

Appendix 3: Cohort and Community Surveillance

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ARIC

Atherosclerosis Risk in Communities

CORONER / MEDICAL EXAMINER FORM

EVENT ID:

FORM CODE: C O R

VERSION: C DATE: 05/22/07

LAST NAME:

INITIALS:

Public reporting burden for this collection of information is estimated to average 6-15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: **NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0281)**. Do not return the completed form to this address.

INSTRUCTIONS: The Coroner/Medical Examiner Form is completed for each eligible out-of-hospital death that was identified as a coroner or medical examiner case on the death certificate, and recorded as such on the Death Certificate Form. Event ID, Name (or Soundex code) must be entered above. Refer to this form's Q x Q instructions for information on specific items. For multiple choice and "yes/no" questions, circle the letter corresponding to the most appropriate response. If a letter is circled incorrectly, mark through it with an "X" and circle the correct response.

CORONER/MEDICAL EXAMINER FORM (CORC Screen 1 of 13)

1. Date of death from death certificate:

-

Month Day Year

2. Is the name of coroner's or medical examiner's office available?

Yes Y

No N

If "Yes", Specify: _____

3. Abstracting for:

Cohort C

Surveillance S

4. Has an official coroner's or medical examiner's report or another source of information from the coroner's or medical examiner's office been located?

Yes Y

No N

Go to Item 25,
Screen 13.

5. Was an autopsy performed as part of the medical examiner (coroner) investigation?

Yes Y

No N

CORONER/MEDICAL EXAMINER FORM (CORC Screen 2 of 13)

<p>6. Did the coroner's report mention any of the following as contributing to or being present at death?</p> <p align="right"><u>Yes</u> <u>No</u></p> <p>a. Recent myocardial infarction Y N</p> <p>b. Coronary heart disease/ischemic/atherosclerotic heart disease (other than MI) Y N</p> <p>c. Hypertensive heart disease Y N</p> <p>d. Valvular heart disease Y N</p> <p>e. Other heart disease Y N</p>	<p align="right"><u>Yes</u> <u>No</u></p> <p>6.f. Recent cerebral hemorrhage Y N</p> <p>g. Recent cerebral infarction Y N</p> <p>h. Recent cerebral embolus Y N</p> <p>i. Recent subarachnoid hemorrhage Y N</p> <p>j. Recent stroke, other or unspecified type Y N</p>
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CORONER/MEDICAL EXAMINER FORM (CORC Screen 3 of 13)

<p>7.a. Was any non-cardiac, non-stroke finding mentioned as contributing to death?</p> <p align="center">Yes Y No N</p> <div style="border: 1px solid black; padding: 2px; width: fit-content; margin: 10px auto;"> <p>Go to Item 8, Screen 4</p> </div> <p align="right"><u>Yes</u> <u>No</u></p> <p>b. Kidney disease Y N</p> <p>c. Chronic respiratory disease Y N</p> <p>d. Psychiatric illness/depression Y N</p>	<p align="right"><u>Yes</u> <u>No</u></p> <p>7.e. Alcohol or drug addiction Y N</p> <p>f. Epilepsy Y N</p> <p>g. Liver disease Y N</p> <p>h. Other Y N</p> <p>If Other is Yes, Specify:</p> <p>_____</p> <p>_____</p> <p>_____</p>
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CORONER/MEDICAL EXAMINER FORM (CORC Screen 4 of 13)

ID LABEL

8. Do you have the final diagnoses?

Yes Y
No N

Specify:

CORONER/MEDICAL EXAMINER FORM (CORC Screen 5 of 13)

<p>9. Pick one of the following (A,B*,C*,D*,U*):</p> <p>Patient had acute symptoms (cardiac or non-cardiac) which led to an overt change in activity or to seeking medical care..... A</p>	<p>Patient died suddenly and was known to have no acute symptoms B</p> <p>Patient was found dead with no documentation of symptoms C</p> <p>Patient had symptoms but they were chronic (without change) or did not lead to a change in activity or seeking medical care D</p> <p>Unknown U</p> <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: auto; margin-right: auto;"> <p>Go to Item 11.a, Screen 7.</p> </div>
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CORONER/MEDICAL EXAMINER FORM (CORC Screen 6 of 13)

<p>10. Within 3 days of death or just before death, did any of the following symptoms begin for the first time?</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:70%;"></th> <th style="width:10%; text-align: center;"><u>Yes</u></th> <th style="width:10%; text-align: center;"><u>No</u></th> <th style="width:10%; text-align: center;"><u>Unknown</u></th> </tr> </thead> <tbody> <tr> <td>a. Shortness of breath</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> <td style="text-align: center;">U</td> </tr> <tr> <td>b. Dizziness.....</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> <td style="text-align: center;">U</td> </tr> <tr> <td>c. Palpitations</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> <td style="text-align: center;">U</td> </tr> <tr> <td>d. Marked or increased fatigue, tiredness or weakness</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> <td style="text-align: center;">U</td> </tr> <tr> <td>e. Headache</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> <td style="text-align: center;">U</td> </tr> <tr> <td>f. Sweating</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> <td style="text-align: center;">U</td> </tr> </tbody> </table>		<u>Yes</u>	<u>No</u>	<u>Unknown</u>	a. Shortness of breath	Y	N	U	b. Dizziness.....	Y	N	U	c. Palpitations	Y	N	U	d. Marked or increased fatigue, tiredness or weakness	Y	N	U	e. Headache	Y	N	U	f. Sweating	Y	N	U	<table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:70%;"></th> <th style="width:10%; text-align: center;"><u>Yes</u></th> <th style="width:10%; text-align: center;"><u>No</u></th> <th style="width:10%; text-align: center;"><u>Unknown</u></th> </tr> </thead> <tbody> <tr> <td>10.g. Paralysis</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> <td style="text-align: center;">U</td> </tr> <tr> <td>h. Loss of speech</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> <td style="text-align: center;">U</td> </tr> <tr> <td>i. Attack of indigestion or nausea or vomiting.....</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> <td style="text-align: center;">U</td> </tr> <tr> <td>j. Other</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> <td style="text-align: center;">U</td> </tr> </tbody> </table> <p>If other is Yes, Specify:</p> <p>_____</p> <p>_____</p>		<u>Yes</u>	<u>No</u>	<u>Unknown</u>	10.g. Paralysis	Y	N	U	h. Loss of speech	Y	N	U	i. Attack of indigestion or nausea or vomiting.....	Y	N	U	j. Other	Y	N	U
	<u>Yes</u>	<u>No</u>	<u>Unknown</u>																																														
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b. Dizziness.....	Y	N	U																																														
c. Palpitations	Y	N	U																																														
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j. Other	Y	N	U																																														

CORONER/MEDICAL EXAMINER FORM (CORC Screen 7 of 13)

<p>11.a. Was there an acute episode(s) of pain or discomfort anywhere in the chest, left arm or shoulder or jaw either just before death or within 72 hours of death?</p> <p>Yes Y</p> <p>No N</p> <p>Unknown U</p> <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 20px;"> Go to Item 12 Screen 8. </div> <p>b. Did this pain or discomfort specifically involve the chest?</p> <p>Yes Y</p> <p>No N</p> <p>Unknown U</p>	<p>11.c. Did the patient take or was he/she given nitrates at the time of the acute episode?</p> <p>Yes Y</p> <p>No N</p> <p>Unknown U</p> <p>d. Was the discomfort or pain diagnosed as having a non-cardiac origin?</p> <p>Yes Y</p> <p>No N</p> <p>Unknown U</p> <p>If "Yes", Specify:</p> <p>_____</p>
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CORONER/MEDICAL EXAMINER FORM (CORC Screen 8 of 13)

<p>12. Place of death (circle only one):</p> <p>Home (or other private residence) A</p> <p>Work B</p> <p>In a public building C</p> <p>On a bus or public transportation D</p> <p>On the street E</p> <p>In an automobile F</p> <p>In nursing home G</p> <p>In emergency room H</p> <p>In an ambulance I</p> <p>In hospital J</p> <p>Other O</p> <p>Unknown U</p>	<p>13.a. Did anyone witness the death?</p> <p>Yes Y</p> <p>No N</p> <p>Unknown U</p> <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 20px;"> Go to Item 15a Screen 10. </div> <p>b. Do you have the name and address for this witness?</p> <p>Yes Y</p> <p>No N</p> <p>If "Yes", Specify:</p> <p>Name: _____</p> <p>Address: _____</p> <p>_____</p>
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CORONER/MEDICAL EXAMINER FORM (CORC Screen 9 of 13)

<p>13.c. Relationship of this witness to deceased:</p> <p>Spouse S</p> <p>Parent P</p> <p>Daughter/Son C</p> <p>Other Relative R</p> <p>Friend F</p> <p>Workmate W</p> <p>Other O</p> <p>Unknown U</p>	<p>14. Time from onset of acute symptoms to death (or time since last known to be alive if no known acute symptoms) (Choose only one):</p> <p>5 minutes or less A</p> <p>More than 5 minutes to 1 hour B</p> <p>More than 1 hour to 24 hours C</p> <p>More than 24 hours D</p> <p>Unknown U</p>
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CORONER/MEDICAL EXAMINER FORM (CORC Screen 10 of 13)

<p>15.a. Is there a history of a myocardial infarction prior to the onset of this event?</p> <p>Yes Y</p> <p>No N</p> <p>Unknown U</p> <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 100px;">Go to Item 16 Screen 11.</div> <p>b. Did an MI occur within four weeks prior to this event?</p> <p>Yes Y</p> <p>No N</p> <p>Unknown U</p> <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 100px;">Go to Item 16 Screen 11.</div>	<p>15.c. Was the deceased hospitalized for the MI?</p> <p>Yes Y</p> <p>No N</p> <p>Unknown U</p> <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 100px;">Go to Item 16 Screen 11.</div> <p>d. Do you know the name of the hospital?</p> <p>Yes Y</p> <p>No N</p> <p>If "Yes", Specify:</p> <p>_____</p>
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CORONER/MEDICAL EXAMINER FORM (CORC Screen 11 of 13)

<p>16. Is there any history of angina pectoris or coronary insufficiency?</p> <p>Yes Y</p> <p>No N</p> <p>Unknown U</p> <p>17. Is there a history of any other chronic ischemic heart disease?</p> <p>Yes Y</p> <p>No N</p> <p>Unknown U</p>	<p>18. Is there a history of valvular disease or cardiomyopathy?</p> <p>Yes Y</p> <p>No N</p> <p>Unknown U</p> <p>19. Is there a history of coronary bypass surgery prior to this event?</p> <p>Yes Y</p> <p>No N</p> <p>Unknown U</p>
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CORONER/MEDICAL EXAMINER FORM (CORC Screen 12 of 13)

<p>20. Is there a history of coronary angioplasty prior to this event?</p> <p>Yes Y</p> <p>No N</p> <p>Unknown U</p> <p>21.a. Is there a history of stroke prior to this event?</p> <p>Yes Y</p> <p>No N</p> <p>Unknown U</p> <p><input type="button" value="Go to Item 22"/></p> <p>b. Did a stroke occur within four weeks prior to this event?</p> <p>Yes Y</p> <p>No N</p> <p>Unknown U</p>	<p>22. Is there a history of hypertension (high blood pressure) prior to this event?</p> <p>Yes Y</p> <p>No N</p> <p>Unknown U</p> <p>a. Is there a history of diabetes?</p> <p>Yes Y</p> <p>No N</p> <p>Unknown U</p> <p>b. Is there a history of smoking?</p> <p>Yes Y</p> <p>No N</p> <p>Unknown U</p>
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CORONER/MEDICAL EXAMINER FORM (CORC Screen 13 of 13)

23. Was the decedent taking any of the following medications as an outpatient within the four weeks prior to death?

Yes No Unknown

- a. Nitrates Y N U
- b. Calcium channel blockers Y N U
- c. Beta-blockers Y N U
- d. Digitalis Y N U
- e. ACE or angiotensin II inhibitors Y N U
- f. Aspirin Y N U

24. Was this form completed by abstraction or by interview with the coroner?

Abstraction A

Interview I

25. Abstractor Number:

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26. Date abstract completed:

		-			-				
Month			Day		Year				

RECORD OF CALLS

Day of Week	Date	Time	Notes	Code*	Int
S M T W R F S	MM/DD/YYYY	A P			
S M T W R F S	MM/DD/YYYY	A P			
S M T W R F S	MM/DD/YYYY	A P			
S M T W R F S	MM/DD/YYYY	A P			
S M T W R F S	MM/DD/YYYY	A P			
S M T W R F S	MM/DD/YYYY	A P			
S M T W R F S	MM/DD/YYYY	A P			
S M T W R F S	MM/DD/YYYY	A P			
S M T W R F S	MM/DD/YYYY	A P			
S M T W R F S	MM/DD/YYYY	A P			
S M T W R F S	MM/DD/YYYY	A P			
S M T W R F S	MM/DD/YYYY	A P			
S M T W R F S	MM/DD/YYYY	A P			

* RESULT CODES (CIRCLE THE FINAL SCREENING RESULT CODE)

- 1 Complete
- 2 Partially complete
- 3 Unknowledgable
- 4 Refusal

- 5 Informant away or can't be found
- 6 Language barrier
- 7 No one home
- 9 Other (specify in Notes)

INFORMANT INTERVIEW FORM (IFIC Screen 1 of 16)

<p>A. HISTORY</p> <p>1. Before we get started could you please tell me what was your relationship to the deceased?</p> <p>{Respondent was deceased's}</p> <p>Spouse S</p> <p>Parent P</p> <p>Daughter/Son ... C</p> <p>Other relative .. R</p> <p>Friend F</p> <p>Workmate W</p> <p>Other O</p>	<p>"I'd like to ask you about (_____)’s medical history. If you have any questions as we go along, please ask me."</p> <p>2. First, think back to about one month before (____) died. At that time, was he/she sick or ill, with his/her activities limited, or was he/she normally active for the most part?</p> <p>Sick/ill/limited activities R</p> <p>Normally Active N</p> <p>Unknown U</p>
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INFORMANT INTERVIEW FORM (IFIC Screen 2 of 16)

<p>3. Was (_____) being cared for at a nursing home, or at another place at the time of death?</p> <p>Yes, nursing home R</p> <p>Yes, at home H</p> <p>Yes, assisted living A</p> <p>Yes, Hospice facility F</p> <p>Go to Item 5 — Yes, other O</p> <p>No N</p> <p>Unknown U</p> <p>4. Could you tell me the name and location of the nursing home?</p> <p>Specify Name, City, State — Yes Y</p> <p>Skip Name, City, State — No N</p> <p>[Place Name, City, State in notelog]</p> <p>Name _____</p> <p>_____</p> <p>City _____</p> <p>State _____</p>	<p>5. Was (_____) hospitalized within the four weeks prior to death?</p> <p>Yes Y</p> <p>Go to Item 9, Screen 3 — No N</p> <p>Unknown ... U</p> <p>6. What was the reason for hospitalization?</p> <p>{ Circle (Y), (N), or (U) for each. Probe if not offered. }</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="border: 1px solid black; padding: 5px;">If no or unknown, go to Item 9, Screen 3</th> <th style="text-align: center; padding: 5px;"><u>Yes</u></th> <th style="text-align: center; padding: 5px;"><u>No</u></th> <th style="text-align: center; padding: 5px;"><u>Unknown</u></th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;">a. Heart attack or chest pain</td> <td style="text-align: center; padding: 5px;">Y</td> <td style="text-align: center; padding: 5px;">N</td> <td style="text-align: center; padding: 5px;">U</td> </tr> <tr> <td style="padding: 5px;">b. Heart surgery</td> <td style="text-align: center; padding: 5px;">Y</td> <td style="text-align: center; padding: 5px;">N</td> <td style="text-align: center; padding: 5px;">U</td> </tr> <tr> <td style="padding: 5px;">c. Other</td> <td style="text-align: center; padding: 5px;">Y</td> <td style="text-align: center; padding: 5px;">N</td> <td style="text-align: center; padding: 5px;">U</td> </tr> </tbody> </table>	If no or unknown, go to Item 9, Screen 3	<u>Yes</u>	<u>No</u>	<u>Unknown</u>	a. Heart attack or chest pain	Y	N	U	b. Heart surgery	Y	N	U	c. Other	Y	N	U
If no or unknown, go to Item 9, Screen 3	<u>Yes</u>	<u>No</u>	<u>Unknown</u>														
a. Heart attack or chest pain	Y	N	U														
b. Heart surgery	Y	N	U														
c. Other	Y	N	U														

INFORMANT INTERVIEW FORM (IFIC Screen 3 of 16)

7. What was the date of the hospital admission?

Month			Day			Year			

8. Could you tell me the name and location of the hospital?

Specify Name, City, State — Yes Y
 Skip Name, City, State — No N

[Place Name, City, State in notelog]

Name _____

 City _____
 State _____

9. Was (_____) seen by a physician anytime in the last four weeks prior to death?

Yes Y

No N

Unknown ... U

Go to Item 11

10. Could you tell me the name and address of this physician?

Specify Name, City, State — Yes Y
 Skip Name, City, State — No N

[Place Name, City, State in notelog]

Name _____

 City _____
 State _____

11. Could you tell me the name and address of (_____)’s usual physician? (If same as Q10 record as "same.")

Specify Name, City, State — Yes Y
 Skip Name, City, State — No N

[Place Name, City, State in notelog]

Name _____

 City _____
 State _____

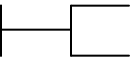
12. Before (_____)’s final illness, had he/she ever had pains in the chest from heart disease, for example angina pectoris?

Yes Y

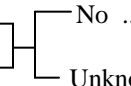
Go to Item 14, Screen 4 — No N

Unknown ... U

INFORMANT INTERVIEW FORM (IFIC Screen 4 of 16)

<p>13. Did (____) ever take nitroglycerin for this pain?</p> <p style="text-align: right;">Yes Y</p> <p style="text-align: right;">No N</p> <p style="text-align: right;">Unknown ... U</p> <p>14. Did a doctor ever say that (____) had a heart attack prior to his/her final illness?</p> <p style="text-align: right;">Yes Y</p> <p style="text-align: right;">No N</p> <p style="text-align: right;">Unknown ... U</p> <div style="border: 1px solid black; display: inline-block; padding: 2px; margin-top: 10px;">Go to Item 16</div> 	<p>15. Was (____) hospitalized for a heart attack?</p> <p style="text-align: right;">Yes Y</p> <p style="text-align: right;">No N</p> <p style="text-align: right;">Unknown ... U</p> <p>16. Did he/she ever have a coronary bypass operation, balloon angioplasty or some other operation or procedure to improve the circulation of blood to the heart?</p> <p style="text-align: right;">Yes Y</p> <p style="text-align: right;">No N</p> <p style="text-align: right;">Unknown ... U</p>
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INFORMANT INTERVIEW FORM (IFIC Screen 5 of 16)

<p>17. Did (____) ever have any other heart disease or heart condition before his/her final illness?</p> <p style="text-align: right;">Yes Y</p> <p style="text-align: right;">No N</p> <p style="text-align: right;">Unknown ... U</p> <p>If yes, specify: _____</p> <p>_____</p> <p>_____</p> <p>18. Did (____) ever have a stroke?</p> <p style="text-align: right;">Yes Y</p> <p style="text-align: right;">No N</p> <p style="text-align: right;">Unknown ... U</p> <div style="border: 1px solid black; display: inline-block; padding: 2px; margin-top: 10px;">Go to Item 19b</div> 	<p>19.a. Did he/she have a stroke within four weeks of his/her final illness?</p> <p style="text-align: right;">Yes Y</p> <p style="text-align: right;">No N</p> <p style="text-align: right;">Unknown ... U</p> <p>b. Did he/she have a history of cigarette smoking?</p> <p style="text-align: right;">Yes Y</p> <p style="text-align: right;">No N</p> <p style="text-align: right;">Unknown ... U</p> <p>c. Did he/she have a history of diabetes?</p> <p style="text-align: right;">Yes Y</p> <p style="text-align: right;">No N</p> <p style="text-align: right;">Unknown ... U</p>
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B. CIRCUMSTANCES SURROUNDING DEATH

Attach Event ID Label Here

"The next few questions are concerned with the circumstances surrounding (____)'s death."

20. Could you please tell me what you can of (____)'s general health, on the day he/she died, and of the death itself?

Yes Y
No N
Unknown ... U

Specify: _____

INFORMANT INTERVIEW FORM (IFIC Screen 7 of 16)

"The next set of questions may go over some of what you have already told me. Although it may seem repetitious, I must ask these questions for consistency of information."

21. Were you present when (____) died?

Go to Item 25, Screen 8 — Yes Y
No N

22. Did anyone see or hear (____) when he/she died?

Go to Item 25, Screen 8 — Yes Y
No N
Unknown ... U

23. Was anyone close enough to hear (____) if he/she had called out?

Go to Item 25, Screen 8 — Yes Y
No N
Unknown ... U

24. How long after (____) was last known to be alive was he/she found dead?

{Enter the shortest interval known to be true}

- 5 minutes or less A
- 1 hour or less B
- 24 hours or less C
- More than 24 hours D
- Unknown U

INFORMANT INTERVIEW FORM (IFIC Screen 8 of 16)

25. Where was (____) when he/she died?

- Home (or other private residence) A
- Work B
- In a public building C
- On a bus or public transportation D
- On the street E
- In an automobile F
- In a nursing home G
- In an emergency room H
- In an ambulance I
- In the hospital J
- Other O
- Unknown U

C. SYMPTOMS

"The next few questions are concerned with any symptoms (____) may have had shortly before he/she died."

26. Did (____) experience pain or discomfort in his/her chest, left arm, or shoulder or jaw either just before death or within 3 days (72 hours) of death?

Yes Y

No N

Unknown ... U

Go to Item 30, Screen 10

INFORMANT INTERVIEW FORM (IFIC Screen 9 of 16)

<p>"The next set of questions deal specifically with the last episode of (____)'s pain or discomfort. The last episode is defined as starting at the time (____) noticed discomfort that caused him/her to stop or change what he/she was doing."</p> <p>27. Did (____)'s last episode of pain or discomfort specifically involve the chest?</p> <p style="text-align: center;">Yes Y</p> <p style="text-align: center;">No N</p> <p style="text-align: center;">Unknown ... U</p>	<p>28. Did he/she take nitroglycerin because of this last episode of pain or discomfort?</p> <p style="text-align: center;">Yes Y</p> <p style="text-align: center;">No N</p> <p style="text-align: center;">Unknown ... U</p>
--	--

INFORMANT INTERVIEW FORM (IFIC Screen 10 of 16)

<p>29. How long was it from the beginning of (____)'s last episode of pain or discomfort to the time he/she stopped breathing on his/her own?</p> <p>{Circle the shortest interval known to be true}</p> <p style="text-align: center;">5 minutes or less A</p> <p style="text-align: center;">10 minutes or less B</p> <p style="text-align: center;">1 hour or less C</p> <p style="text-align: center;">24 hours or less D</p> <p style="text-align: center;">More than 24 hours E</p> <p style="text-align: center;">Unknown U</p>	<p>30. Within 3 days of death or just before (____) died, did any of the following symptoms begin for the first time?</p> <p>{Circle (Y), (N) or (U) for each}</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="text-align: center; border-bottom: 1px solid black;">Yes</th> <th style="text-align: center; border-bottom: 1px solid black;">No</th> <th style="text-align: center; border-bottom: 1px solid black;">Unknown</th> </tr> </thead> <tbody> <tr> <td>a. Shortness of breath</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> <td style="text-align: center;">U</td> </tr> <tr> <td>b. Dizziness</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> <td style="text-align: center;">U</td> </tr> <tr> <td>c. Palpitations (pounding in the chest)</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> <td style="text-align: center;">U</td> </tr> <tr> <td>d. Marked or increased fatigue, tiredness, or weakness</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> <td style="text-align: center;">U</td> </tr> <tr> <td>e. Headache</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> <td style="text-align: center;">U</td> </tr> <tr> <td>f. Sweating</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> <td style="text-align: center;">U</td> </tr> <tr> <td>g. Paralysis</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> <td style="text-align: center;">U</td> </tr> <tr> <td>h. Loss of speech</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> <td style="text-align: center;">U</td> </tr> <tr> <td>i. Attack of indigestion or nausea or vomiting</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> <td style="text-align: center;">U</td> </tr> <tr> <td>j. Other</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> <td style="text-align: center;">U</td> </tr> </tbody> </table> <p>— If Other, specify: _____</p> <p>_____</p> <p>_____</p>		Yes	No	Unknown	a. Shortness of breath	Y	N	U	b. Dizziness	Y	N	U	c. Palpitations (pounding in the chest)	Y	N	U	d. Marked or increased fatigue, tiredness, or weakness	Y	N	U	e. Headache	Y	N	U	f. Sweating	Y	N	U	g. Paralysis	Y	N	U	h. Loss of speech	Y	N	U	i. Attack of indigestion or nausea or vomiting	Y	N	U	j. Other	Y	N	U
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j. Other	Y	N	U																																										

INFORMANT INTERVIEW FORM (IFIC Screen 11 of 16)

D. EMERGENCY MEDICAL CARE

" The next few questions are concerned with emergency medical care (_____) may have received prior to or at the time of death. You may have already given this information in an answer to an earlier question. Since it is important to obtain information specifically on emergency medical care, I hope you don't mind if these questions seem repetitive."

31. Was a physician, ambulance, or other emergency medical team called?

Yes Y

No N

Unknown ... U

Go to Item 35,
Screen 13

32. Was (the physician, ambulance, or EMS team) called because of symptoms (_____) was having or after he/she was already dead?

Symptoms S

Already Dead ... D

Go to Item 35,
Screen 13

INFORMANT INTERVIEW FORM (IFIC Screen 12 of 16)

33. How long was it from the time the last episode of symptoms started to the time that medical assistance was called for?

{Circle the shortest interval known to be true}

5 minutes or less A

10 minutes or less B

1 hour or less C

6 hours or less D

24 hours or less E

More than 24 hours F

Unknown U

34. How long was it from the time that medical care was called to the time when it arrived?

{Circle the shortest interval known to be true}

5 minutes or less A

10 minutes or less B

1 hour or less C

6 hours or less D

24 hours or less E

More than 24 hours F

Unknown U

Did not come X

INFORMANT INTERVIEW FORM (IFIC Screen 13 of 16)

<p>35. Were resuscitation measures, such as closed chest massage or CPR, attempted at the time?</p> <p style="text-align: right;">Yes Y</p> <p style="text-align: right;">No N</p> <p style="text-align: right;">Unknown U</p> <div style="border: 1px solid black; display: inline-block; padding: 2px; margin-left: 20px;">Go to Item 38,</div>	<p>37. Where was resuscitation or CPR started?</p> <p style="text-align: right;">Home (or other private residence) A</p> <p style="text-align: right;">Work B</p> <p style="text-align: right;">Public place C</p> <p style="text-align: right;">Ambulance or other emergency vehicle D</p> <p style="text-align: right;">Emergency room E</p> <p style="text-align: right;">Hospital F</p> <p style="text-align: right;">Other O</p> <p style="text-align: right;">Unknown U</p> <div style="border: 1px solid black; display: inline-block; padding: 2px; margin-left: 20px;">Go to Item 39, Screen 14</div>
<p>36. Who started the resuscitation or CPR?</p> <p style="text-align: right;">Bystander, non-health professional A</p> <p style="text-align: right;">M.D. B</p> <p style="text-align: right;">Ambulance attendant, paramedic, or other health professional C</p> <p style="text-align: right;">Fireman or policeman D</p> <p style="text-align: right;">Other O</p> <p style="text-align: right;">Unknown U</p>	

INFORMANT INTERVIEW FORM (IFIC Screen 14 of 16)

<p>38. Was (_____) taken to a hospital?</p> <p style="text-align: right;">Yes Y</p> <p style="text-align: right;">No N</p> <p style="text-align: right;">Unknown U</p> <div style="border: 1px solid black; display: inline-block; padding: 2px; margin-left: 20px;">Go to Item 40</div>	<p>E. ADDITIONAL INFORMATION</p> <p>40. Is there someone else whom we could contact, who might know more about the circumstances surrounding (_____)’s death or his/her usual state of health?</p> <p style="text-align: right;">Yes Y</p> <p style="text-align: right;">No N</p> <p style="text-align: right;">Unknown U</p> <div style="border: 1px solid black; display: inline-block; padding: 2px; margin-left: 20px;">Read "final script" then go to Item 43, Screen 15</div>
<p>39. Could you tell me the name and location of this hospital?</p> <div style="border: 1px solid black; display: inline-block; padding: 2px; margin-left: 20px;">Specify Name, City, State</div> Yes Y	<p>41. Could you tell me the name, address, and telephone number of this person?</p> <div style="border: 1px solid black; display: inline-block; padding: 2px; margin-left: 20px;">Specify Name, City, State, Phone</div> Yes Y
<div style="border: 1px solid black; display: inline-block; padding: 2px; margin-left: 20px;">Skip Name, City, State</div> No N	<div style="border: 1px solid black; display: inline-block; padding: 2px; margin-left: 20px;">Skip Name, City, State, Phone</div> No N
<p>[Place Name, City, State in notelog]</p> <p>Name _____</p> <p>City _____</p> <p>State _____</p>	<p>[Place Name, City, State, Phone in notelog]</p> <p>Name _____</p> <p>City _____</p> <p>State _____</p> <p>Phone _____</p>

INFORMANT INTERVIEW FORM (IFIC Screen 15 of 16)

42. How was he/she related to the deceased?

- Spouse S
- Parent P
- Daughter/Son C
- Other relative R
- Friend F
- Workmate W
- Other O

[Read "final script", then go to Item 43]

F. RELIABILITY

{To be completed immediately after the interview}

43. Did the respondent frequently contradict himself/herself or give information that he/she would have no way of knowing? Yes Y
No N

44. Did the respondent seem to be reluctant to answer questions and thus might not have given all the information the interviewer would wish to know? Yes Y
No N

INFORMANT INTERVIEW FORM (IFIC Screen 16 of 16)

45. On the basis of these questions, give your rating of reliability of the interview. Good G
Fair F
Poor P

46. Would you like to add other details concerning the quality of the interview?
Yes Y
No N

If Yes, specify: _____

47. Informant agreed to provide consent to gather further information?
Yes Y
No N
Not applicable ... A

If Yes, specify _____

G. ADMINISTRATIVE INFORMATION

48. Date of data collection:

		-			-				
--	--	---	--	--	---	--	--	--	--

Month Day Year

49. Method of data collection:
Computer C
Paper Form P

50. Code number of the person completing this form.

--	--	--

51. Result Code:

--	--



ARIC Heart Failure Survey

O.M.B 0925-0281
Exp. XX/XXXX

Dear < Dr > ,

Your patient, < Ms/Mr. > who is a long time participant in the ARIC Study, has indicated to ARIC study personnel that < s/he > has been diagnosed with heart failure. We have your patient's authorization to ask you to provide this information for our study records. We appreciate your response to the following questions and request that you return this form in the enclosed envelope at your earliest convenience (ideally within 2 weeks).

Thank you.

Sincerely,

< Field center medical director >

Date < Date letter is sent >

Patient Name < Ms/Mr. > **Patient Date of Birth** < mm/dd/yyyy >

1. Has this patient ever had heart failure or cardiomyopathy of any type? Yes Unsure No
(If response is NO, skip to question 3)
2. If the patient has or ever had heart failure or cardiomyopathy:
 - (a) Is this patient's condition characterized as predominantly:
 Systolic dysfunction Diastolic dysfunction Mixed Not determined
 - (b) Estimated LVEF (worst): ____%
 - (b.1.) If LVEF is not specifically available, estimate LV function:
 Normal Decreased mildly Decreased moderately Decreased severely
 - (c) Estimated date of onset or diagnosis: ___ / _____ (month/year)
3. Has this patient ever had (check all that apply):

<input type="checkbox"/> Atrial fibrillation on an ECG?	<input type="checkbox"/> Angina pectoris?
<input type="checkbox"/> Pulmonary rales on a physical examination?	<input type="checkbox"/> Previous MI?
<input type="checkbox"/> Rhonchi on a physical examination?	<input type="checkbox"/> Other coronary heart disease?
	<input type="checkbox"/> None of the above
4. Was s/he prescribed treatment specifically for heart failure during the past year?
 Yes No Not known
5. Was this patient prescribed any of the following during the past year? (check all that apply)

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

Form completed by:

Date:

(Signature or stamp)

(MM/ DD /YY)



ARIC Heart Failure Survey

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

Public reporting burden for this collection of information is estimated to average 4 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: **NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0281)**. Do not return the completed form to this address.

ARIC

Atherosclerosis Risk in Communities

PHYSICIAN QUESTIONNAIRE FORM

Public reporting burden for this collection of information is estimated to average 6-15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: **NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0281)**. Do not return the completed form to this address.

ARIC Center use only

Version C: 05/22/07

Decedent's Name: _____ Age: ____ Date of Birth: __/__/____ Date of Death: __/__/____

EVENT ID: Sequence Number: Physician's Name _____

Please complete the following and return in the enclosed envelope.

A. MEDICAL HISTORY

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

Yes

No

If **No**, skip to Item 5 on Page 3.

2. When did you last see the decedent?

-
Month Year

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

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

g. If MI **Yes**, date of most recent event:

-
Month Year

3. (cont'd) Did the decedent have a history of any of the following?

	<u>Yes</u>	<u>No</u>	<u>Uncertain</u>
h. Other chronic ischemic heart disease:....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Stroke (CVA):.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

j. If Yes, date of most recent event: -

Month Year

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

If Yes, specify: _____

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

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

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

If Yes, specify: _____

B. DETAILS OF DEATH

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

Yes No

6. Did you witness the death?

Yes No

If you answered **No** to both 5 & 6, skip to Item 14 on page 4. Otherwise, continue with Item 7.

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

Yes No Uncertain

If **No** or **Uncertain**, skip to item 8

b. Did the pain include the chest?

Yes No Uncertain

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

Yes No Uncertain

If **No**, specify what you think was the cause:

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

Yes No Uncertain

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

Yes No Uncertain

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

Yes No Uncertain

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

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

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

- Yes No Uncertain
-

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

- | | <u>Yes</u> | <u>No</u> | <u>Uncertain</u> |
|------------------------------|--------------------------|--------------------------|--------------------------|
| a. Pulmonary embolism | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Acute pulmonary edema ... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Stroke | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Pneumonia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Other | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Specify: _____

C. SIGNATURE

14. Form completed by: _____

Signature

15. Date: -- --

Month Day Year

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

OFFICE USE ONLY: 16. Self (A)___ Interview (B)___ E.R. records (C) __