OMB#: 0925-0584
Exp. X/XX/XXXX

# HCHS/SOL Follow-up Interview Form
## Contact Year 1

| ID NUMBER: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|

FORM CODE: AFE
VERSION: A

Contact Occasion: 0 1

SEQ #: ____

**ADMINISTRATIVE INFORMATION**

0a. Completion Date: ____/____/____ 0b. Staff ID: ____

***Instructions:*** See the detailed QxQ instructions for completion of the Annual Follow-up form.

**INTRODUCTION**

Hello, my name is *(interviewer name)*, and I am calling to follow up with *(participant name)* about the Hispanic Community Health Study / Study of Latinos (SOL), a health study in which s/he is currently enrolled. Is s/he available?

No → When would it be convenient to call back? .....Thank you. I will call again.

Yes → Hello, *(participant name)*, this is *(interviewer name)* with the Hispanic Community Health Study / Study of Latinos (SOL). I'm calling to see how you have been since your visit to our center and to update our SOL records. Do you have a few minutes to speak on the phone?

No → When would it be convenient to call back?.....Thank you. I will call again.

Yes → We'd like to gather information about your general health and about specific medical conditions that you may have had since your visit to our center. I will ask you some questions about your health since your center visit on *(date of center visit)*. I want you to focus on what happened from *(date of center visit)* until today.

**A**. [GHE section for data entry screens begins here]

1. Participant status (choose one):

| | | |
|---|---|---|
| Contacted and alive | 1 ☐ | Go to item 2 |
| Contacted and refused interview | 2 ☐ | Go to *Contact tracking*, item 31a1 |
| Not contacted, reported alive | 3 ☐ | Go to *Contact tracking*, item 31a1 |
| Not contacted, reported deceased | 4 ☐ | Continue to 1a, below |
| Unknown | 9 ☐ | Go to *Contact tracking*, item 31a1 |

1a. What was the date of death? ____ / ____ / ____

1b. What city, state, and country did the death occur? _____

1c. Do you know if (insert decedent's name) was hospitalized or visited an emergency room for any reason since (date of center visit) and his/her death?

No 0 ☐ End interview

Yes 1 ☐ Record date and name of each hospitalization and/or ER visit. End interview after last event is reported.

**GENERAL HEALTH**

2. Since your SOL center visit on *(date)*, would you say, in general, your health is Excellent, Very good, Good, Fair, or Poor?

Excellent 1☐ Very good 2☐ Good 3☐ Fair 4☐ Poor 5☐

**[**HOE section for data entry screens begins here**]**

**B. HOSPITALIZED AND EMERGENCY ROOM EVENTS**

*"The following questions are about any hospitalizations or visits to an emergency room you may have had since your SOL center visit on (date)."* [ Note: This section will repeat depending upon number of reported events ]

3. Since your SOL center visit on *(date)*, have you at any time been admitted to a hospital or seen in an emergency room?

| | | |
|---|---|---|
| No | 0 ☐ | Go to item 5 |
| Yes | 1 ☐ | |
| Unsure | 9 ☐ | Go to item 5 |

*"The next few questions are about one event, if there were more than one we would like to talk about each one separately, let's start with the first event after your SOL visit on (date)."*

4. Was this visit to the emergency room only, a hospital admission only, or a visit to the emergency room that resulted in being admitted to the hospital?

| | |
|---|---|
| Emergency Department (only) | 1 ☐ |
| Hospital Admission (only) | 2 ☐ |
| Both | 3 ☐ |
| Unsure | 9 ☐ |

4a. What was the main reason for going to the (*insert emergency room or hospital)* that day?
[*Check one and do not read choices]*

| | |
|---|---|
| Myocardial infarction, heart attack | 0 ☐ |
| Angina, chest pain | 1 ☐ |
| Heart failure | 2 ☐ |
| Stroke or TIA | 3 ☐ |
| Peripheral vascular disease | 4 ☐ |
| Venous thrombosis or pulmonary embolism | 5 ☐ |
| Chronic Obstructive Pulmonary Disease, emphysema, or chronic bronchitis | 6 ☐ |
| Asthma | 7 ☐ |
| Other: | 8 ☐ |

Specify: _____

4b. What was the date of this event? ☐☐ / ☐☐ / ☐☐☐☐

4c. What is the name of the medical facility?_____

4d. What is the address of this medical facility? _____
(Leave blank if unknown)

4e. For clarification of our records, under what name is this record?

4e1. First Name: _____

4e2. Second Name: _____

4e3. Last Name: _____

4e4. Maternal Last Name: _____

4f. Were you admitted to a hospital or seen at an ER at any another time since your SOL center visit?

No 0 ☐ Go to item 5
Yes 1 ☐ (Line entry saved, screen refreshes to a new series at item 4)

**[**OPE section for data entry screens begins here**]**

## C. OUT-PATIENT SELF-REPORTED CONDITIONS

*"Now I would like to ask you about conditions that may have resulted in you seeing a doctor or health profession at a clinic or doctor's office, but not actually being admitted to the hospital or visiting an emergency room."*

5. Since your SOL center visit on *(date)*, has a doctor or health professional told you that you had emphysema, chronic bronchitis, or chronic obstructive pulmonary disease (COPD)? This does not include doctor's visits for tuberculosis or TB.

No 0 ☐ Go to item 6
Yes 1 ☐
Unsure 9 ☐ Go to item 6

Did your doctor or healthcare professional order any of the following tests to help make the diagnosis?

5a. Breathing test or pulmonary function test?

No 0 ☐ Yes 1 ☐ Unsure 9 ☐

5b. Chest X-ray:

No 0 ☐ Yes 1 ☐ Unsure 9 ☐

5c. CT Scan of your chest:

No 0 ☐ Yes 1 ☐ Unsure 9 ☐

5d. Were you told by a doctor or health professional that you were having an attack, worsening or an exacerbation of your emphysema, chronic obstructive pulmonary disease (COPD), or chronic bronchitis?

No 0 ☐ Go to item 6
Yes 1 ☐
Unsure 9 ☐ Go to item 6

5e. Did the doctor or health care professional prescribe a change in your medication, such as increasing your inhalers, oxygen or pills for your lungs or prescribing a steroid pill for your lungs?

No 0 ☐ Yes 1 ☐ Unsure 9 ☐

6. Since your SOL center visit on *(date)*, has a doctor or health professional told you that you had asthma?

No 0 ☐ Go to item 7
Yes 1 ☐
Unsure 9 ☐ Go to item 7

Did your doctor or healthcare professional order any of the following tests to help make the diagnosis?

6a. Breathing test or pulmonary function test

No 0 ☐ Yes 1 ☐ Unsure 9 ☐

6b. Chest X-ray

No 0 ☐ Yes 1 ☐ Unsure 9 ☐

6c. CT Scan of your chest

No 0 ☐ Yes 1 ☐ Unsure 9 ☐

6d. Were you told by a doctor or health professional that you were having an attack, worsening or an exacerbation of your asthma?

No 0 ☐ Go to item 7
Yes 1 ☐
Unsure 2 ☐ Go to item 7

6e. Did the doctor or health care professional prescribe a change in your medication, such as increasing your inhalers, oxygen or pills for your lungs or prescribing a steroid pill for your lungs?

No 0 ☐ Yes 1 ☐ Unsure 9 ☐

7. Since your SOL center visit on *(date)*, has a doctor or health professional told you that you had diabetes or high sugar in the blood?

No 0 ☐ Go to item 8
Yes 1 ☐
Unsure 9 ☐ Go to item 8

7a. Did the doctor recommend any new or different treatments?

No 0 ☐ Go to item 8
Yes 1 ☐
Unsure 9 ☐ Go to item 8

7b.What treatment was recommended?
(Do not prompt for specific response. Mark all that apply)

- Pills ☐
- Insulin Alone ☐
- Insulin and pills ☐
- Referred for eye exam ☐
- Advice to change diet ☐
- Advice to stop smoking ☐
- Advice to increase excercise ☐
- Other ☐
  Specify: _____

8. Since your SOL center visit on *(date)*, has a doctor or health professional told you that you had high blood pressure or hypertension?

- No 0 ☐ Go to item 9
- Yes 1 ☐
- Unsure 9 ☐ Go to item 9

8a. Did the doctor recommend any new or different treatments?

- No 0 ☐ Go to item 9
- Yes 1 ☐
- Unsure 9 ☐ Go to item 9

8b. What treatment was recommended? *(Do not prompt for specific response. Mark all that apply)*

- Start new medicine ☐
- Increase dose of existing medicine ☐
- Advice to lose weight ☐
- Advice to change diet ☐
- Advice to stop smoking ☐
- Advice to increase exercise ☐
- Other ☐
  Specify: _____

9. Since your SOL center visit on *(date)*, has a doctor or health professional told you that you had high blood cholesterol?

- No 0 ☐ Go to item 10
- Yes 1 ☐
- Unsure 9 ☐ Go to item 10

9a. Did the doctor recommend any new or different treatments?

- No 0 ☐ Go to item 10
- Yes 1 ☐
- Unsure 9 ☐ Go to item 10

9b. What treatment was recommended? *(Do not prompt for specific response. Mark all that apply.)*

- Start new medicine ☐
- Increase dose of existing medicine ☐
- Advice to lose weight ☐
- Advice to change diet ☐
- Advice to stop smoking ☐
- Advice to increase exercise ☐
- Other ☐
  - Specify: _____

**[MEE** section for data entry screens begins here**]**

**D. MEDICATIONS**

*"Now I would like to ask about the prescription medications you currently use. By currently I mean in the past two weeks. Can you to bring all these prescription medications to the telephone?"*

10. *(Interviewer: Do not ask)* Does the participant have medications to report?

| | | |
|---|---|---|
| No | 0 ☐ | Skip items 11-30 |
| Yes | 1 ☐ | |
| Participant refused | 2 ☐ | Skip items 11-30 |

Please read the names of all the medications prescribed by a doctor. This includes pills, liquid medications, skin patches, inhalers, injections and suppositories. Please do not include over the counter medications unless prescribed by a doctor.

| # | (a) Medication UPC / NDC | | Medication name (b) |
|---|---|---|---|
| 11. | | | |
| | (c) Strength | (d) Units | |
| | | | |
| 12. | | | |
| | (c) Strength | (d) Units | |
| | | | |
| 13. | | | |
| | (c) Strength | (d) Units | |
| | | | |
| 14. | | | |
| | (c) Strength | (d) Units | |
| | | | |
| 15. | | | |
| | (c) Strength | (d) Units | |
| | | | |
| 16. | | | |
| | (c) Strength | (d) Units | |
| | | | |
| 17. | | | |
| | (c) Strength | (d) Units | |
| | | | |
| 18. | | | |
| | (c) Strength | (d) Units | |
| | | | |
| 19. | | | |
| | (c) Strength | (d) Units | |
| | | | |
| 20. | | | |
| | (c) Strength | (d) Units | |
| | | | |

| # | (a) Medication UPC | (c) Strength | (d) Units | Medication name (b) |
|---|---|---|---|---|
| 21. | | | | |
| 22. | | | | |
| 23. | | | | |
| 24. | | | | |
| 25. | | | | |
| 26. | | | | |
| 27. | | | | |
| 28. | | | | |
| 29. | | | | |
| 30. | | | | |

*Thank you so much for answering these questions. We greatly appreciate your participation in the SOL study. Now, I'd just like to make sure our records are up to date.*

-

**[CIE** section for data entry screens begins here.**]**

## E. PARTICIPANT TRACKING

31. Interviewer: Current tracking information from HCHS/SOL database is shown below. Record tracking information changes reported during the interview in the space provided.

*"It is very important for this study to be able to reach you in the future. Although you provided your contact information at the time of your visit, in order to keep our records up to date please provide us with your current home address. All information you give us in strictly confidential and will not be shared with anyone else".*

31. Current home address*

31.A.1. PO Box, Box &/or Route and Number

31.B.1. Street Number Prefix

31.B.2. **Street Number**

31.B.3. Street Number Suffix

31.C.1. Street Name Prefix

31.C.2. **Street Name**

31.C.3. **Street Name Type**

31.C.4. Street Name Suffix

31.D.1. Unit Type

31.D.2. Unit Type Identifier

31.D.3. Unit Subtype

31.D.4. Unit Subtype Identifier

31.E.1. Other

31.F.1. City

31.G.1. County

31.H.1. State

31.I.1. Country/Territory *(Select code from list)*

31.J.1. Zip Code

*IF THE PARTICIPANT LIVES AT SEVERAL LOCATIONS, ENTER WHERE HE OR SHE LIVES MOST. IF THE EXACT ADDRESS IS UNKNOWN, ENTER THE NAME OF THE INTERSECTION OR STREET CLOSEST TO THE HOME LOCATION IN 31.C.2. AND THE NAME OF THE BUILDING OR LOCATION IN 31.E.1.

IF THE ONLY KNOWN HOME ADDRESS IS A POST OFFICE BOX, BOX, OR ROUTE AND NUMBER, ENTER IT IN 31.A.1., BUT ALSO ENTER THE NAME OF THE INTERSECTION OR STREET CLOSEST TO THE ACTUAL HOME LOCATION IN 31.C.2. AND THE NAME OF THE BUILDING OR LOCATION IN 31.E.1.

32. Primary Phone Number: ( ) -

33. What is the best time of day to reach you at this number?

Morning 1
Afternoon 2
Evening 3

34. Secondary Phone Number: ( ) -

35. What is the best time of day to reach you at this number?

Morning 1
Afternoon 2
Evening 3

**Local Contact 1**

36. a. Title: _____ b. First Name: _____

c. Second Name: _____

d. Last Name: _____

_ e. Maternal Last Name: _____

37. Relationship: _____

38. Current home address of primary contact*

38.A.1. PO Box, Box &/or Route and Number

38.B.1. Street Number Prefix

38.B.2. **Street Number**

38.B.3. Street Number Suffix

38.C.1. Street Name Prefix

38.C.2. **Street Name**

38.C.3. **Street Name Type**

38.C.4. Street Name Suffix

38.D.1. Unit Type

38.D.2. Unit Type Identifier

38.D.3. Unit Subtype

38.D.4. Unit Subtype Identifier

38.E.1. Other

38.F.1. City

38.G.1. County

38.H.1. State

38.I.1. Country/Territory *(Select code from list)*

38.J.1. Zip Code

*IF THE PERSON LIVES AT SEVERAL LOCATIONS, ENTER WHERE HE OR SHE LIVES MOST. IF THE EXACT ADDRESS IS UNKNOWN, ENTER THE NAME OF THE INTERSECTION OR STREET CLOSEST TO THE HOME LOCATION IN 38.C.2. AND THE NAME OF THE BUILDING OR LOCATION IN 38.E.1.

IF THE ONLY KNOWN HOME ADDRESS IS A POST OFFICE BOX, BOX, OR ROUTE AND NUMBER, ENTER IT IN 138.A.1., BUT ALSO ENTER THE NAME OF THE INTERSECTION OR STREET CLOSEST TO THE ACTUAL HOME LOCATION IN 38.C.2. AND THE NAME OF THE BUILDING OR LOCATION IN 38.E.1.

39. Telephone: ( ) -

**Local Contact 2**

40. a. Title: _____ b. First Name: _____

c. Middle/Second Name: _____

d. Paternal Last Name: _____

_ e. Maternal Last Name: _____

41. Relationship: _____

42. Current home address of secondary contact*

42.A.1. PO Box, Box &/or Route and Number

42.B.1. Street Number Prefix

42.B.2. **Street Number**

42.B.3. Street Number Suffix

42.C.1. Street Name Prefix

42.C.2. **Street Name**

42.C.3. **Street Name Type**

42.C.4. Street Name Suffix

42.D.1. Unit Type

42.D.2. Unit Type Identifier

42.D.3. Unit Subtype

42.D.4. Unit Subtype Identifier

42.E.1. Other

42.F.1. City

42.G.1. County

42.H.1. State

42.I.1. Country/Territory *(Select code from list)*

42.J.1. Zip Code

43. Telephone: ( ) -

*IF THE PERSON LIVES AT SEVERAL LOCATIONS, ENTER WHERE HE OR SHE LIVES MOST. IF THE EXACT ADDRESS IS UNKNOWN, ENTER THE NAME OF THE INTERSECTION OR STREET CLOSEST TO THE HOME LOCATION IN 42.C.2. AND THE NAME OF THE BUILDING OR LOCATION IN 42.E.1.

IF THE ONLY KNOWN HOME ADDRESS IS A POST OFFICE BOX, BOX, OR ROUTE AND NUMBER, ENTER IT IN 42.A.1., BUT ALSO ENTER THE NAME OF THE INTERSECTION OR STREET CLOSEST TO THE ACTUAL HOME LOCATION IN 42.C.2. AND THE NAME OF THE BUILDING OR LOCATION IN 42.E.1.

**Local Contact 3**

44. a. Title: _____ b. First Name: _____

c. Middle/Second Name: _____

d. Paternal Last Name: _____

_ e. Maternal Last Name: _____

45. Relationship: _____

46. Current home address of third contact*

46.A.1. PO Box, Box &/or Route and Number

46.B.1. Street Number Prefix

46.B.2. **Street Number**

46.B.3. Street Number Suffix

46.C.1. Street Name Prefix

46.C.2. **Street Name**

46.C.3. **Street Name Type**

46.C.4. Street Name Suffix

46.D.1. Unit Type

46.D.2. Unit Type Identifier

46.D.3. Unit Subtype

46.D.4. Unit Subtype Identifier

46.E.1. Other

46.F.1. City

46.G.1. County

46.H.1. State

46.I.1. Country/Territory *(Select code from list)*

46.J.1. Zip Code

47. Telephone: ( ) -

48. For this portion of the call, I have one more question. What is the name of your physician or other health care provider (HCP)?"

a. Name: _____

b. Address: _____

_____

c. City, State, Zip Code: _____

**F. END OF THIS PORTION OF THE CALL**

*"Thank you for answering the questions about your health. Now we would like to continue with the call by asking you some questions about the food that you eat. (GO to FPQ opening script)*