

Public reporting burden for this collection of information is estimated to average 45 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 (0925-0216). Do not return the completed form to this address.

Numerical Data (Anthropometry)

_	Check here if whole page is blank.	Reason why _____
---	------------------------------------	------------------

_ _ _	Technician Number.
-------	---------------------------

Basic Information		
<i>Check Protocol Modification ONLY if there was one and document it in Comment section</i>		
_	Marital Status (1=Single, 2=Married, 3=Widowed, 4=Divorced, 5=Separated)	
_	Site of Exam (0=Heart Study, 1=Nursing home, 2=Residence, 3=Other, 9=Unk.)	
_ _ _	Weight (to nearest pound, 999=Unk.)	
	_	Protocol modification for weight (check if Yes)
if not FHS protocol fill	_	Method used to obtain weight, if not FHS protocol or field visit with portable scale (1=recorded in NH chart, 2=Other write in _____)
	_ _ * _ _ * _ _ _ _	Date weight obtained (99/99/9999=Unk.) <i>if not Exam date</i>
_ _ * _ _	Height (inches, to next lower 1/4 inch, 99/99=Unk.)	88/88=field visit
	_	Protocol modification for height. (check if Yes)

Comments on all protocol modifications: <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/> <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/> <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/> <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/>

TECH01

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

EXAM 32 Procedures Sheet		
<input type="checkbox"/>	ECG	
<input type="checkbox"/>	Physician Medical History (Tech. Medical History, off-site)	
<input type="checkbox"/>	Observed Physical Performance	0=No
<input type="checkbox"/>	CES-D, 10-item	
<input type="checkbox"/>	MMSE	1=Yes
<input type="checkbox"/>	Physical function: Katz, Rosow-Breslau, Nagi, IADL	
<input type="checkbox"/>	Leisure Time Cognitive and Physical Activities	9=Unk.
<input type="checkbox"/>	Height	8=not done due to offsite visit
<input type="checkbox"/>	Weight	
<input type="checkbox"/>	Socio-demographic, Nursing (Community) Services Use	

Adverse Events	
<input type="checkbox"/>	Technician ID#
<input type="checkbox"/>	Was there an adverse event in clinic/offsite exam that does not require further medical evaluation? (0=No, 1=Yes, 9=Unk.) Comments: _____
<input type="checkbox"/>	Was a FHS physician contacted during the offsite examination due to medical concern? (0=No, 1=Yes, 9=Unk.) (offsite exam only) Comments: _____

Exit Interview	
<input type="checkbox"/>	Technician ID
<input type="checkbox"/>	Procedure Sheet Review
<input type="checkbox"/>	Referral Sheet Review
<input type="checkbox"/>	Left Clinic with all belongings 8=n/a, offsite
<input type="checkbox"/>	Feedback 0=No feedback, 1=Positive feedback, 2=Negative feedback, 3=Other
	Comments _____

Your exam today was for research purposes only and is not designed to make a medical diagnosis. The exam cannot identify all serious heart and health issues. It is important that you continue regular follow-up with your physician or health care provider.

TECH02

Observed performance. Part 1 Technician Administered

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

HAND GRIP TEST <i>Measured to the nearest kilogram</i>		
Right hand		
Trial 1	99=Unk.	_ _
Trial 2	99=Unk.	_ _
Trial 3	99=Unk.	_ _
Left hand		
Trial 1	99=Unk.	_ _
Trial 2	99=Unk.	_ _
Trial 3	99=Unk.	_ _
<input type="checkbox"/> Check if this test not completed or not attempted.		
If not attempted or completed, why not? <input type="checkbox"/> 1=Physical limitation, 2=Refused, 3=Other _____ write in, 9=Unk.		

PHYSICAL FUNCTION TEST 10 seconds stand		
Side by Side		
Was this test completed? Held for 10 seconds (0=No, 1=Yes, 8=N/A, 9=Unk.)		_
Number of seconds held if less than 10	99.99=Unk.	_ _ * _ _
If not attempted or completed, why not?		
1=Physical limitation	3=Other _____ write in	_
2=Refused	9=Unk.	
Semi-Tandem		
Was this test completed? Held for 10 seconds (0=No, 1=Yes, 8=N/A, 9=Unk.)		_
Number of seconds held if less than 10	99.99=Unk.	_ _ * _ _
If not attempted or completed, why not?		
1=Physical limitation	3=Other _____ write in	_
2=Refused	9=Unk.	
Tandem		
Was this test completed? Held for 10 seconds (0=No, 1=Yes, 8=N/A, 9=Unk.)		_
Number of seconds held if less than 10	99.99=Unk.	_ _ * _ _
If not attempted or completed, why not?		
1=Physical limitation	3=Other _____ write in	_
2=Refused	9=Unk.	

TECH03

Observed performance. Part 2 Technician Administered

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

<input style="width: 100%;" type="text"/>	Technician Number
---	--------------------------

Repeated Chair Stands	
Time to complete five stands in seconds (99.99=Unk.)	<input style="width: 40px;" type="text"/> * <input style="width: 40px;" type="text"/>
If less than five stands, enter the number (9=Unk.)	<input style="width: 40px;" type="text"/>
IF OFFSITE visit, Chair height (in inches, 99*99=Unk.)	<input style="width: 40px;" type="text"/> * <input style="width: 40px;" type="text"/>
<input type="checkbox"/> Check if this test not completed or not attempted.	
<input type="checkbox"/> If not attempted or completed, why not? 1=Physical limitation, 2=Refused, 3=Other _____ write in, 9=Unk.	

Measured Walks	
Course in meters. <i>OFFSITE ONLY</i> (check one)	<input type="checkbox"/> 3m <input type="checkbox"/> 4m
Walking aid used: (0=No aid, 1=Cane, 2=Walker, 3=Other, 9=Unk.)	<input style="width: 40px;" type="text"/>
First Walk	
Walk time (in seconds, 99.99=Unk.)	<input style="width: 40px;" type="text"/> * <input style="width: 40px;" type="text"/>
<input type="checkbox"/> Check if this test not completed or not attempted.	
<input type="checkbox"/> If not attempted or completed, why not? (1=Physical limitation, 2=Refused, 3=Other _____ write in, 9=Unk.)	
Second Walk	
Walk time (in seconds, 99.99=Unk.)	<input style="width: 40px;" type="text"/> * <input style="width: 40px;" type="text"/>
<input type="checkbox"/> Check if this test not completed or not attempted.	
<input type="checkbox"/> If not attempted or completed, why not? (1=Physical limitation, 2=Refused, 3=Other _____ write in, 9=Unk.)	
Quick Walk	
Walk time (in seconds, 99.99=Unk.)	<input style="width: 40px;" type="text"/> * <input style="width: 40px;" type="text"/>
<input type="checkbox"/> Check if this test not completed or not attempted.	
<input type="checkbox"/> If not attempted or completed, why not? (1=Physical limitation, 2=Refused, 3=Other _____ write in, 9=Unk.)	

TECH04

Mini-Mental State Exam

_ _ Check here if whole page is blank.	Reason why _____
---	------------------

Read Script: I'm going to ask some questions that require concentration and memory. Some questions are more difficult than others and some will be asked more than one time.

_ _ _	Technician Number
-------	--------------------------

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

TECH05

Mini-Mental State Exam

_	Check here if whole page is blank.	Reason why _____
---	------------------------------------	------------------

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

0=No, 1=Yes, 2=Maybe, 9=Unk	Factor Potentially Affecting Mental State Testing
0 1 2 9	Illiterate or low education
0 1 2 9	Poor eyesight
0 1 2 9	Poor hearing
0 1 2 9	Depression / possible depression
0 1 2 9	Other

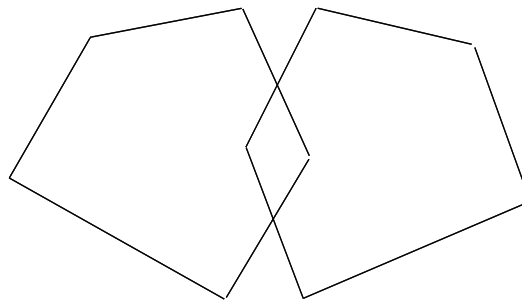
TECH06

Mini-Mental State Exam

Sentence and Design Handout for Participant

PLEASE WRITE A SENTENCE

PLEASE COPY THIS DESIGN



Socio-demographics

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

<input type="text"/>	Technician Number for Socio-demographics
----------------------	---

Socio-demographics	
<input type="checkbox"/>	Where do you live? (0=Private residence, 1=Nursing home, 2=Other institution, such as: assisted living or retirement community, 9=Unk.)
<input type="checkbox"/>	Does anyone live with you? (0=No, 1=Yes, 9=Unk.) Code Nursing Home Residents as NO to these questions
If Yes ☞ If 0 or 9, skip down	<input type="checkbox"/> Spouse 0=No
	<input type="checkbox"/> Children 1=Yes
	<input type="checkbox"/> Other Relatives 9=Unk.
<input type="checkbox"/>	Are you Currently doing volunteer or community work? (0=No, 1=Yes.)
<input type="checkbox"/>	Do you have health insurance other than Medicare or Medicaid? (0=No, 1=Yes, 9=Unk.)

** Proxy may NOT be used to help complete this section **	
<input type="checkbox"/>	In general, how is your health now: (1=Excellent, 2=Good, 3=Fair, 4=Poor, 9=Unk)
<input type="checkbox"/>	Compare your health to most people your own age: (1=Better, 2=About the same, 3=Worse than most people your own age, 9=Unk.)
<input type="checkbox"/>	As I get older, things are: (1= Better than I thought they'd be, 2=About the same that I thought they'd be, 3= Worse, 9=Unk.)

TECH07

Instrumental Activities of Daily Living (Lawton IADL)*(Not administered to nursing home residents)*

_ _	Check here if whole page is blank.	Reason why _____
-----	------------------------------------	------------------

Instructions: Use the prompt cards when asking these questions .If code=2 -write in definition of "some help"

_ _	1. Can you use the phone:
	01 completely unable to use the phone
	02 with some help
	03 without help (operates phone on own initiative, looks up, dials number, etc.)
_ _	2. Can you get to places out of walking distance:
	01 completely unable to travel unless special arrangements are made (taxi or car with human assistance)
	02 with some help (when assisted or accompanied by another)
	03 without help (travels independently: drives car, public transportation or use of taxi)
_ _	3. Can you go shopping for groceries :
	01 completely unable to do any shopping
	02 with some help (needs to be accompanied on any shopping trip)
	03 without help
	88 resides in assisted living facility, does not do
_ _	4. Can you prepare your own meals:
	01 completely unable to prepare meals (needs meals prepared and served)
	02 with some help (heat and serve prepared meals)
	03 without help (plans, prepares, serves meals)
	88 resides in assisted living facility, does not do
_ _	5. Can you do your own housework :
	01 completely unable to do any housework
	02 with some help
	03 without help (performs light daily tasks – dishwashing, bed making, etc).
	88 resides in assisted living facility, does not do
_ _	6. Can you do your own handyman work:
	01 completely unable to do any handyman work
	02 with some help
	03 without help
	88 resides in assisted living facility, does not do
_ _	7. Can you do your own laundry:
	01 completely unable to use the laundry
	02 with some help (such as using laundry service)
	03 without help (does personal laundry completely)
	88 resides in assisted living facility, does not do
_ _	8. A. Do you take medicines or use any medications:
	01 Yes Go to question 8B
	02 No Go to question 8C
_ _	8. B. Do you take your own medicines:
	01 completely unable to take own medicine
	02 with some help (if someone prepares it or reminds you)
	03 without help (in the right doses at the right time)
_ _	8. C. If you had to take medicine, could you do it:
	01 completely unable to take own medicine
	02 with some help (if someone prepares it or reminds you)
	03 without help (in the right doses at the right time)
_ _	9. Can you manage your own money:
	01 completely unable to manage own money
	02 with some help (manages day-to-day purchases, needs help with banking, major purchases)
	03 without help

TECH08

Self-Reported Physical Function.

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

Note: If the participant is unable to answer the Nagi & Rosow-Breslau questions, Proxy may answer these questions.

<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Technician Number for Rosow-Breslau and Nagi Quest.
---	--

Nagi Questions

For each thing tell me whether you have

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

<input type="checkbox"/>	Pulling or pushing large objects like a living room chair
<input type="checkbox"/>	Either stooping, crouching, or kneeling
<input type="checkbox"/>	Reaching or extending arms below shoulder level
<input type="checkbox"/>	Reaching or extending arms above shoulder level
<input type="checkbox"/>	Either writing, or handling or fingering small objects
<input type="checkbox"/>	Standing in one place for long periods, say 15 minutes
<input type="checkbox"/>	Sitting for long periods, say 1 hour
<input type="checkbox"/>	Lifting or carrying weights under 10 pounds (like a bag of potatoes)
<input type="checkbox"/>	Lifting or carrying weights over 10 pounds (like a very heavy bag of groceries)

Rosow-Breslau Questions

<input type="checkbox"/>	Are you able to do heavy work around the house, like shoveling snow or washing windows, walls, or floors without help?	0=No, unable to do
<input type="checkbox"/>	Are you able to walk half a mile without help? (About 4-6 blocks)	1=Yes, able
if NO then ☞	<input type="checkbox"/> Are you able to walk a quarter of a mile without help? (About 2-3 blocks)	2=Does not do
<input type="checkbox"/>	Are you able to walk up and down stairs to the second floor without any help?	9=Unk.
if NO then ☞	<input type="checkbox"/> Are you able to climb up 10 steps without help?	
<input type="checkbox"/>	Do you drive now? (0=No, 1=Yes, 9=Unk)	
if NO then ☞	<input type="checkbox"/> Reason for <u>not</u> driving now (1=Health, 2=Other non-health reason, 3=never licensed, 9=Unk.)	

TECH09

Self-Reported Physical Function.

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

<input type="text"/>	Technician Number for Physical Function
----------------------	--

Katz: Activities of Daily Living

During the Course of a Normal Day, can you do the following activities independently or do you need help from another person or use special equipment or a device?.

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

- | | |
|--------------------------|--|
| <input type="checkbox"/> | Dressing (undressing and redressing) <i>Devices such as: velcro, elastic laces.</i> |
| <input type="checkbox"/> | Bathing (including getting in and out of tub or shower) <i>Devices such as: bath chair, long handled sponge, hand held shower, safety bars.</i> |
| <input type="checkbox"/> | Eating <i>Devices such as: rocking knife, spork, long straw, plate guard.</i> |
| <input type="checkbox"/> | Transferring (getting in and out of a chair) <i>Devices such as: sliding board, grab bars, special seat.</i> |
| <input type="checkbox"/> | Toileting Activities (using bathroom facilities and handle clothing) <i>Devices such as: special toilet seat, commode.</i> |
| <input type="checkbox"/> | Bladder Continence (ask if person has "accidents"; code=5 if use special products) <i>Devices such as: external catheter, drainage bags, ileal appliance, protective devices.</i> |
| <input type="checkbox"/> | Bowel Continence (ask if person has "accidents") (code=5 if use special products) <i>Devices such as: suppositories, bedpan, regular enemas, colostomy.</i> |
| <input type="checkbox"/> | Walking on Level Surface about 50 Yards <i>Devices such as: cane, crutches, or walker.</i> |
| <input type="checkbox"/> | Walking up and down One Flight Stairs <i>Devices such as: handrail, cane.</i> |

TECH10

Activities Questions.

Check here if whole page is blank. Reason why _____

Technician Number for Activities Questions

Use of Nursing and Community Services

<input type="checkbox"/>	Have you been admitted to a nursing home (or skilled facility) since your last exam or medical history update? (0=No, 1=Yes, 9=Unk.)
<input type="checkbox"/>	Since your last exam, have you been visited by a nursing service, or used home, community, or outpatient programs? (0=No, 1=Yes, 9=Unk.)
if yes, check all services	<input type="checkbox"/> Home health aides
	<input type="checkbox"/> Homemaker visits
	<input type="checkbox"/> Visiting Nurses
	<input type="checkbox"/> Other (write in) _____

<input type="checkbox"/>	Are you in bed or a chair for most or all of the day (on the average)? (0=No, 1=Yes, 9=Unk.)
<input type="checkbox"/>	Do you need a special aid (wheelchair, cane, walker) to get around? (0=No, 1=Yes, 9=Unk.)
if yes then	If yes, which of the following equipment do you use?
	<input type="checkbox"/> Cane or walking stick
	<input type="checkbox"/> Wheelchair
	<input type="checkbox"/> Walker
	<input type="checkbox"/> Other (Write in) _____

0=No
 1=Yes, always
 2=Yes, sometimes
 9=Unk.

TECH11

Falls and Fractures

_	Check here if whole page is blank.	Reason why _____
---	------------------------------------	------------------

_ _ _	Technician Number for Falls and Fractures
-------	--

_	Since your last exam have you accidentally fallen and hit the floor or ground? <i>(code as no if during sports activity) (0=No, 1=Yes, 2=Maybe, 9=Unk)</i>		
if yes, fill ☞	<table style="width: 100%;"> <tr> <td style="width: 20%; text-align: center;"> _ _ </td> <td>How many times did you fall in the past year? (99=Unk.)</td> </tr> </table>	_ _	How many times did you fall in the past year? (99=Unk.)
_ _	How many times did you fall in the past year? (99=Unk.)		

_	Since your last exam or medical history update have you broken any bones? <i>(0=No, 1=Yes, 2=Maybe, 9=Unk.)</i>						
If 1 or 2, fill ☞	<table style="width: 100%;"> <tr> <td style="width: 20%; text-align: center;"> _ _ </td> <td>Location of 1st fracture</td> </tr> <tr> <td style="width: 20%; text-align: center;"> _ _ </td> <td>Location of 2nd fracture</td> </tr> <tr> <td style="width: 20%; text-align: center;"> _ _ </td> <td>Location of 3rd fracture</td> </tr> </table>	_ _	Location of 1st fracture	_ _	Location of 2nd fracture	_ _	Location of 3rd fracture
_ _	Location of 1st fracture						
_ _	Location of 2nd fracture						
_ _	Location of 3rd fracture						

- | Location Fracture Code |
|--|
| 1. Clavicle (collar bone) |
| 2. Upper arm (humerus) or elbow |
| 3. Forearm or wrist |
| 4. Hand |
| 5. Back (If disc disease only, code as no) |
| 6. Pelvis |
| 7. Hip |
| 8. Leg |
| 9. Foot |
| 10. Other (specify) _____ |

TECH12

Leisure Time Cognitive and Physical Activities
 Check here if whole page is blank. Reason why _____

 Technician Number for Leisure time activities.

During the past year, how often have you participated in the following leisure time activities?

<i>Questions to be answered</i> <i>Circle best answer for each question</i>	Never	Daily (7 days per week)	Several days per week (2-6 days per week)	Once weekly (1 day per week)	Monthly (once a month)	Occasionally (< once a month)	Unk.
1. Reading books/newspapers	0	1	2	3	4	5	9
2. Writing for pleasure	0	1	2	3	4	5	9
3. Doing crossword puzzles	0	1	2	3	4	5	9
4. Playing board games or cards	0	1	2	3	4	5	9
5. Participating in organized group discussions	0	1	2	3	4	5	9
6. Group exercises	0	1	2	3	4	5	9
7. Housework	0	1	2	3	4	5	9
8. Playing musical instruments	0	1	2	3	4	5	9

TECH13

CES-D Scale
 Check here if whole page is blank. Reason why _____

 Technician Number for CES-D Scale

The next questions ask about your feelings. For each of the following statements, please say if you felt that way during the past week.

DURING THE PAST WEEK	Circle best answer for each question			
	<u>Rarely</u> or none of the time (less than 1 day)	<u>Some</u> or a little of the time (1-2 days)	<u>Occasionally</u> or moderate amount of time (3-4 days)	<u>Most</u> or all of the time (5-7 days)
I was bothered by things that usually don't bother me.	0	1	2	3
I had trouble keeping my mind on what I was doing.	0	1	2	3
I felt that everything I did was an effort.	0	1	2	3
I felt depressed.	0	1	2	3
I felt hopeful about the future.	0	1	2	3
I felt fearful.	0	1	2	3
My sleep was restless.	0	1	2	3
I was happy.	0	1	2	3
I felt lonely.	0	1	2	3
I could not "get going"	0	1	2	3

TECH14

Proxy form

	<input type="checkbox"/> Proxy used to complete this exam (0=No, 1=Yes, 1 proxy, 2=Yes, more than 1 proxy, 9=Unk)
if yes, fill	<input type="checkbox"/> Proxy Name _____ <input type="checkbox"/> Relationship (1=1 st Degree Relative(spouse, child), 2=Other Relative, 3=Friend, 4=Health Care Professional, 5=Other, 9=Unk.)
	<input type="checkbox"/> How long have you known the participant? (Years, months; 99.99=Unk) example: 3m=00*03
	<input type="checkbox"/> Are you currently living in the same household with the participant? (0=No, 1=Yes, 9=Unk)
	<input type="checkbox"/> How often did you talk with the participant during the prior 11 months? (1=Almost every day, 2=Several times a week, 3=Once a week, 4=1 to 3 times per month, 5=Less than once a month, 9=Unk.)
	<input type="checkbox"/> Proxy Name _____ <input type="checkbox"/> Relationship (1=1 st Degree Relative(spouse, child), 2=Other Relative, 3=Friend, 4=Health Care Professional, 5=Other, 9=Unk.)
	<input type="checkbox"/> How long have you known the participant? (Years, months; 99.99=Unk) example: 3 m=00*03
	<input type="checkbox"/> Are you currently living in the same household with the participant? (0=No, 1=Yes, 9=Unk)
	<input type="checkbox"/> How often did you talk with the participant during the prior 11 months? (1=Almost every day, 2=Several times a week, 3=Once a week, 4=1 to 3 times per month, 5=Less than once a month, 9=Unk.)

TECH15

Date of exam

____/____/____

**Framingham Heart Study
 Cohort Exam 32**

Summary Sheet to Personal Physician

Blood Pressure	First Reading	Second Reading
Systolic		
Diastolic		

ECG Diagnosis _____

Summary of Findings _____

 Examining Physician

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

Referral Tracking

Check here if whole page is blank. Reason why _____

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

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

<input type="checkbox"/> Blood Pressure result ____/____ mmHg ____/____ mmHg	SBP or DBP Phone call ≥ 200 or ≥110 Expedite ≥ 180 or ≥100 Elevated ≥ 140 or ≥90
---	---

Write in abnormality

ECG abnormality _____

Clinic Physician identified medical problem _____

Other _____

Method used to inform participant of need for further medical evaluation
 (Check ALL that apply)

Face-to-face in clinic

Phone call

Result letter

Other

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

Phone call

Result letter mailed

Result letter FAX'd (inform staff if Fax needed)

Other

Date referral made: ____/____/____

ID number of person completing the referral: _____

Notes documenting conversation with participant or participant's personal physician: _____

REF1

Medical History—Hospitalizations, ER Visits, MD Visits

Cohort Exam32

DATE _____

DATE of last exam «Lastexamdate»

DATE of last health update «Evdate»

Health Care	
Since your last exam or health update	
_ _ _	1st Examiner ID _____ 1st Examiner Name
_	Hospitalizations (<i>not just E.R.</i>) (0=No; 1=yes, hospitalization, 2=yes, more than 1 hospitalization, 9=Unk.)
_	E.R. Visits (0=No; 1=Yes, 1 visit, 2=Yes, more than 1 visit, 9=Unk.)
_	Day Surgery (0=No, 1=Yes, 9=Unk.)
_	Major illness with visit to doctor (0=No, 1=Yes, 1 visit; 2=Yes, more than 1 visit; 9=Unk)
_	Check up by doctor or other health care provider? (0=No, 1=Yes, 9=Unk.)
_ _ _ _ _ _ _ _	Date of this FHS exam (<i>Today's date - See above</i>)
MM DD YYYY	


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

MD01

Medical History—Medications

Since your last exam	
(0=No, 1=Yes, now, 2=Yes, not now, 9=Unk.)	
<input type="checkbox"/>	Have you taken medication for the treatment of hypertension? (high blood pressure)
<input type="checkbox"/>	Have you taken medication for the treatment of high blood cholesterol or high triglycerides?
<input type="checkbox"/>	Have you taken medication for the treatment of high blood sugar or diabetes?

Aspirin use

<input type="checkbox"/>	Take aspirin regularly? (0=No, 1=Yes, 9=Unk)	
If yes, fill 	<input type="text"/>	Number of aspirins taken regularly (99=Unk.)
	<input type="text"/>	Aspirin frequency- number taken regularly (0=Never, 1=Day, 2=Week, 3=Month, 4=Year, 9=Unk)
	<input type="text"/>	Usual dose (write in mgs, 999=Unk.)
	<p><u>Examples:</u> 081=baby, 160=half dose, 250=like in Excedrin , 325=usual dose, 500=extra strength</p>	

MD02

Medical History – Prescription and Non-Prescription Medications

Copy the name of medicine, the strength including units, and the total number of doses per day/week/month/year. Include vitamins and minerals.

Medication bag with medications brought to exam or med bottles/packs used by examiner to complete form? (0=No 1=Yes) ****List medications taken regularly in past month/ongoing medications****
Code ASPIRIN ONLY on screen MD02.

Medication Name (Print first 20 letters)	Strength (include mg, IU, etc)	Route 1= oral, 2=topical, 3=injection, 4=inhaled, 5=drops,6=nasal 88=other	Number per (circle one)		PRN 0=no, 1=yes, 9=Unk.	Check if OTC med
			#	day/week/month/year 1 / 2 / 3 / 4		
EXAMPLE: S A M P L E D R U G N A M E	100 mg	1	1	D W M Y	0	<input type="checkbox"/>
				D W M Y		<input type="checkbox"/>
				D W M Y		<input type="checkbox"/>
				D W M Y		<input type="checkbox"/>
				D W M Y		<input type="checkbox"/>
				D W M Y		<input type="checkbox"/>
				D W M Y		<input type="checkbox"/>
				D W M Y		<input type="checkbox"/>
				D W M Y		<input type="checkbox"/>
				D W M Y		<input type="checkbox"/>

Continue on the next page →

MD03

Medical History – Prescription and Non-Prescription Medications

Medication Name (Print first 20 letters)	Strength (include mg, IU, etc)	Route 1= oral, 2=topical, 3=injection, 4=inhaled, 5=drops,6=nasal 88=other	Number per (circle one)		PRN 0=no, 1=yes, 9-Unk	Check if OTC med.
			#	day/week/month/year 1 / 2 / 3 / 4		
EXAMPLE: S A M P L E	100 mg	1	1	D W M Y	0	<input type="checkbox"/>
				D W M Y		<input type="checkbox"/>
				D W M Y		<input type="checkbox"/>
				D W M Y		<input type="checkbox"/>
				D W M Y		<input type="checkbox"/>
				D W M Y		<input type="checkbox"/>
				D W M Y		<input type="checkbox"/>
				D W M Y		<input type="checkbox"/>
				D W M Y		<input type="checkbox"/>
				D W M Y		<input type="checkbox"/>
				D W M Y		<input type="checkbox"/>
				D W M Y		<input type="checkbox"/>
				D W M Y		<input type="checkbox"/>
				D W M Y		<input type="checkbox"/>

MD04

Medical History—Blood Pressure, Smoking

Blood Pressure	
(first reading)	
Systolic	BP cuff size
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> to nearest 2 mm Hg 999=Unk.	<input type="text"/> <input type="text"/> 0=pediatric, 1=regular adult, 2=large adult, 3= thigh, 9=Unk.
Diastolic	Protocol modification
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> to nearest 2 mm Hg 999=Unk.	<input type="text"/> <input type="text"/> 0=No, 1=Yes, 9=Unk. write in _____

Smoking	
<input type="text"/>	<p style="text-align: center;">Have you smoked cigarettes regularly since your last exam?</p>
if yes fill ☞	<div style="float: right; text-align: right; font-size: small;"> 0=No, 1=Yes, now, 2=Yes, not now, 9=Unk. </div> <div style="clear: both;"></div> <p style="text-align: center;"> <input type="text"/> <input type="text"/> </p> <p style="text-align: center;">How many cigarettes do/did you smoke a day? (01=one or less, 99=Unk.)</p>

MD05


Medical History –Alcohol Consumption.

Now I will ask you questions regarding your alcohol use.

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

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

MD06

Medical History—Respiratory Symptoms. Part 1**Cough** (0=No, 1=Yes, 9=Unk.) **Do you usually have a cough?** (*Exclude clearing of the throat*) **Do you usually have a cough at all on getting up or first thing in the morning?**If **YES** to **either** question above **answer** the following: **Do you cough like this on most days for three consecutive months or more during the past year?** **How many years have you had this cough? (# of years.)** 1=1 year or less
99=Unk**Phlegm** (0=No, 1=Yes, 9=Unk.) **Do you usually bring up phlegm from your chest?** **Do you usually bring up phlegm at all on getting up or first thing in the morning?**If **YES** to **either** question above **answer** the following: **Do you bring up phlegm from your chest on most days for three consecutive months or more during the year?** **How many years have you had trouble with phlegm? (# of years)** 1=1 year or less
99=Unk**Wheeze** (0=No, 1=Yes, 9=Unk.)**In the past 12 months...** **Have you had wheezing or whistling in your chest at any time?**if yes,
fill
all  **How often have you had this wheezing or whistling?**
0=Not at all 1=MOST days or nights 2=A few days or nights a WEEK
3=A few days or nights a MONTH 4=A few days or nights a YEAR 9=Unk. **Have you had this wheezing or whistling in the chest when you had a cold?** **Have you had this wheezing or whistling in the chest apart from colds?** **Have you had an attack of wheezing or whistling in the chest that had made you feel short of breath?**

MD07

Medical History—Respiratory Symptoms. Part 2

Nocturnal chest symptoms (0=No, 1=Yes, 9=Unk.)	
In the past 12 months...	
<input type="checkbox"/>	Have you been awakened by shortness of breath?
<input type="checkbox"/>	Have you been awakened by a wheezing/whistling in your chest?
<input type="checkbox"/>	Have you been awakened by coughing?
if yes, fill all	How often have you been awakened by coughing? 0=Not at all 1=MOST days or nights 2=A few days or nights a WEEK 3=A few days or nights a MONTH 4=A few days or nights a YEAR 9=Unk.

Shortness of breath (0=No, 1=Yes, 9=Unk.)	
<input type="checkbox"/>	Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill?
if yes, fill all	<input type="checkbox"/> Do you have to walk slower than people of your age on level ground because of shortness of breath? <input type="checkbox"/> Do you have to stop for breath when walking at your own pace on level ground? <input type="checkbox"/> Do you have to stop for breath after walking 100 yards (or after a few minutes) on level ground?
<input type="checkbox"/>	Do you/have you needed to sleep on two or more pillows to help you breathe (Orthopnea)?
<input type="checkbox"/>	Have you since last exam had swelling in both your ankles (ankle edema)?
<input type="checkbox"/>	Have you been told by your doctor you had heart failure or congestive heart failure?
if yes, fill	Name of doctor _____ Date of visit __ _ * __ _ * __ _ _ _ 99/99/9999=Unk.
<input type="checkbox"/>	Have you been hospitalized for heart failure?
if yes, fill	Name of hospital _____ Date of visit __ _ * __ _ * __ _ _ _ 99/99/9999=Unk.

Examiner Opinion		
<input type="checkbox"/>	First examiner believes CHF	0=No, 1=Yes 2=Maybe, 9=Unk.

Comments _____

Medical History—Heart

<input type="checkbox"/>	Any chest discomfort since last exam or medical history update? (0=No, 1=Yes, 2=Maybe, 9=Unk.) <i>(please provide narrative comments in addition to checking the appropriate boxes)</i>	
if yes, fill and below	<input type="checkbox"/>	Chest discomfort with exertion or excitement (0=No, 1=Yes, 2=Maybe, 9=Unk.)
	<input type="checkbox"/>	Chest discomfort when quiet or resting (0=No, 1=Yes, 2=Maybe, 9=Unk.)
Chest Discomfort Characteristics <i>(must have checked box at top of table)</i>		
	<input type="checkbox"/> * <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date of onset mo/yr, 99/9999=Unk.
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Usual duration (min) 1=1 min or less, 900=15 hrs or more, 999=Unk.
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Longest duration (min) 1=1 min or less, 900=15 hrs or more, 999=Unk.
	<input type="checkbox"/>	Location 0=No, 1=Central sternum and upper chest, 2=L up per Quadrant, 3=L lower ribcage, 4=R chest, 5=Other, 6=Combination, 9=Unk.
	<input type="checkbox"/>	Radiation 0=No, 1=Left shoulder or L arm, 2=Neck, 3=R shoulder or arm, 4=Back, 5=Abdomen, 6=Other, 7=Combination, 9=Unk.
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Frequency (number in past month) 999=Unk.
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Frequency (number in past year) 999=Unk.
	<input type="checkbox"/>	Type 1=Pressure, heavy, vise, 2=Sharp, 3=Dull, 4=Other, 9=Unk
	<input type="checkbox"/>	Relief by Nitroglycerine in <15 minutes
	<input type="checkbox"/>	Relief by Rest in <15 minutes
	<input type="checkbox"/>	Relief Spontaneously in <15 minutes
	<input type="checkbox"/>	Relief by Other cause in <15 minutes

MD09

Medical History—Heart (Continued)

<input type="checkbox"/>	Have you since your last exam been told by doctor you have/had a heart attack or myocardial infarction? (0=No, 1=Yes, 2=Maybe, 9=Unknown)
if yes, fill	Name of doctor _____
	Date of visit __ _ * __ _ * __ _ _ _ 99*99*9999=Unk.
<input type="checkbox"/>	Have you been hospitalized for heart attack?
if yes, fill	Name of hospital _____
	Date of visit __ _ * __ _ * __ _ _ _ 99*99*9999=Unk.

CHD First Opinions	
<input type="checkbox"/>	Angina pectoris in interim
<input type="checkbox"/>	Angina pectoris since revascularization procedure
<input type="checkbox"/>	Coronary insufficiency in interim
<input type="checkbox"/>	Myocardial infarct in interim

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

Comments _____

Medical History—Atrial Fibrillation/Syncope

<input type="checkbox"/>	Have you been told you have/had a heart rhythm problem called atrial fibrillation? (0=No, 1=Yes, 2=Maybe, 9=Unk.)
if yes, fill	<input type="text"/> * <input type="text"/> * <input type="text"/> <input type="text"/> <input type="text"/> Date of first episode (99/99/9999=Unk.)
	<input type="checkbox"/> ER/hospitalized or saw M.D. (0=No, 1=Hosp/ER, 2=Saw M.D., 9=Unk.)
	Hospitalized at: _____
	M.D. seen: _____

<input type="checkbox"/>	Have you fainted or lost consciousness since your last exam? <i>(If due to stroke skip to screen 11)</i> If event immediately preceded by head injury, or accident code 0=No	Code: 0=No, 1=Yes, 2=Maybe, 9=Unk.
if yes, fill all	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Number of episodes in the past two years	(999=Unk.)
	<input type="text"/> * <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Date of first episode	(mo/yr, 99/9999=Unk.)
	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Usual duration of loss of consciousness	(minutes, 999=Unk.)
<input type="checkbox"/>	Did you have any injury caused by the event? (0=No, 1=Yes, 2=Maybe, 9=Unk.)	
if yes, fill	<input type="checkbox"/> ER/hospitalized or saw M.D. (0=No, 1=ER/Hosp., 2=Saw M.D., 9=Unk.)	
	Hospitalized at: _____	
	M.D. seen: _____	

Syncope First Opinions		
<input type="checkbox"/>	Syncope (0=No, 1=Yes, 2=Maybe, 3=Presyncope, 9=Unk.)	
<input type="checkbox"/>	Cardiac syncope	0=No, 1=Yes,
<input type="checkbox"/>	Vasovagal syncope	2=Maybe,
<input type="checkbox"/>	Other-Specify: _____	9=Unk.
<input type="checkbox"/>	Seizure Disorder (0=No, 1=Yes, 2=Maybe., 9=Unk.)	

Comments _____

Medical History—Cerebrovascular Disease

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

Comments: _____

Medical History—Cerebrovascular Disease Continued

Details for "Serious" Cerebrovascular Event in Interim

Examiner's opinion that TIA or stroke took place in interim

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

**if yes or
 maybe
 fill all** ☞

*

Date (mo/yr, 99/9999=Unk.)

Observed by _____

**

Duration (use format days/hours/mins, 99/99/99=Unk.)

Hospitalized or saw M.D. (0=No, 1=Hosp.2=Saw M.D, 9=Unk)

Name _____

Address _____

Neurology First Opinions

Stroke in Interim

TIA

0=No,

1=Yes,

Dementia

2=Maybe,

9=Unk.

Parkinson Disease

Other, Specify: _____

Comments _____

MD13

Medical History--Peripheral Arterial Disease

Peripheral Arterial Disease			
<input type="checkbox"/>	Are you able to walk 50 feet without help? (0=Able to walk 50 feet without help, 1=Needs help, 2=Can't walk, 9=Unknown)		
<input type="checkbox"/>	Do you get discomfort in either leg on walking? (0=No, 1=Yes, 9=Unk.)		
if yes, fill	<input type="checkbox"/>	Does this discomfort ever begin when you are standing still or sitting? (0=no, 1=yes, 9=Unk)	
	<input type="checkbox"/> <input type="checkbox"/>	When walking at an ordinary pace on level ground, how many city blocks until symptoms develop (1=1 block or less, 99=Unk.) <i>where 10 blocks=1 mile, code as no if more than 98 blocks required to develop symptoms</i>	
	Left	Right	Claudication symptoms
			0=No, 1=Yes, 9=Unk.
	<input type="checkbox"/>	<input type="checkbox"/>	Discomfort in calf while walking
	<input type="checkbox"/>	<input type="checkbox"/>	Discomfort in lower extremity (not calf) while walking Write in site of discomfort _____
		<input type="checkbox"/>	Occurs with first steps (code worse leg)
		<input type="checkbox"/>	After walking a while.
		<input type="checkbox"/>	Do you get the discomfort when you walk up hill or hurry?
		<input type="checkbox"/>	Does the discomfort ever disappear while you are still walking?
	What do you do if you get discomfort when you are walking? <i>Check <u>ONLY ONE</u> box below</i>		
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1=stop	2=slow down	3=continue at same pace
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Time for discomfort to be relieved by stopping (minutes) (000=No relief with stopping, 999=Unk.)	
	<input type="checkbox"/> <input type="checkbox"/>	Number of days/month of lower limb discomfort (1=1 day/month or less, 99=Unk.)	

Medical History--Peripheral Arterial Disease Continued

<input type="checkbox"/>	Since your last exam have you been told you have intermittent claudication or peripheral artery disease? (0=No, 1=Yes, 2=Maybe, 9=Unk.)
if yes, fill	Name of doctor _____
	Date of visit __ __ * __ __ * __ __ __ __
<input type="checkbox"/>	Have you been hospitalized for intermittent claudication or peripheral artery disease? (0=No, 1=Yes, 2=Maybe, 9=Unk.)
if yes, fill	Name of hospital _____
	Date of visit __ __ * __ __ * __ __ __ __

PAD First Opinions	
<input type="checkbox"/>	Intermittent Claudication
	0=No, 1=Yes, 2=Maybe, 9=Unk.

Comments _____

Venous Disease and Second Blood Pressure

Venous Disease		
<input type="checkbox"/>	Since your last exam have you had a Deep Vein Thrombosis (blood clots in legs or arms)	0=No, 1=Yes, 9=Unk.
<input type="checkbox"/>	Since your last exam have you had a Pulmonary Embolus (blood clots in lungs)	

Blood Pressure (second reading)	
Systolic	BP cuff size
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> to nearest 2 mm Hg 999=Unk.	<input type="text"/> 0=pediatric, 1=regular adult, 2=large adult, 3= thigh, 9=Unk.
Diastolic	Protocol modification
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> to nearest 2 mm Hg 999=Unk.	<input type="text"/> 0=No, 1=Yes, 9=Unk. write in _____

Comments on Protocol modification

MD16

Medical History-- CVD Procedures

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

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

Cardiovascular Procedures

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

<input type="checkbox"/>		Heart Valvular Surgery	
	if yes fill	_ _ _ _ Year done (9999=Unk)	
<input type="checkbox"/>		Exercise Tolerance Test	
	if yes fill	_ _ _ _ Year done (9999=Unk)	
<input type="checkbox"/>		Coronary arteriogram	
	if yes fill	_ _ _ _ Year done (9999=Unk)	
<input type="checkbox"/>		Coronary artery angioplasty or stent	
	if yes fill	_ _ _ _ Year done (9999=Unk)	
<input type="checkbox"/>		Coronary bypass surgery	
	if yes fill	_ _ _ _ Year done (9999=Unk)	
<input type="checkbox"/>		Permanent pacemaker insertion	
	if yes fill	_ _ _ _ Year done (9999=Unk)	
<input type="checkbox"/>		Carotid artery surgery or stent	
	if yes fill	_ _ _ _ Year done (9999=Unk)	
<input type="checkbox"/>		Thoracic aorta surgery	
	if yes fill	_ _ _ _ Year done (9999=Unk)	
<input type="checkbox"/>		Abdominal aorta surgery	
	if yes fill	_ _ _ _ Year done (9999=Unk)	
<input type="checkbox"/>		Femoral or lower extremity surgery	
	if yes fill	_ _ _ _ Year done (9999=Unk)	
<input type="checkbox"/>		Lower extremity amputation	
	if yes fill	_ _ _ _ Year done (9999=Unk)	
<input type="checkbox"/>		Other Cardiovascular Procedure (write in below)	
	if yes fill	_ _ _ _ Year done (9999=Unk) Description _____	

Comments: _____

Cancer Site or Type

Since your last exam or health update have you had a cancer or a tumor?
 (0=No and skip to MD19 (next screen); If 1=Yes, 2=Maybe, 9=Unk. please continue)

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

Diagnostic biopsy done? (0=No, 1=Yes, 9=Unk.)

if yes fill - - Date Location of biopsy _____

Hosp./office name _____ Address (city/state) _____

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

MD18

Electrocardiograph--Part I

_ _ _	Examiner ID Number _____	Examiner Last Name _____
_ if Yes, fill out rest of form	ECG done (0=No, 1=Yes)	
Rates and Intervals		
_ _ _	Ventricular rate per minute (999=Unk.)	
_ _ _	P-R Interval (milliseconds) (999=Fully Paced, Atrial Fib, or Unk.)	
_ _ _	QRS interval (milliseconds) (999=Fully Paced, Unk.)	
_ _ _	Q-T interval (milliseconds) (999=Fully Paced, Unk.)	
_ _ _ _	QRS angle (put plus or minus as needed) (e.g. -045 for minus 45 degrees, +090 for plus 90, 9999=Fully paced or Unk.)	
Rhythm--predominant		
_	0 or 1 = Normal sinus, (including s.tach, s.brady, s arrhy, 1 degree AV block) 3 = 2nd degree AV block, Mobitz I (Wenckebach) 4 = 2nd degree AV block, Mobitz II 5 = 3rd degree AV block / AV dissociation 6 = Atrial fibrillation / atrial flutter 7 = Nodal 8 = Paced 9 = Other or combination of above (list) _____	
Ventricular conduction abnormalities		
_	IV Block (0=No, 1=Yes, 9=Fully paced or Unk.)	
	_	Pattern (1=Left, 2=Right, 3=Indeterminate, 9=Unk.)
if yes, fill ☞	_	Complete (QRS interval=.12 sec or greater)(0=No, 1=Yes, 9=Unk.)
	_	Incomplete (QRS interval = .10 or .11 sec) (0=No, 1=Yes, 9=Unk.)
_	Hemiblock (0=No, 1=Left Ant, 2=Left Post, 9=Fully paced or Unk.)	
_	WPW Syndrome (0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unk.)	
Arrhythmias		
_	Atrial premature beats (0=No, 1=Atr, 2=Atr Aber, 9=Unk.)	
_	Ventricular premature beats (0=No, 1=Simple, 2=Multifoc, 3=Pairs, 4=Run, 5=R on T, 9=Unk)	
_ _	Number of ventricular premature beats in 10 seconds (see 10 second rhythm strip, 99=Unk.)	

MD19

Electrocardiograph-Part II

Myocardial Infarction Location	
<input type="checkbox"/>	Anterior (0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unk.)
<input type="checkbox"/>	Inferior
<input type="checkbox"/>	True Posterior
Left Ventricular Hypertrophy Criteria	
<input type="checkbox"/>	R > 20mm in any limb lead (0=No, 1=Yes, 9=Fully paced, Complete LBBB or Unk)
<input type="checkbox"/>	R > 11mm in AVL
<input type="checkbox"/>	R in lead I plus S ≥ 25mm in lead III
Measured Voltage	
* <input type="checkbox"/>	R AVL in mm (at 1 mv = 10 mm standard) <i>Be sure to code these voltages</i>
* <input type="checkbox"/>	S V3 in mm (at 1 mv = 10 mm standard) <i>Be sure to code these voltages</i>
R in V5 or V6-----S in V1 or V2	
<input type="checkbox"/>	R ≥ 25mm
<input type="checkbox"/>	S ≥ 25mm
<input type="checkbox"/>	R or S ≥ 30mm (0=No, 1=Yes, 9=Fully paced, Complete LBBB or Unk)
<input type="checkbox"/>	R + S ≥ 35mm
<input type="checkbox"/>	Intrinsicoid deflection ≥ .05 sec
<input type="checkbox"/>	S-T depression (strain pattern)
Hypertrophy, enlargement, and other ECG Diagnoses	
<input type="checkbox"/>	Nonspecific S-T segment abnormality (0=No, 1=S-T depression, 2=S-T flattening, 3=Other, 9=Fully paced or Unk.)
<input type="checkbox"/>	Nonspecific T-wave abnormality (0=No, 1=T inversion, 2=T flattening, 3=Other, 9=Fully paced or Unk.)
<input type="checkbox"/>	U-wave present (0=No, 1=Yes, 2=Maybe, 9=Paced or Unk.)
<input type="checkbox"/>	Atrial enlargement (0=None, 1=Left, 2=Right, 3=Both, 9=Atrial fib. or Unk.)
<input type="checkbox"/>	RVH (0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unk.; If complete RBBB present, RVH=9)
<input type="checkbox"/>	LVH (0=No, 1=LVH with strain, 2=LVH with mild S-T Segment Abn, 3=LVH by voltage only, 9=Fully paced or Unk., If complete LBBB present, LVH=9)

Comments and Diagnosis _____

MD20

Clinical Diagnostic Impression.

Non Cardiovascular Diagnoses First Examiner Opinions	
<input type="checkbox"/> Diabetes Mellitus	
<input type="checkbox"/> Prostate disease	8=Female
<input type="checkbox"/> Renal disease (specify) _____	
<input type="checkbox"/> Emphysema	
<input type="checkbox"/> Chronic bronchitis	0=No,
<input type="checkbox"/> Pneumonia	1=Yes,
<input type="checkbox"/> Asthma	2=Maybe,
<input type="checkbox"/> Other pulmonary disease	9=Unk.
<input type="checkbox"/> Gout	
<input type="checkbox"/> Degenerative joint disease	
<input type="checkbox"/> Rheumatoid arthritis	
<input type="checkbox"/> Gallbladder disease	
<input type="checkbox"/> Other non C-V diagnosis (for cancer, see special screen)	

Comments CDI Other
Diagnoses _____

Continue Comments on the next page→

MD21

Continue from MD21

**Comments CDI Other
Diagnoses**

MD22