OMB#: 0925-0584
Exp. n/nn/nnnn

HCHS/SOL Follow-up Interview Form
Contact Year 2

ID NUMBER:								

FORM CODE: FE2
VERSION: A

Contact Occasion: 0 2

SEQ #: 0 1

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 last telephone interview 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 in the past year. I will ask you some questions about your health since the last telephone interview with you on *(date of last follow-up call)*. I want you to focus on what happened from *(date of last follow-up call)* 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 last time interviewed) 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 our last telephone interview with you on *(date),* would you say, in general, your health is Excellent, Very good, Good, Fair, 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 our last telephone interview with you on (date)." [Note: This section will repeat depending upon number of reported events]

3. Since our last telephone interview with you 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 since our last telephone interview with you 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: Specify: _____ 8☐

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 last telephone interview?

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 our last telephone interview with you 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 our last telephone interview with you 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 our last telephone interview with you 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 exercise ☐
Other ☐ Specify: _____

8. Since our last telephone interview with you 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 our last telephone interview with you 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: _____

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

D. SELF REPORT OF EVENTS SINCE BASELINE VISIT

"Now I would like to ask you about symptoms you may have had since your SOL center visit 2 years ago on (date)."

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

No 0 ☐ Yes 1 ☐ Unsure 9 ☐

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

No 0 ☐ Yes 1 ☐ Unsure 9 ☐

12. Since your SOL center visit on *(date)*, has a doctor or health professional told you that you had a blood clot in your leg vein or lung requiring blood thinning medicine?

No 0 ☐ Yes 1 ☐ Unsure 9 ☐

13. Since your SOL center visit on *(date)*, do you often have swelling in your feet or ankles at the end of the day?

No 0 ☐ Yes 1 ☐ Unsure 9 ☐

14. Since your SOL center visit on *(date)*, are there times when you wake up at night because of difficulty breathing?

No 0 ☐ Yes 1 ☐ Unsure 9 ☐

15. Since your SOL center visit on *(date)*, are there times when you have been troubled by shortness of breath when hurrying on level ground or walking up a slight hill?

No 0 ☐ Yes 1 ☐ Unsure 9 ☐

16. Since your SOL center visit on *(date)*, are there times when you stop for breath when walking at your own pace on level ground?

No 0 ☐ Yes 1 ☐ Unsure 9 ☐

17. Since your SOL center visit on *(date)*, are there times when you have difficulty breathing when you are not walking or active?

No 0 ☐ Yes 1 ☐ Unsure 9 ☐

18. Since your SOL center visit on *(date)*, have you had a cough on most days or nights of the week during at least 3 months in a row?

No 0 ☐ Yes 1 ☐ Unsure 9 ☐

19. Since your SOL center visit on *(date)*, have you brought up phlegm from your chest on most days or nights of the week during at least 3 months in a row?

No 0 ☐ Yes 1 ☐ Unsure 9 ☐

20. Since your SOL center visit on *(date)*, have you had wheezing or whistling in your chest?

No 0 ☐ Go to item 21
Yes 1 ☐
Unsure 9 ☐ Go to item 21

20a. Have you had an attack of wheezing or whistling in the chest that has made you feel short of breath?

No 0 ☐ Yes 1 ☐ Unsure 9 ☐

21. Which statement best describes your <u>current</u> hearing (without a hearing aid)?

Excellent 0 ☐
Good 1 ☐
A little trouble 2 ☐
Moderate hearing trouble 3 ☐
A lot of trouble 4 ☐
Deaf 5 ☐
Refused 6 ☐
Don’t know 7 ☐

22. Since your SOL center visit on *(date)*, has a doctor or health professional told you that you need a hearing aid?

No	0 ☐	Go to item 23
Yes	1 ☐	
Unsure	9 ☐	Go to item 23

22a. Did you acquire a hearing aid?

No	0 ☐	Go to item 23
Yes	1 ☐	

22b. How often do you wear it?

Always	0 ☐
Sometimes	1 ☐
Rarely	2 ☐
Never	3 ☐

23. When exposed to loud noise (by loud, we mean so loud that you had to speak in a raised voice to be heard) in the past year, how often have you worn hearing protection, such as earplugs or earmuffs while working?

None of the time	1	☐
25% of the time	2	☐
50%	3	☐
75%	4	☐
100%	5	☐
Occasionally	6	☐
Don’t know	9	☐

24. When exposed to loud noise in the past year, how often have you worn hearing protection, such as earplugs, or earmuffs while outside of work, for example at sporting events or while participating in other noisy activities (using power tools, firearms, lawn mower, etc.)?

None of the time	1	☐
25% of the time	2	☐
50%	3	☐
75%	4	☐
100%	5	☐
Occasionally	6	☐
Don’t know	9	☐

25. Since your SOL center visit on *(date)*, have you had buzzing, ringing, or noise in your ears?

No	0 ☐	Go to item 26
Yes	1 ☐	
Unsure	9 ☐	Go to item 26

25a. Does this noise usually last longer than 5 minutes?

No 0 ☐ Yes 1 ☐ Unsure 9 ☐

25b. Do you hear this noise only following very loud sounds? For example, concerts, shooting, or loud noise at work.

No 0 ☐ Yes 1 ☐ Unsure 9 ☐

26. Since your SOL center visit on *(date)*, has a doctor or health professional told you that you have sleep apnea?

No 0 ☐ Go to item 27
Yes 1 ☐
Unsure 9 ☐ Go to item 27

26a. Has your sleep apnea been treated with any of the following? (check all that apply)

0 ☐ Surgery
1 ☐ Use of a dental appliance during sleep (a device put in your mouth at night that moves the jaws open)
2 ☐ Use of oxygen during sleep
3 ☐ A pressure machine such as CPAP or BILEVEL?

27. How often do you snore now?

Never 1 ☐
Rarely (1-2 nights a week) 2 ☐
Sometimes (3-5 nights a week) 3 ☐
Always or almost always (6-7 nights a week) 4 ☐
Don't know 9 ☐

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

E. 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?"

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

No 0 ☐ Go to items 49
Yes 1 ☐
Participant refused 2 ☐ Go to items 49

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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. (If they ask what do we mean with 'medications you are currently taking', that means medications you have been taken in the last 2 weeks.)

#	(a) Medication UPC / NDC		Medication name (b)
29.			
	(c) Strength	(d) Units	
30.			
	(c) Strength	(d) Units	
31.			
	(c) Strength	(d) Units	
32.			
	(c) Strength	(d) Units	
33.			
	(c) Strength	(d) Units	
34.			
	(c) Strength	(d) Units	
35.			
	(c) Strength	(d) Units	
36.			
	(c) Strength	(d) Units	
37.			
	(c) Strength	(d) Units	
38.			
	(c) Strength	(d) Units	

#	(a) Medication UPC		Medication name (b)
39.			
	(c) Strength	(d) Units	
40.			
	(c) Strength	(d) Units	
41.			
	(c) Strength	(d) Units	
42.			
	(c) Strength	(d) Units	
43.			
	(c) Strength	(d) Units	
44.			
	(c) Strength	(d) Units	
45.			
	(c) Strength	(d) Units	
46.			
	(c) Strength	(d) Units	
47.			
	(c) Strength	(d) Units	
48.			
	(c) Strength	(d) Units	

"Next, I would like to ask you about your regular use of aspirin. By regular use, I mean taking aspirin every other day or more frequently."

49. Are you NOW taking aspirin, or a medicine containing aspirin, on a regular basis? This does NOT include Tylenol or Advil or Motrin, ibuprofen.

No	0 ☐	Go to item50
Yes	1 ☐	
Unsure	9 ☐	Go to item 50

49a. What dose do you take?

81 mg per day of aspirin	0 ☐	
325 mg per day of aspirin	1 ☐	
Other	2 ☐	specify: _____

F. OTHER ITEMS

"Next I would like to ask you some other final questions."

50. Which of the following best describes your current cigarette smoking status?

Never smoker	0 ☐	(Go to item 52)
Former smoker, quit more than 1 year ago	1 ☐	
Former smoker, quit less than 1 year ago	2 ☐	
Current smoker	3 ☐	
Don't know	4 ☐	

51. Have you smoked cigarettes during the last 30 days?

No	0 ☐	Go to item 52
Yes	1 ☐	
Unsure	9 ☐	Go to item 52

51a. On average, about how many cigarettes a day do you smoke?

☐☐

52. Please tell me which of the following best describes your marital status?

Married	0 ☐
Widow (er)	1 ☐
Divorced	2 ☐
Separated	3 ☐
Single	4 ☐
Living with partner	5 ☐

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.

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

53. Interviewer: Current tracking information from 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".

53. Current home address*

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

53.B.1. Street Number Prefix

53.B.2. **Street Number**

53.B.3. Street Number Suffix

53.C.1. Street Name Prefix

53.C.2. **Street Name**

53.C.3. **Street Name Type**

53.C.4. Street Name Suffix

53.D.1. Unit Type

53.D.2. Unit Type Identifier

53.D.3. Unit Subtype

53.D.4. Unit Subtype Identifier

53.E.1. Other

53.F.1. City

53.G.1. County

53.H.1. State

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

53.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 53.C.2. AND THE NAME OF THE BUILDING OR LOCATION IN 53.E.1.

IF THE ONLY KNOWN HOME ADDRESS IS A POST OFFICE BOX, BOX, OR ROUTE AND NUMBER, ENTER IT IN 53.A.1., BUT ALSO ENTER THE NAME OF THE INTERSECTION OR STREET CLOSEST TO THE ACTUAL HOME LOCATION IN 53.C.2. AND THE NAME OF THE BUILDING OR LOCATION IN 53.E.1.

54. Primary Phone Number: ( ) -

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

Morning 1
Afternoon 2
Evening 3

56. Secondary Phone Number: ( ) -

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

Morning 1
Afternoon 2
Evening 3

Local Contact 1

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

c. Second Name: _____

d. Last Name: _____

_ e. Maternal Last Name: _____

59. Relationship: _____

60. Current home address of primary contact*

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

60.B.1. Street Number Prefix

60.B.2. **Street Number**

60.B.3. Street Number Suffix

60.C.1. Street Name Prefix

60.C.2. **Street Name**

60.C.3. **Street Name Type**

60.C.4. Street Name Suffix

60.D.1. Unit Type

60.D.2. Unit Type Identifier

60.D.3. Unit Subtype

60.D.4. Unit Subtype Identifier

60.E.1. Other

60.F.1. City

60.G.1. County

60.H.1. State

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

60.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 60.C.2. AND THE NAME OF THE BUILDING OR LOCATION IN 60.E.1.

IF THE ONLY KNOWN HOME ADDRESS IS A POST OFFICE BOX, BOX, OR ROUTE AND NUMBER, ENTER IT IN 160.A.1., BUT ALSO ENTER THE NAME OF THE INTERSECTION OR STREET CLOSEST TO THE ACTUAL HOME LOCATION IN 60.C.2. AND THE NAME OF THE BUILDING OR LOCATION IN 60.E.1.

61. Telephone: ( ) -

Local Contact 2

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

c. Middle/Second Name: _____

d. Paternal Last Name: _____

e. Maternal Last Name: _____

63. Relationship: _____

64. Current home address of secondary contact*

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

64.B.1. Street Number Prefix

64.B.2. **Street Number**

64.B.3. Street Number Suffix

64.C.1. Street Name Prefix

64.C.2. **Street Name**

64.C.3. **Street Name Type**

64.C.4. Street Name Suffix

64.D.1. Unit Type

64.D.2. Unit Type Identifier

64.D.3. Unit Subtype

64.D.4. Unit Subtype Identifier

64.E.1. Other

64.F.1. City

64.G.1. County

64.H.1. State

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

64.J.1. Zip Code

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65. 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 64.C.2. AND THE NAME OF THE BUILDING OR LOCATION IN 64.E.1.

IF THE ONLY KNOWN HOME ADDRESS IS A POST OFFICE BOX, BOX, OR ROUTE AND NUMBER, ENTER IT IN 64.A.1., BUT ALSO ENTER THE NAME OF THE INTERSECTION OR STREET CLOSEST TO THE ACTUAL HOME LOCATION IN 64.C.2. AND THE NAME OF THE BUILDING OR LOCATION IN 64.E.1.

Local Contact 3

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

c. Middle/Second Name: _____

d. Paternal Last Name: _____

_ e. Maternal Last Name: _____

67. Relationship: _____

68. Current home address of third contact*

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

68.B.1. Street Number Prefix

68.B.2. **Street Number**

68.B.3. Street Number Suffix

68.C.1. Street Name Prefix

68.C.2. **Street Name**

68.C.3. **Street Name Type**

68.C.4. Street Name Suffix

68.D.1. Unit Type

68.D.2. Unit Type Identifier

68.D.3. Unit Subtype

68.D.4. Unit Subtype Identifier

68.E.1. Other

68.F.1. City

68.G.1. County

68.H.1. State

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

68.J.1. Zip Code

69. Telephone: ( ) -

70. 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. We wish to continue to stay in touch with you and will be contacting you again next year"

Location Codes for Questions 53, 60, 64, 68

1 Afghanistan
2 Anguilla
3 Antigua and Barbuda
4 Argentina
5 Aruba
6 Australia
7 Austria
8 Bangladesh
9 Belgium
10 Belize
11 Bolivia
12 Brazil
13 Canada
14 Chile
15 China
16 Colombia
17 Costa Rica
18 Cuba
19 Czech Republic
20 Denmark
21 Dominican Republic
22 Ecuador
23 El Salvador
24 Finland
25 France
26 Germany
27 Great Britain
28 Greece
29 Guam
30 Guatemala
31 Haiti
32 Holland
33 Honduras
34 Hungary
35 India
36 Indonesia
37 Iran
38 Iraq
39 Ireland
40 Israel
41 Italy
42 Japan
43 Korea
44 Lebanon
45 Malaya
46 Mexico
47 New Zealand
48 Nicaragua
49 Norway
50 Pakistan
51 Panama
52 Paraguay
53 Peru
54 Philippines
55 Poland
56 Portugal
57 Puerto Rico
58 Russia
59 South Africa
60 Spain
61 Sweden
62 Switzerland
63 United States
64 Uruguay
65 Venezuela
66 Virgin Islands
67 Other
99 Unknown/refused