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HCHS/SOL Follow-up Interview Form Contact Year 2

ID NUMBER:									
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FORM CODE: AFE
VERSION: A 11/03/08

Contact Occasion	0	1
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SEQ #		
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Acrostic: _____

ADMINISTRATIVE INFORMATION

0a. Completion Date:

		/			/				
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0b. Staff ID:

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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, 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. I'm calling to see how you have been since your last telephone interview and to update our HCHS/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 we had a 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.

1. Participant status:

- Contacted and alive 0 Go to item 2 of this form
- Contacted and refused interview 1 Go to *Contact tracking, item 35*
- Not contacted, reported alive 2 Go to *Contact tracking, item 35*
- Not contacted, reported deceased 3 See Death investigation protocol
- Unknown 4 Go to *Contact tracking, item 35*

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4. Since our last telephone interview with you on *(date)*, were you seen in an emergency room but not admitted to the hospital?

- No 0 Go to item 5
 Yes 1
 Unsure 2 Go to item 5

4a. What was the reason of going to the emergency room? *(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
 COPD 6
 Asthma 7
 Other: 8 Specify: _____

4b. What was the date of this visit: / /

4c. What was the name of the emergency room: _____ Facility code:

4d. What was the address of the emergency room: _____ ; Don't know 0

4e. Were you seen in an emergency room on any other occasion since your HCHS/SOL clinic visit?

- No 0 Go to item 5
 Yes 1 Data saved and screen refreshes to 4a.

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 department/room.”

5. Since our last telephone interview with you (*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 2 Go to item 6

5a. Did your doctor or healthcare professional order any of the following tests to help make the diagnosis?

i. Breathing test or pulmonary function test?
 No 0 Yes 1 Unsure 2

ii. Chest X-ray:
 No 0 Yes 1 Unsure 2

iii. CT Scan of your chest:
 No 0 Yes 1 Unsure 2

5b. 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 bronchitis?

- No 0 Go to item 6
- Yes 1
- Unsure 2 Go to item 6

i. 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 2

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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 2 Go to item 7

6a. Did your doctor or healthcare professional order any of the following tests to help make the diagnosis?

i. Breathing test or pulmonary function test?
 No 0 Yes 1 Unsure 2

ii. Chest X-ray:
 No 0 Yes 1 Unsure 2

iii. CT Scan of your chest:
 No 0 Yes 1 Unsure 2

6b. 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

i. 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 2

7. Since your HCHS/SOL clinic 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 2 Go to item 8

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

- No 0 Go to item 8
 Yes 1
 Unsure 2 Go to item 8

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

- Pills 0
 Insulin Alone 1
 Insulin and pills 2
 Referred for eye exam 3
 Advice to change diet 4
 Advice to stop smoking 5
 Advice to increase exercise 6
 Other: 7 Specify: _____

8. Since your HCHS/SOL clinic 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 2 Go to item 9

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

- No 0 Go to item 9
 Yes 1
 Unsure 2 Go to item 9

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

- Start new medicine 0
 Increase dose of existing medicine 1
 Advice to lose weight 2
 Advice to change diet 3
 Advice to stop smoking 4
 Advice to increase exercise 5

Other 6 specify _____

9. Since your HCHS/SOL clinic 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 2 Go to item 10

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

- No 0 Go to item 10
 Yes 1
 Unsure 2 Go to item 10

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

- Start new medicine 0
 Increase dose of existing medicine 1
 Advice to lose weight 2
 Advice to change diet 3
 Advice to stop smoking 4
 Advice to increase exercise 5
 Other 6 specify _____

SELF REPORT OF EVENTS SINCE CLINIC VISIT

“Now I would like to ask you about symptoms you may have had since your HCHS/SOL clinic visit 2 years ago on *(date)*.”

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

- No 0
 Yes 1
 Unsure 2

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

- No 0
 Yes 1
 Unsure 2

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12. Since your HCHS/SOL clinic visit on *(date)*, has a doctor or health professional told you that you had a blood clot in a leg or deep vein thrombosis?

- No 0
Yes 1
Unsure 2

13. Since your HCHS/SOL clinic visit on *(date)*, has a doctor or health professional told you that you had a blood clot in your lungs or a pulmonary embolus?

- No 0
Yes 1
Unsure 2

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

- No 0
Yes 1
Unsure 2

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

- No 0
Yes 1
Unsure 2

16. Since your HCHS/SOL clinic visit on *(date)*, are there times when you have trouble breathing or shortness of breath when walking at ordinary pace on a level surface?

- No 0
Yes 1
Unsure 2

17. Since your HCHS/SOL clinic visit on *(date)*, are there times when you stop for breath when walking at your own pace?

- No 0
Yes 1
Unsure 2

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

- No 0
Yes 1
Unsure 2

19. Since your HCHS/SOL clinic 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 2

20. Since your HCHS/SOL clinic 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 2

21. Since your HCHS/SOL clinic visit on *(date)*, have you had wheezing or whistling in your chest?

- No 0 Go to item 22
 Yes 1
 Unsure 2 Go to item 22

21a. 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 2

22. Which statement best describes your current 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

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

- No 0 Go to item 24
 Yes 1
 Unsure 2 Go to item 24

23a. Did you acquire a hearing aid?

No 0 Go to item 24
 Yes 1

i. How often do you wear it?

Always 0
 Sometimes 1
 Rarely 2
 Never 3

24. 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?

always or almost always 0
 about half the time 1
 sometimes but less than half the time 2
 never 3

25. 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.)?

always or almost always 0
 about half the time 1
 sometimes but less than half the time 2
 never 3

26. Since your HCHS/SOL clinic visit on (date), have you had buzzing, ringing, or noise in your ears?

No 0 Go to item 27
 Yes 1
 Unsure 2 Go to item 27

26a. Does this noise usually last longer than 5 minutes?

No 0 Yes 1 Unsure 2

26b. Do you hear this noise only following very loud sounds? For example, concerts shooting, or loud noise at work.

No 0 Yes 1 Unsure 2

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

- No 0 Go to item 28
- Yes 1
- Unsure 2 Go to item 28

27a. 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?

28. Do you snore?

- Never 1 Go to item 29
- 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 Go to item 29

28a. How often do you snore?

- Rarely 0
- Sometimes 1
- Most nights 2

MEDICATIONS

“Now I would like to ask about the prescription medications you currently use. Can I ask you to bring all the prescription medications you are taking to the telephone?”

29. (do not ask) Does the participant have medications to report?

- No 0 Skip to item 31
- Yes 1
- Participant refused 2 Skip to item 31

30. Please read the names of all the medications prescribed by a doctor. This includes pills, liquid medications, skin patches, inhalers, and injections. Please do not include over the counter medications unless prescribed by a doctor. (If asked, currently taking applies to medications taken in the past two weeks.)

- a. _____
- b. _____
- c. _____
- d. _____

“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.”

31. 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 Skip to item 32
- Yes 1
- Unsure 2 Skip to item 32

31a. What dose do you take?

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

OTHER ITEMS

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

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

- Never smoker 0 (Skip to item 34)
- 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

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

- No 0 Skip to item 34
- Yes 1
- Unsure 2 Skip to item 34

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33a. On average, about how many cigarettes a day do you smoke?

<input type="text"/>	<input type="text"/>
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34. Please tell me which of the following best describes your marital status?

Married	0	<input type="text"/>
Widowed	1	<input type="text"/>
Divorced	2	<input type="text"/>
Separated	3	<input type="text"/>
Single	4	<input type="text"/>
Living with partner	5	<input type="text"/>

Thank you so much for answering these questions. We greatly appreciate your participation in the HCHS/SOL study. Should you have any questions, please feel free to call us at the clinic at (*telephone number*). Before we hang up, I'd just like to make sure our records are up to date. Could you please tell me if the following information I have is still correct?

PARTICIPANT TRACKING

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

a. Participant Tracking:	Changes:
<i>Current data to be shown here</i>	<i>Record changes here</i>

b. Contacts/proxies:	Changes:
<i>Current data to be shown here</i>	<i>Record changes here</i>

c. Health care providers:	Changes:
<i>Current data to be shown here</i>	<i>Record changes here</i>