests are done on a routine basis: Blood Glucose, Blood Lipids, Pulmonary Function Test (results enclosed). Echocardiogram findings will be forwarded at a later date **only if abnormal.**

**Summary of Findings** \_\_\_\_\_

1. **No history or physical exam findings to suggest cardiovascular disease.**  
*(check box if applicable)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Examining Physician

*The Heart Study Clinic examination is not comprehensive and does not take the place of a routine physical examination.*



**Referral Tracking**

Check here if whole page is blank. Reason why \_\_\_\_\_

Was further medical evaluation recommended for this participant? 0=No, 1=Yes, if yes fill below 9=Unk.

**RESULT Reason for further evaluation:** (Check ALL that apply).

**Blood Pressure**

result \_\_\_\_/\_\_\_\_ mmHg

result \_\_\_\_/\_\_\_\_ mmHg

SBP or DBP

Phone call  $\geq 200$  or  $\geq 110$ Expedite  $\geq 180$  or  $\geq 100$ Elevated  $\geq 140$  or  $\geq 90$ **Abnormal laboratory result** \_\_\_\_\_*Write in abnormality***ECG abnormality** \_\_\_\_\_**Clinic Physician** identified medical problem \_\_\_\_\_**Other** \_\_\_\_\_

**Method used to inform participant of need for further medical evaluation**

*(Check ALL that apply)***Face-to-face in clinic****Phone call****Result letter****Other**

**Method used to inform participant's personal physician of need for further medical evaluation** (check ALL that apply)

**Phone call****Result letter mailed****Result letter FAX'd** (inform staff if Fax needed)**Other**

Date referral made: \_\_\_\_/\_\_\_\_/\_\_\_\_

ID number of person completing the referral: \_\_\_\_\_

Notes documenting conversation with participant or participant's personal physician: \_\_\_\_\_

**TECH31****CL**



**Medical History—Hospitalizations, ER Visits, MD Visits**

**OFFSPRING EXAM 9**

DATE \_\_\_\_\_

**DATE of last exam** «Lexam»

**DATE of last medical history update** «Lupdate»

<b>Health Care</b>	
<b>Since your last exam or medical history update</b>	
_ _ _	<b>1st Examiner ID</b> _____ <b>1st Examiner Name</b>
_	<b>1st Examiner Prefix</b> (0=MD, 1=Tech. for OFFSITE visit)
_	<b>Hospitalizations</b> ( <i>not just E.R.</i> ) (0=No; 1=yes, hospitalization, 2=yes, more than 1 hospitalization, 9=Unk.)
_	<b>E.R. Visits</b> (0=No; 1=Yes, 1 visit, 2=Yes, more than 1 visit, 9=Unk.)
_	<b>Day Surgery</b> (0=No, 1=Yes, 9=Unk.)
_	<b>Major illness with visit to doctor</b> (0=No, 1=Yes, 1 visit; 2=Yes, more than 1 visit; 9=Unk)
_	<b>Check up by doctor or other health care provider?</b> (0=No, 1=Yes, 9=Unk.)
_	<b>Have you had a fever or infection in <u>past two weeks</u>?</b> (0=No, 1=Yes, 9=Unk.)
_ _     _ _     _ _ _ _	<b>Date of this FHS exam</b> ( <i>Today's date - See above</i> )
MM    DD    YYYY	

*Note: if FHS needs outside hospital record, please obtain details: mo/yr, hospital site.*

Medical Encounter	Month/Year (of last visit)	Name & Address of Hospital or Office	Doctor

**MD01    CL**

## Medical History—Medications

<input type="checkbox"/>	<b>Do you take aspirin regularly?</b> ( 0=No, 1=Yes, 9=Unk)	
<b>If yes,</b>	<input type="text"/>	<b>Number of aspirins taken regularly</b> (99=Unk.)
<b>fill</b>	<input type="text"/>	<b>Frequency per</b> ( 1=Day, 2=Week 3=Month, 4=Year, 9=Unk)
	<input type="text"/>	<b>Usual dose</b> (write in mgs, 999=Unk.)
		<u>Examples:</u> 081=baby,160=half dose, 250= like in Excedrin , 325=usual dose, 500=extra strength

<b>Since your last exam</b>	
(0=No, 1=Yes, 9=Unk)	
<input type="checkbox"/>	<b>Have you been told by doctor you have high blood pressure or hypertension?</b>
<input type="checkbox"/>	<b>Have you taken medication for high blood pressure or hypertension?</b>
<input type="checkbox"/>	<b>Have you been told by doctor you have high blood cholesterol or high triglycerides?</b>
<input type="checkbox"/>	<b>Have you taken medication for high blood cholesterol or high triglycerides?</b>
<input type="checkbox"/>	<b>Have you been told by doctor you have high blood sugar or diabetes?</b>
<input type="checkbox"/>	<b>Have you taken medication for high blood sugar or diabetes?</b>
<input type="checkbox"/>	<b>Have you taken medication for cardiovascular disease? (for example angina/chest pain, heart failure, atrial fibrillation/heart rhythm abnormality, stroke, leg pain when walking, peripheral artery disease)</b>

MD02      CL





## Medical History–Female Reproductive History. Part 1.

Check here if Male Participant (and skip to Smoking Questions page 46/MD07)

Check here if definitely menopausal (and skip to Female History Part 3 page 45)  
*to be preloaded from previous exam*

Since your last exam have you taken or used birth control pills, shots, or hormone implants for birth control or medical indications (not post menopausal hormone replacement)?  
(0=no, 1=yes, now, 2=yes, not now, 9=Unk.)

Have you been pregnant since last exam? (0=no, 1=yes, 9=Unk.)

If yes,   Number of pregnancies?

fill in number

fill   Number of live births?

During any of these pregnancies, were you told you had high blood pressure or hypertension?

0=No

During any of these pregnancies, were you told you had eclampsia, pre-eclampsia (toxemia)

1=Yes

During any of these pregnancies, were you told you had high blood sugar or diabetes?

9=Unk

MD05 CL

## Medical History–Female Reproductive History. Part 2

*below: content is the same but the wording was changed*

**What is the best way to describe your periods? Check the BEST answer – only one.**

- Not stopped**
- Periods stopped due to pregnancy, breast feeding, or hormonal contraceptive** (for example: depo-provera, progestin releasing IUD, extended release birth control pill)
- Periods stopped due to low body weight, heavy exercise, or due to medication or health condition such as thyroid disease, pituitary tumor, hormone imbalance, stress,**
- Write in cause** \_\_\_\_\_
- Periods stopped for less than 1 year (perimenopausal)**
- \_\_\_\_ Number of months since last period 99=Unk.
- Periods stopped for 1 year or more**
- Periods stopped, but now have periods induced by hormones.**
- \_\_\_\_ Number months stopped before hormones started. 99=Unk.

\_\_\_\_\*\_\_\_\_\*\_\_\_\_  
\_\_

**When was the first day of your last menstrual period?** 99/99/9999=Unk.

**88/88/8888=** periods stopped for more than 1 year or using postmenopausal hormones

*If periods stopped due to pregnancy, breast feeding, hormonal contraception or health condition code date of last menstrual period*

**Age when periods stopped** (00=not stopped, 99=Unk.)

*If periods now induced by hormones, code age when periods naturally stopped.*

*If periods stopped due to pregnancy, breast feeding, or hormonal contraception code as “0=not stopped”*

**Was your menopause natural or the result of surgery, chemotherapy, or radiation?**

(0=still menstruating, 1=natural, 2=surgical, 3=chemo/radiation, 4=other, 9=Unk.)

*If periods stopped due to pregnancy, breast feeding, or hormonal contraception code as “0=still menstruating”*

MD06 CL

### Medical History–Female Reproductive History. Part 3

<b>Surgery History</b>													
<input type="checkbox"/>	<b>Since your last exam have you had a hysterectomy (uterus/womb removed)?</b> (0=no, 1=yes, 9=Unk.)												
<b>If yes, fill</b>	<table style="width: 100%; border: none;"> <tr> <td style="width: 20%; border: none;"><input type="text"/></td> <td style="border: none;">Age at hysterectomy? 99=Unk.</td> </tr> <tr> <td style="border: none;"><input type="text"/>*<input type="text"/></td> <td style="border: none;">Date of surgery (mo/yr) 99/9999=Unk.</td> </tr> </table>	<input type="text"/>	Age at hysterectomy? 99=Unk.	<input type="text"/> * <input type="text"/>	Date of surgery (mo/yr) 99/9999=Unk.								
<input type="text"/>	Age at hysterectomy? 99=Unk.												
<input type="text"/> * <input type="text"/>	Date of surgery (mo/yr) 99/9999=Unk.												
<input type="checkbox"/>	<b>Since last exam have you had an operation to remove one or both of your ovaries?</b> (0=no, 1=yes, 9=Unk.)												
<b>If yes, fill</b>	<table style="width: 100%; border: none;"> <tr> <td style="width: 20%; border: none;"><input type="text"/></td> <td style="border: none;">Age when ovaries removed? <i>If more than one surgery, use age at last surgery</i> 99=Unk.</td> </tr> <tr> <td colspan="2" style="text-align: center; border: none;"><b>Number of ovaries removed? (check one)</b></td> </tr> <tr> <td style="text-align: center; border: none;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center; border: none;">1=one ovary</td> <td style="text-align: center; border: none;">2=two ovaries</td> <td style="text-align: center; border: none;">3= unknown. number of ovaries</td> <td style="text-align: center; border: none;">4= part of an ovary</td> </tr> </table>	<input type="text"/>	Age when ovaries removed? <i>If more than one surgery, use age at last surgery</i> 99=Unk.	<b>Number of ovaries removed? (check one)</b>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1=one ovary	2=two ovaries	3= unknown. number of ovaries	4= part of an ovary
<input type="text"/>	Age when ovaries removed? <i>If more than one surgery, use age at last surgery</i> 99=Unk.												
<b>Number of ovaries removed? (check one)</b>													
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>										
1=one ovary	2=two ovaries	3= unknown. number of ovaries	4= part of an ovary										

<input type="checkbox"/>	<b>Have you since your last exam taken hormone replacement therapy (estrogen/progesterone) or a selective estrogen receptor modulator (such as evista or raloxifene)?</b> (0=no, 1=yes, now, 2=yes, not now, 9=Unk.)
--------------------------	--

**Comments** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Medical History--Smoking

#### Cigarettes

Since your last exam have you smoked cigarettes regularly? (0=no, 1=yes, 9=Unk.)

If yes,  
fill

Have you smoked cigarettes regularly in the last year? (No means less than 1 cigarette a day for 1 year.) (0=no, 1=yes, 9=Unk.)

Do you now smoke cigarettes (as of 1 month ago)? (0=no, 1=yes, 9=Unk.)

How many cigarettes do you smoke per day now? (99=Unk.)

#### Questions below refer to "since your last exam"

During the time you were smoking, on average how many cigarettes per day did you smoke (99=Unk)

If you have stopped smoking cigarettes completely, how old were you when you stopped? (Age stopped, 00=not stopped, 99=Unk.)

When you were smoking, did you ever stop smoking for >6 months? (0=no, 1=yes, 9=Unk.)

If yes,  
fill

For how many years in total did you stop smoking cigarettes (1=6 months – 1 year, 99=Unk.)

#### Pipes or Cigars

Since your last exam, have you regularly smoked a pipe or cigar? 0=No

If yes,  
fill

Do you smoke a pipe or cigar now 1=Yes  
9=Unk.

Comments: \_\_\_\_\_

MD07

CL

### Medical History –Alcohol Consumption.

Now I will ask you questions regarding your alcohol use.

Do you drink any of the following beverages at least once a month? (0=no, 1=yes, 9=Unk.)		
<input type="checkbox"/>	Beer	
<input type="checkbox"/>	Wine	
<input type="checkbox"/>	Liquor/spirits	
<b>If yes, what is your average number of servings in a typical week or month over past year?</b> (999=Unknown) <i>Code alcohol intake as EITHER weekly OR monthly as appropriate.</i>		
Beverage	Per week	Per month
<b>Beer</b> (12oz bottle, glass, can)	_ _ _	_ _ _
<b>Wine</b> (red or white, 4oz glass)	_ _ _	_ _ _
<b>Liquor/spirits</b> (1oz cocktail/highball)	_ _ _	_ _ _

_ _ _	<b>At what age did you stop drinking alcohol?</b> (0= not stopped, 888=Never drinker 999=Unk.)
-------	--

<input type="checkbox"/>	<b>Over the past year, on average on how many days per week did you drink an alcoholic beverage of any type?</b> (0=no drinks, 1=1or less, 9=Unk.)
_ _	<b>Over the past year, on a typical day when you drink, how many drinks do you have?</b> (0=no drinks, 1=1or less, 99=Unk.)
_ _	<b>What was the maximum number of drinks you had in 24 hr. period during the past month?</b> (0=no drinks, 1=1or less, 99=Unk.)
<input type="checkbox"/>	<b>Since last exam has there been a time when you drank 5 or more alcoholic drinks of any kind almost daily?</b> (0=no, 1=yes, 9=Unk.)

<input type="checkbox"/>	<b>Check if over past year participant drinks less than one alcoholic drink of any type per month.</b>
--------------------------	--

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

MD08

CL

## Medical History—Respiratory Symptoms. Part I

<b>Cough</b> (0=No, 1=Yes, 9=Unk.)	
<input type="checkbox"/>	<b>Do you usually have a cough?</b> ( <i>Exclude clearing of the throat</i> )
<input type="checkbox"/>	<b>Do you usually have a cough at all on getting up or first thing in the morning?</b>
If <b>YES</b> to <b>either</b> question above <b>answer</b> the following:	
<input type="checkbox"/>	<b>Do you cough like this on most days for three consecutive months or more during the past year?</b>
<input type="checkbox"/>	<b>How many years have you had this cough? (# of years.)</b> <span style="float: right;">1=1 year or less 99=Unk</span>

<b>Phlegm</b> (0=No, 1=Yes, 9=Unk.)	
<input type="checkbox"/>	<b>Do you usually bring up phlegm from your chest?</b>
<input type="checkbox"/>	<b>Do you usually bring up phlegm at all on getting up or first thing in the morning?</b>
If <b>YES</b> to <b>either</b> question above <b>answer</b> the following:	
<input type="checkbox"/>	<b>Do you bring up phlegm from your chest on most days for three consecutive months or more during the year?</b>
<input type="checkbox"/>	<b>How many years have you had trouble with phlegm? (# of years)</b> <span style="float: right;">1=1 year or less 99=Unk</span>

<b>Wheeze</b> (0=No, 1=Yes, 9=Unk.)	
<b>In the past 12 months...</b>	
<input type="checkbox"/>	<b>Have you had wheezing or whistling in your chest at any time?</b>
<b>if yes, fill all</b>	<input type="checkbox"/> <b>How often have you had this wheezing or whistling?</b> 0=Not at all    1=MOST days or nights    2=A few days or nights a WEEK 3=A few days or nights a MONTH    4=A few days or nights a YEAR    9=Unk.
<input type="checkbox"/>	<b>Have you had this wheezing or whistling in the chest when you had a cold?</b>
<input type="checkbox"/>	<b>Have you had this wheezing or whistling in the chest apart from colds?</b>
<input type="checkbox"/>	<b>Have you had an attack of wheezing or whistling in the chest that had made you feel short of breath?</b>

MD09      CL

**Medical History—Respiratory Symptoms. Part II****Nocturnal chest symptoms** (0=No, 1=Yes, 9=Unk.)**In the past 12 months...** **Have you been awakened by shortness of breath?** **Have you been awakened by a wheezing/whistling in your chest?** **Have you been awakened by coughing?**if yes,  
fill all **How often have you been awakened by coughing?**

0=Not at all 1=MOST days or nights 2=A few days or nights a WEEK

3=A few days or nights a MONTH 4=A few days or nights a YEAR 9=Unk.

**Shortness of breath**

(0=No, 1=Yes, 9=Unk.)

**Since your last exam...** **Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill?**if yes,  
fill all **Do you have to walk slower than people of your age on level ground because of shortness of breath?****Do you have to stop for breath when walking at your own pace on level ground?****Do you have to stop for breath after walking 100 yards (or after a few minutes) on level ground?** **Do you/have you needed to sleep on two or more pillows to help you breathe (Orthopnea)?** **Have you since last exam had swelling in both your ankles (ankle edema)?** **Have you been told by your doctor you had heart failure or congestive heart failure?**if yes,  
fill 

Name of doctor \_\_\_\_\_

Date of visit |\_\_|\_\_\*|\_\_|\_\_\*|\_\_|\_\_|\_\_|\_\_|

99/99/9999=Unk.

 **Have you been hospitalized for heart failure? (Provide details on MD01-Health Care page 47)****CHF First Examiner Opinion** **First examiner believes CHF**

0=No, 1=Yes

2=Maybe, 9=Unk.

**Comments** \_\_\_\_\_**MD10 CL**

### Physical Exam—Blood Pressure

<b>Physician Blood Pressure</b> First reading	
<b>Systolic</b>	<b>BP cuff size</b>
_ _ _  to nearest 2 mm Hg	_  0=pedi, 1=reg. adult, 2=large adult, 3= thigh, 9=Unk.
<b>Diastolic</b>	<b>Protocol modification</b>
_ _ _  to nearest 2 mm Hg	_  0=No, 1=Yes, 9=Unk.

**Comments for Protocol modification** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MD11 CL**

### Medical History—Chest pain

<input type="checkbox"/>	<b>Since your last exam have you experienced any chest discomfort?</b> <i>(please provide narrative comments in addition to completing the appropriate boxes)</i>	0=No, 1=Yes, 2=Maybe, 9=Unk.
if yes, fill <input type="checkbox"/>	<input type="checkbox"/> <b>Chest discomfort with exertion or excitement</b>	
and below <input type="checkbox"/>	<input type="checkbox"/> <b>Chest discomfort when quiet or resting</b>	
<b>Chest Discomfort Characteristics</b>		
<input type="checkbox"/>	<input type="text"/> * <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>Date of onset (mo/yr)</b>	99/9999=Unk.
<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>Usual duration (minutes)</b>	1=1 min or less, 900=15 hrs or more, 999=Unk.
<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>Longest duration (minutes)</b>	1=1 min or less, 900=15 hrs or more, 999=Unk.
<input type="checkbox"/>	<b>Location</b>	0=No, 1=Central sternum and upper chest, 2=L Up Quadrant, 3=L Lower ribcage, 4=R Chest, 5=Other, 6=Combination, 9=Unk.
<input type="checkbox"/>	<b>Radiation</b>	0=No, 1=Left shoulder or L arm, 2=Neck, 3=R shoulder or arm, 4=Back, 5=Abdomen, 6=Other, 7=Combination, 9=Unk.
<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>Number of episodes of chest pain in past month</b>	999=Unk.
<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>Number of episodes of chest pain in past year.</b>	999=Unk.
<input type="checkbox"/>	<b>Type</b>	1=Pressure, heavy, vise, 2=Sharp, 3=Dull, 4=Other, 9=Unk.
<input type="checkbox"/>	<b>Relief by Nitroglycerin in &lt;15 minutes</b>	0=No,
<input type="checkbox"/>	<b>Relief by Rest in &lt;15 minutes</b>	1=Yes,
<input type="checkbox"/>	<b>Relief Spontaneously in &lt;15 minutes</b>	8= <i>Not tried</i>
<input type="checkbox"/>	<b>Relief by Other cause in &lt;15 minutes</b>	9=Unk.

<input type="checkbox"/>	<b>Since your last exam have you been told by a doctor you had a heart attack or myocardial infarction?</b>	0=No, 1=Yes, 2=Maybe, 9=Unk.
if yes, fill <input type="checkbox"/>	<b>Name of doctor</b> _____	
	<b>Date of visit</b> <input type="text"/> * <input type="text"/> * <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> _____	99/99/9999=Unk.

<b>CHD First Examiner Opinions</b>		
<input type="checkbox"/>	<b>Angina pectoris</b>	
if yes,fill <input type="checkbox"/>	<input type="checkbox"/> <b>Angina pectoris since revascularization procedure</b>	0=No, 1=Yes, 2=Maybe, 9=Unk.
<input type="checkbox"/>	<b>Coronary insufficiency</b>	
<input type="checkbox"/>	<b>Myocardial infarct</b>	

Comments \_\_\_\_\_



**Medical History—Atrial Fibrillation/Syncope**

**Since your last exam or medical history update...**

<input type="checkbox"/>	<b>Have you been told you have/had atrial fibrillation?</b>	0=No, 1=Yes, 2=Maybe, 9=Unk.										
<b>if yes, fill</b>	<input type="text"/> * <input type="text"/> * <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>Date of first episode</b>	99/99/9999=Unk										
<input type="checkbox"/>	<b>ER/hospitalized or saw M.D.</b>	0=No, 1=Hosp/ER, 2=Saw M.D., 9=Unk.										
<b>if yes, fill</b>	<input type="text"/> <b>Name of the Hospital (write Unk. if unknown)</b>											
	<input type="text"/> <b>Name of M.D. (write Unk. if unknown)</b>											
<input type="checkbox"/>	<b>Do you have a family history of a heart rhythm problem called atrial fibrillation?</b>	0=No, 1=Yes, 9=Unk										
<b>if yes, fill</b>	<table border="0"> <tr> <td><b>Mother</b></td> <td><b>Father</b></td> <td><b>Siblings</b></td> <td><b>Children</b></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>0=No, 1=Yes, 9=Unk</td> </tr> </table>	<b>Mother</b>	<b>Father</b>	<b>Siblings</b>	<b>Children</b>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	0=No, 1=Yes, 9=Unk	
<b>Mother</b>	<b>Father</b>	<b>Siblings</b>	<b>Children</b>									
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	0=No, 1=Yes, 9=Unk								
<input type="checkbox"/>	<b>Have you fainted or lost consciousness?</b> <i>(If event immediately preceded by head injury or accident code 0=No)</i>	0=No, 1=Yes, 2=Maybe, 9=Unk.										
<b>if yes, fill all</b>	<input type="text"/> <b>Number of episodes in the past two years</b>	999=Unk.										
	<input type="text"/> * <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>Date of first episode (mo/yr)</b>	99/9999=Unk.										
	<input type="text"/> <b>Usual duration of loss of consciousness (minutes)</b>	999=Unk., 1=1 min or less										
<input type="checkbox"/>	<b>Did you have any injury caused by the event?</b>	0=No, 1=Yes, 2=Maybe, 9=Unk.										
<input type="checkbox"/>	<b>ER/hospitalized or saw M.D.</b>	0=No, 1=Hosp/ER, 2=Saw M.D., 9=Unk.										
<b>if yes, fill</b>	<input type="text"/> <b>Name of the Hospital (write Unk. if unknown)</b>											
	<input type="text"/> <b>Name of M.D. (write Unk. if unknown)</b>											
<input type="checkbox"/>	<b>Have you had a head injury with loss of consciousness?</b>	0=No, 1=Yes, 2=Maybe, 9=Unk.										
<b>if yes, fill</b>	<input type="text"/> * <input type="text"/> * <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>Date of serious head injury with loss of consciousness</b>	99/99/9999=Unk.										
<input type="checkbox"/>	<b>Have you had a seizure?</b>	0=No, 1=Yes, 2=Maybe, 9=Unk.										
<b>if yes, fill</b>	<input type="text"/> * <input type="text"/> * <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>Date of most recent seizure</b>	99/99/9999=Unk.										
<input type="checkbox"/>	<b>Are you being treated for a seizure disorder?</b>	0=No, 1=Yes, 2=Maybe, 9=Unk.										

**Syncope First Examiner Opinion**

<input type="checkbox"/>	<b>Syncope (0=No, 1=Yes, 2=Maybe, 3=Presyncope, 9=Unk.) needs second opinion</b>	
<b>if yes, fill</b>	<input type="checkbox"/> <b>Cardiac syncope</b>	0=No,
	<input type="checkbox"/> <b>Vasovagal syncope</b>	1=Yes,
	<input type="checkbox"/> <b>Other-Specify: _____</b>	2=Maybe,
		9=Unk.

Comments: \_\_\_\_\_

MD13 CL

**Medical History—Cerebrovascular, Neurological and Venous Diseases**

Since your last exam or medical history update have you had...		
<input type="checkbox"/>	Sudden muscular weakness	
<input type="checkbox"/>	Sudden speech difficulty	0=No,
<input type="checkbox"/>	Sudden visual defect	1=Yes,
<input type="checkbox"/>	Sudden double vision	2=Maybe,
<input type="checkbox"/>	Sudden loss of vision in one eye	9=Unk.
<input type="checkbox"/>	Sudden numbness, tingling	
if yes, fill <input type="checkbox"/>	<input type="checkbox"/> Numbness and tingling is positional	
<input type="checkbox"/>	Head CT scan <i>OTHER THAN FOR THE FHS</i>	0=No,1=Yes, 2= Maybe,9=Unk.
if yes, fill <input type="checkbox"/>	<input type="text"/> * <input type="text"/> * <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Date _____ Place	99/99/9999=Unk.
<input type="checkbox"/>	Head MRI scan <i>OTHER THAN FOR THE FHS</i>	0=No,1=Yes, 2= Maybe,9=Unk.
if yes, fill <input type="checkbox"/>	<input type="text"/> * <input type="text"/> * <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Date _____ Place	99/99/9999=Unk.
<input type="checkbox"/>	Seen by neurologist (write in who and when below.)	
<input type="checkbox"/>	Have you been told by a doctor you had a stroke or TIA (transient ischemic attack, mini-stroke)?	0=No,
<input type="checkbox"/>	Have you been told by a doctor you have Parkinson Disease?	1=Yes,
<input type="checkbox"/>	Have you been told by a doctor you have memory problems, dementia or Alzheimer's disease?	2=Maybe,
<input type="checkbox"/>	Do you feel or do other people think that you have memory problems that prevent you from doing things you've done in the past?	9=Unk.
<input type="checkbox"/>	<b>Do you feel like your memory is becoming worse?</b>	

Cerebrovascular Disease First Examiner Opinion		
<input type="checkbox"/>	TIA or stroke took place	0=No, 1=Yes,2=Maybe, 9=Unk.
if yes or maybe fill <input type="checkbox"/>	<input type="text"/> * <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Date (mo/yr, 99/9999=Unk.) Observed by _____ <input type="text"/> * <input type="text"/> * <input type="text"/> Duration (use format days/hours/mins, 99/99/99=Unk.) Hospitalized or saw M.D. (0=No, 1=Hosp.,2=Saw M.D, 9=Unk) Name _____ Address _____	

Comments \_\_\_\_\_

**Medical History--Venous and Peripheral Arterial Disease****Venous Disease**

Since your last exam or medical history update have you had...

- |                          |   |                 |
|--------------------------|---|-----------------|
| <input type="checkbox"/> | <b>Deep Vein Thrombosis - DVT</b> (blood clots in legs or arms) | 0=No,1=Yes,     |
| <input type="checkbox"/> | <b>Pulmonary Embolus – PE</b> (blood clot in lungs)             | 2=Maybe, 9=Unk. |

**Peripheral Arterial Disease**

Since your last exam have you had...

- |  |  |  |
|--|--|--|
| <input type="checkbox"/>                 | <b>Do you get discomfort in either leg on walking?</b> (0=No, 1=Yes, 9=Unk.)   |  |
| if yes,<br>fill <input type="checkbox"/> | <b>Does this discomfort ever begin when you are standing still or sitting?</b> (0=no, 1=yes, 9=Unk.)   |  |
| <input type="checkbox"/>                 | <b>When walking at an ordinary pace on level ground, how many city blocks until symptoms develop</b> (1=1 block or less, 99=Unk.) <i>where 10 blocks=1 mile, code as no if more than 98 blocks required to develop symptoms</i>  |  |
|  | <b>Left</b>  | <b>Right</b>   |
|  | <input type="checkbox"/>   | <input type="checkbox"/>   |
|  | <b>Claudication symptoms</b> 0=No, 1=Yes, 9=Unk.   |  |
|  | <input type="checkbox"/>   | <input type="checkbox"/>   |
|  | <b>Discomfort in calf while walking</b>  |  |
|  | <input type="checkbox"/>   | <input type="checkbox"/>   |
|  | <b>Discomfort in lower extremity (not calf) while walking</b>  |  |
|  | Write in site of discomfort _____  |  |
|  | <input type="checkbox"/>   | <b>Occurs with first steps (code worse leg)</b>  |
|  | <input type="checkbox"/>   | <b>Do you get the discomfort when you walk up hill or hurry?</b>   |
|  | <input type="checkbox"/>   | <b>Does the discomfort ever disappear while you are still walking?</b>   |
|  | <input type="checkbox"/>   | <b>What do you do if you get discomfort when you are walking?</b> (1=stop, 2=slow down, 3=continue at same pace, 9=Unk.) |
|  | <input type="checkbox"/>   | <b>Time for discomfort to be relieved by stopping (minutes)</b> (000=No relief with stopping, 999=Unk.)                  |
|  | <input type="checkbox"/>   | <b>Number of days/month of lower limb discomfort</b> (1=1 day/month or less, 99=Unk.)                                    |
| <input type="checkbox"/>                 | <b>Since your last exam have you been told by a doctor you have intermittent claudication or peripheral artery disease?</b> (0=No, 1=Yes, 9=Unk.)  |  |
| if yes,<br>fill <input type="checkbox"/> | <b>Name of doctor</b> _____  |  |
|  | <b>Date of visit</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> * <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> * <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | 99/99/9999=Unk.  |
| <input type="checkbox"/>                 | <b>Since your last exam have you been told by a doctor you have spinal stenosis?</b> (0=No, 1=Yes, 9=Unk.)   |  |

**Intermittent Claudication First Examiner Opinion**

- |                          |                                  |                              |
|--------------------------|----------------------------------|------------------------------|
| <input type="checkbox"/> | <b>Intermittent Claudication</b> | 0=No, 1=Yes, 2=Maybe, 9=Unk. |
|--------------------------|----------------------------------|------------------------------|

**Comments**

MD15 CL

**Medical History-- CVD Procedures**

**Since your last exam or medical history update did you have any of the following cardiovascular procedures?**

0=No, 1=Yes  
2=Maybe, 9=Unk.

**Cardiovascular Procedures**

*(if procedure was repeated code only first and provide narrative)*

**Heart Valvular Surgery**

if yes  
fill

|\_|\_|\_|\_| Year done (9999=Unk)

**Exercise Tolerance Test**

if yes  
fill

|\_|\_|\_|\_| Year done (9999=Unk)

**Coronary arteriogram**

if yes  
fill

|\_|\_|\_|\_| Year done (9999=Unk)

**Coronary artery angioplasty or stent**

if yes  
fill

|\_|\_|\_|\_| Year done (9999=Unk)

**Coronary bypass surgery**

if yes  
fill

|\_|\_|\_|\_| Year done (9999=Unk)

**Permanent pacemaker insertion**

if yes  
fill

|\_|\_|\_|\_| Year done (9999=Unk)

**AICD**

if yes  
fill

|\_|\_|\_|\_| Year done (9999=Unk)

**Carotid artery surgery or stent**

if yes  
fill

|\_|\_|\_|\_| Year done (9999=Unk)

**Thoracic aorta surgery**

if yes  
fill

|\_|\_|\_|\_| Year done (9999=Unk)

**Abdominal aorta surgery**

if yes  
fill

|\_|\_|\_|\_| Year done (9999=Unk)

**Femoral or lower extremity surgery**

if yes  
fill

|\_|\_|\_|\_| Year done (9999=Unk)

**Lower extremity amputation**

if yes  
fill

|\_|\_|\_|\_| Year done (9999=Unk)

**Other Cardiovascular Procedure (write in below)**

if yes  
fill

|\_|\_|\_|\_| Year done (9999=Unk) Description \_\_\_\_\_

**Write in other procedures, year done, and location if more than one.**

**Comments:** \_\_\_\_\_

MD16 CL

### Physical Exam—Blood Pressure

<b>Physician Blood Pressure</b> Second reading	
<b>Systolic</b>	<b>BP cuff size</b>
_ _ _  to nearest 2 mm Hg	_  0=pedi,1=reg.adult, 2=large adult, 3= thigh, 9=Unk.
<b>Diastolic</b>	<b>Protocol modification</b>
_ _ _  to nearest 2 mm Hg	_  0=No, 1=Yes, 9=Unk.

**Comments for Protocol modification** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MD??**

### Cancer Site or Type



**Since your last exam or medical history update have you had a cancer or a tumor?**  
(0=No and skip to next page MD21; If 1=Yes, 2=Maybe, 9=Unk. please continue)

Check ALL that apply	Site of Cancer or Tumor	Year First Diagnosed	Cancer	Maybe cancer	Benign	Name Diagnosing M.D.	City/State of M.D.
			Check ONE				
			1	2	3		
<input type="checkbox"/>	Esophagus		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Stomach		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Colon		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Rectum		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Pancreas		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Larynx		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Trachea/ Bronchus/Lung		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Leukemia		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Skin		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Breast		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Cervix/Uterus		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Ovary		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Prostate		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Bladder		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Kidney		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Brain		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Lymphoma		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Other/Unk. _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

**Comment** (If participant has more details concerning tissue diagnosis, other hospitalization, procedures, and treatments)

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**MD17**

## Physical Exam—Respiratory, Heart, Abdomen

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<b>Respiratory</b>		
<input type="checkbox"/>	<b>Wheezing on auscultation</b>	0=No,
<input type="checkbox"/>	<b>Rales</b>	1=Yes,
<input type="checkbox"/>	<b>Abnormal breath sounds</b>	2=Maybe,
		9=Unk.

<b>Heart</b>		
<input type="checkbox"/>	<b>S3 Gallop</b>	0=No,
<input type="checkbox"/>	<b>S4 Gallop</b>	1=Yes,
<input type="checkbox"/>	<b>Systolic Click</b>	2=Maybe,
<input type="checkbox"/>	<b>Neck vein distention at 90 degrees (sitting upright)</b>	9=Unk.

<input type="checkbox"/>	<b>Systolic murmur(s)</b>				0=No, 1=Yes, 2=Maybe, 9=Unk.
<b>if yes, fill below</b>	<b>Grade</b>	<b>Type</b>	<b>Radiation</b>	<b>Origin</b>	
<b>Murmur Location</b>	0=No sound 1 to 6 for grade of sound heard 9=Unk.	0=None 1=Ejection 2=Regurgitant 3=Other 9=Unk.	0=None 1=Axilla 2=Neck 3=Back 4=Rt. chest 9=Unk.	0=None, indet. 1=Mitral 2=Aortic 3=Tricuspid 4=Pulm 9=Ukn.	
<b>Apex</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Left Sternum</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Base</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<b>Diastolic murmur(s)</b>				0=No, 1=Yes, 2=Maybe, 9=Unk.
<b>if yes, fill</b>	<input type="checkbox"/>	<b>Valve of origin for diastolic murmur(s)</b> (1=Mitral, 2=Aortic, 3=Both, 4=Other, 8=N/A, 9=Unk)			

<b>Abdominal Abnormalities</b>		
<input type="checkbox"/>	<b>Liver enlarged</b>	0=No,
<input type="checkbox"/>	<b>Surgical scar</b>	1=Yes,
<input type="checkbox"/>	<b>Abdominal aneurysm</b>	2=Maybe,
<input type="checkbox"/>	<b>Abdominal bruit</b>	9=Unk.

**Comments** \_\_\_\_\_

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**Physical Exam--Peripheral Vessels—Veins and Arterial pulses**

OFFSITE VISIT – leave page BLANK

Left	Right	Lower Extremity Abnormalities
<input type="checkbox"/>	<input type="checkbox"/>	<b>Stem varicose veins</b> (Do not code reticular or spider varicosities) (0=No abnormality 1=Yes 9=Unk.)
<input type="checkbox"/>	<input type="checkbox"/>	<b>Ankle edema</b> (0=No, 1=Yes, 2=Maybe, 8=absent due to amputation 9=Unk.)
<input type="checkbox"/>	<input type="checkbox"/>	<b>Amputation level</b> (0=No, 1=Toes only, 2=Foot, 3=below Knee, 4=above Knee, 5= Other, write in _____, 9=Unk.)

Artery	Pulse		Bruit	
	(0=Normal, 1=Abnormal, 9=Unk.)		(0=Normal, 1=Abnormal, 9=Unk.)	
	Left	Right	Left	Right
<b>Femoral</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Popliteal</b>			<input type="checkbox"/>	<input type="checkbox"/>
<b>Post Tibial</b>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Dorsalis Pedis</b>	<input type="checkbox"/>	<input type="checkbox"/>		

**Comments** \_\_\_\_\_

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**Physical Exam--Neurological Exam**

OFFSITE VISIT – leave page BLANK

<b>Neurological Exam</b>			
Left	Right		
_	_	<b>Carotid Bruit</b>	
	_	<b>Speech disturbance</b>	0=No,
	_	<b>Disturbance in gait</b>	1=Yes,
	_	<b>Other neurological abnormalities on exam</b>	2=Maybe,
	_	Specify _____	9=Unk.

**Comments** \_\_\_\_\_

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MD20

CL

## Electrocardiograph--Part I

OFFSITE ONLY		
_ _ _	MD Id# _____	MD Name _____

Rates and Intervals		
_ _ _	Ventricular rate per minute	(999=Unk.)
_ _ _	P-R Interval (milliseconds)	(999=Fully Paced, Atrial Fib, or Unk.)
_ _ _	QRS interval (milliseconds)	(999=Fully Paced, Unk.)
_ _ _	Q-T interval (milliseconds)	(999=Fully Paced, Unk.)
_ _ _ _	QRS angle (put plus or minus as needed)	(e.g. -045 for minus 45 degrees, +090 for plus 90, 9999=Fully paced or Unk.)

Rhythm--predominant	
_	<p>0 or 1 = Normal sinus, (including s.tach, s.brady, s arrhy, 1 degree AV block)</p> <p>3 = 2nd degree AV block, Mobitz I (Wenckebach)</p> <p>4 = 2nd degree AV block, Mobitz II</p> <p>5 = 3rd degree AV block / AV dissociation</p> <p>6 = Atrial fibrillation / atrial flutter</p> <p>7 = Nodal</p> <p>8 = Paced</p> <p>9 = Other or combination of above (list)</p>

Ventricular conduction abnormalities		
_	IV Block	(0=No, 1=Yes, 9=Fully paced or Unk.)
if yes, fill □	_  Pattern	(1=Left, 2=Right, 3=Indeterminate, 9=Unk.)
	_  Complete (QRS interval=.12 sec or greater)	(0=No, 1=Yes, 9=Unk.)
	_  Incomplete (QRS interval = .10 or .11 sec)	(0=No, 1=Yes, 9=Unk.)
_	Hemiblock	(0=No, 1=Left Ant, 2=Left Post, 9=Fully paced or Unk.)
_	WPW Syndrome	(0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unk.)

Arrhythmias		
_	Atrial premature beats	(0=No, 1=Atr, 2=Atr Aber, 9=Unk.)
_	Ventricular premature beats	(0=No, 1=Simple, 2=Multifoc, 3=Pairs, 4=Run, 5=R on T, 9=Unk)
_ _	Number of ventricular premature beats in 10 seconds	(see 10 second rhythm strip)

MD21      CL

## Electrocardiograph-Part II

<b>Myocardial Infarction Location</b>		
<input type="checkbox"/>	<b>Anterior</b>	0=No,
<input type="checkbox"/>	<b>Inferior</b>	1=Yes,
<input type="checkbox"/>	<b>True Posterior</b>	2=Maybe,
		9=Fully paced or Unk.

<b>Left Ventricular Hypertrophy Criteria</b>		
<input type="checkbox"/>	<b>R &gt; 20mm in any limb lead</b>	0=No,
<input type="checkbox"/>	<b>R &gt; 11mm in AVL</b>	1=Yes,
<input type="checkbox"/>	<b>R in lead I plus S in lead III <math>\geq</math> 25mm</b>	9=Fully paced, Complete LBBB or Unk
Measured Voltage		
* <input type="checkbox"/>	<b>AVL in mm</b> (at 1 mv = 10 mm standard) <b>Be sure to code these voltages</b>	
* <input type="checkbox"/>	<b>S V3 in mm</b> (at 1 mv = 10 mm standard) <b>Be sure to code these voltages</b>	
R in V5 or V6-----S in V1 or V2		
<input type="checkbox"/>	<b>R <math>\geq</math> 25mm</b>	0=No,
<input type="checkbox"/>	<b>S <math>\geq</math> 25mm</b>	
<input type="checkbox"/>	<b>R or S <math>\geq</math> 30mm</b>	1=Yes,
<input type="checkbox"/>	<b>R + S <math>\geq</math> 35mm</b>	
<input type="checkbox"/>	<b>Intrinsicoid deflection <math>\geq</math>.05 sec</b>	9=Fully paced, Complete LBBB or Unk
<input type="checkbox"/>	<b>S-T depression (strain pattern)</b>	

<b>Hypertrophy, enlargement, and other ECG Diagnoses</b>		
<input type="checkbox"/>	<b>Nonspecific S-T segment abnormality</b> (0=No, 1=S-T depression, 2=S-T flattening, 3=Other, 9=Fully paced or Unk.)	
<input type="checkbox"/>	<b>Nonspecific T-wave abnormality</b> (0=No, 1=T inversion, 2=T flattening, 3=Other, 9=Fully paced or Unk.)	
<input type="checkbox"/>	<b>U-wave present</b> (0=No, 1=Yes, 2=Maybe, 9=Paced or Unk.)	
<input type="checkbox"/>	<b>Atrial enlargement</b> (0=None, 1=Left, 2=Right, 3=Both, 9=Atrial fib. or Unk.)	
<input type="checkbox"/>	<b>RVH</b> (0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unk.; <b>If complete RBBB OR LBBB present, RVH=9</b> )	
<input type="checkbox"/>	<b>LVH</b> (0=No, 1=LVH with strain, 2=LVH with mild S-T Segment Abn, 3=LVH by voltage only, 9=Fully paced or Unk., <b>If complete LBBB present, LVH=9</b> )	

Comments \_\_\_\_\_

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MD22.....CL

## Clinical Diagnostic Impression--Part I

<b>Heart Diagnoses</b>		
<input type="checkbox"/>	<b>Rheumatic Heart Disease</b>	0=No,
<input type="checkbox"/>	<b>Aortic Valve Disease</b>	1=Yes,
<input type="checkbox"/>	<b>Mitral Valve Disease</b>	2=Maybe,
<input type="checkbox"/>	<b>Arrhythmia</b>	9=Unk.
<input type="checkbox"/>	<b>Other Heart Disease (includes congenital)</b>	
(Specify) _____		

<b>Peripheral Vascular Disease</b>		
<input type="checkbox"/>	<b>Other Peripheral Vascular Disease</b>	0=No,
<input type="checkbox"/>	<b>Other Vascular Diagnosis</b>	1=Yes,
(Specify) _____		
2=Maybe,		
9=Unk.		

<b>Neurological Disease</b>		
<input type="checkbox"/>	<b>Stroke/ TIA</b>	0=No,
<input type="checkbox"/>	<b>Dementia</b>	1=Yes,
<input type="checkbox"/>	<b>Parkinson's Disease</b>	2=Maybe,
<input type="checkbox"/>	<b>Adult Seizure Disorder</b>	9=Unk.
<input type="checkbox"/>	<b>Migraine</b>	
<input type="checkbox"/>	<b>Other Neurological Disease</b>	
(Specify) _____		

Comments \_\_\_\_\_

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MD23

CL

**Clinical Diagnostic Impression--Part II. Non Cardiovascular Diagnoses**

<b>Endocrine</b>		
<input type="checkbox"/>	Thyroid Disease	0=No, 1=Yes, 2=Maybe, 9=Unk.
<input type="checkbox"/>	Diabetes Mellitus	
<input type="checkbox"/>	Other endocrine disorders, specify _____	
<b>GU/GYN</b>		
<input type="checkbox"/>	Renal disease, specify _____	0=No, 1=Yes, 2=Maybe, 8=male/female 9=Unk.
<input type="checkbox"/>	Prostate disease	
<input type="checkbox"/>	Gynecologic problems, specify _____	
<b>Pulmonary</b>		
<input type="checkbox"/>	Emphysema	0=No, 1=Yes, 2=Maybe, 9=Unk.
<input type="checkbox"/>	Pneumonia	
<input type="checkbox"/>	Asthma	
<input type="checkbox"/>	Other pulmonary disease, specify _____	
<b>Rheumatologic Disorders</b>		
<input type="checkbox"/>	Gout	0=No, 1=Yes, 2=Maybe, 9=Unk.
<input type="checkbox"/>	Degenerative joint disease	
<input type="checkbox"/>	Rheumatoid arthritis	
<input type="checkbox"/>	Other musculoskeletal or connective tissue disease, specify _____	
<b>GI</b>		
<input type="checkbox"/>	Gallbladder disease	0=No, 1=Yes, 2=Maybe, 9=Unk.
<input type="checkbox"/>	GERD/ulcer disease	
<input type="checkbox"/>	Liver disease	
<input type="checkbox"/>	Other GI disease, specify _____	
<b>Blood</b>		
<input type="checkbox"/>	Hematologic disorder	0=No, 1=Yes, 2=Maybe, 9=Unk
<input type="checkbox"/>	Bleeding disorder	
<b>Infectious Disease</b>		
<input type="checkbox"/>	Infectious Disease	0=No, 1=Yes, 2=Maybe, 9=Unk
if yes <input type="checkbox"/>	specify _____	
<b>Mental Health</b>		
<input type="checkbox"/>	Depression	0=No, 1=Yes, 2=Maybe, 9=Unk.
<input type="checkbox"/>	Anxiety	
<input type="checkbox"/>	Psychosis	
<input type="checkbox"/>	Other Mental health, specify _____	
<b>Other</b>		
<input type="checkbox"/>	Eye	0=No, 1=Yes, 2=Maybe, 9=Unk.
<input type="checkbox"/>	ENT	
<input type="checkbox"/>	Skin	
<input type="checkbox"/>	Other, specify _____	

**Comments**

**Second Examiner Opinions**  
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_ _ _	<b>2nd Examiner ID number</b> _____	<b>2nd Examiner Last Name</b> _____
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<b>Coronary Heart Disease</b>			
(Provide initiators, qualities, radiation, severity, timing, presence after procedures done)			
<b>Item requires 2<sup>nd</sup> opinion</b> <i>Check ALL that apply.</i>	<b>2<sup>nd</sup> opinion</b>		
<input type="checkbox"/>	_	<b>Congestive Heart Failure</b>	0=No, 1=Yes, 2=Maybe, 9=Unk.
<input type="checkbox"/>	_	<b>Cardiac Syncope</b>	
<input type="checkbox"/>	_	<b>Angina Pectoris</b>	
<input type="checkbox"/>	_	<b>Coronary Insufficiency</b>	
<input type="checkbox"/>	_	<b>Myocardial Infarct</b>	

Comments about heart disease \_\_\_\_\_

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<b>Intermittent Claudication</b>			
(Provide initiators, qualities, radiation, severity, timing, presence after procedures done)			
<b>Item requires 2<sup>nd</sup> opinion</b> <i>Check ALL that apply.</i>	<b>2<sup>nd</sup> opinion</b>		
<input type="checkbox"/>	_	<b>Intermittent Claudication</b>	0=No, 1=Yes, 2=Maybe, 9=Unk.

Comments about peripheral artery disease \_\_\_\_\_

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<b>Cerebrovascular Disease</b>			
(Provide initiators, qualities, severity, timing, presence after procedures done)			
<b>Item requires 2<sup>nd</sup> opinion</b> <i>Check ALL that apply.</i>	<b>2<sup>nd</sup> opinion</b>		
<input type="checkbox"/>	_	<b>Stroke</b>	0=No, 1=Yes, 2=Maybe, 9=Unk.
<input type="checkbox"/>	_	<b>TIA</b>	

Comments about possible cerebrovascular disease \_\_\_\_\_

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