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Offspring Exam9, Omni1 Exam4 «IDType»-«ID» «LName», «FName»

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ID: «Idtype» - «Id»

Numerical Data/Anthropometry

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

Basic Information	
«Sex»	Sex of Participant 1=Male, 2=Female
0	Site of Exam (0=Heart Study, 1=Nursing home, 2=Residence, 3=Other)
	Age of Participant (number of years)
	What state do you reside in? (If reside outside the USA, code ZZ, if plans to wear accelerometer while visiting USA code state of visit) Code: AL, AK, AS, etc.

Anthropometry	
<i>Check Protocol Modification ONLY if there was one and document it in Comment section</i>	
88*88=Refused, 99*99=Not done or Unk.	
*	Height (inches, to next lower 1/4 inch)
<input type="checkbox"/>	Protocol modification
	Weight (to nearest pound) (400=400 or more 888=refused, 999=Unk.)
<input type="checkbox"/>	Protocol modification
_	In the past year, have you lost more than 10 pounds? 0=No, 1= Yes, unintentionally, NOT due to dieting or exercise 2= Yes, intentionally, due to dieting or exercise
	Technician Number (for anthropometry)
*	Neck Circumference (inches, to next lower 1/4 inch)
<input type="checkbox"/>	Protocol modification
*	Waist Girth at umbilicus (inches, to next lower 1/4 inch).
<input type="checkbox"/>	Protocol modification
*	Hip Girth (inches, to next lower 1/4 inch)
<input type="checkbox"/>	Protocol modification
*	Thigh Girth (inches, to next lower 1/4 inch)
<input type="checkbox"/>	Protocol modification

Comments for ALL Protocol Modification (specify measurement)

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TECH01

Check here if whole page is blank. Reason why _____

Procedures Sheet		
0=No, 1=Yes, 8=Offsite visit		
<input type="checkbox"/>	Type of Exam	1=Complete exam, 2=Split exam(exam completed in 2 visits), 3=short exam (incomplete exam), 8=offsite
<input type="checkbox"/>	Informed Consent Signed	0=No, 1=Yes, 2= offspring waiver of consent, LAR, or next-of-kin
<input type="checkbox"/>	Urine Specimen	
<input type="checkbox"/>	Blood Draw	
<input type="checkbox"/>	Mini-Mental Status Exam	
<input type="checkbox"/>	Anthropometry	
<input type="checkbox"/>	Sociodemographic Questions (self administered)	
<input type="checkbox"/>	SF-12 Health Survey	
<input type="checkbox"/>	CES-D Scale	
<input type="checkbox"/>	NAGI, Rosow-Breslau, Katz	
<input type="checkbox"/>	Exercise Questionnaire	
<input type="checkbox"/>	ECG	
<input type="checkbox"/>	P Wave Signal Averaged ECG	
<input type="checkbox"/>	If not performed why: 1=AF, 2=Pacemaker, 3=Pat. ran out of time, 4=Pat. couldn't lie flat, 5=equipment malfunction, 6=other	
<input type="checkbox"/>	Observed performance (Timed walk, hand grip, chair stands)	
<input type="checkbox"/>	Tonometry	
<input type="checkbox"/>	Ankle-brachial blood pressure by Doppler. (Participants ≥ 40 years)	
<input type="checkbox"/>	Spirometry	0=Not Done, 1=Done, 2=Attempted, not finished, 3= Attempted, tech aborted ,4=Other
<input type="checkbox"/>	Reason Spirometry not done	1=Medical exclusion, 2=Refused, 3=equipment problems 4=Other
<input type="checkbox"/>	Post Albuterol Spirometry	0=Not Done, 1=Done, 2=Attempted, not finished, 3= Attempted, tech aborted ,4=Other
<input type="checkbox"/>	Reason Post Alb. Spir. not done	1=Medical exclusion, 2=Refused, 3=equipment problems 4=Other 5=Do not qualify
<input type="checkbox"/>	Diffusion Capacity	0=Not Done, 1=Done, 2=Attempted, not finished, 3= Attempted, tech aborted ,4=Other
<input type="checkbox"/>	Reason Diffusion not done	1=Medical exclusion, 2=Refused, 3=equipment problems 4=Other

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□	Accelerometer
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TECH02

For Participants Who Wish to Complete Their Exam on a Second Visit (Split Exam)

<input type="text"/>	Second Exam Date (If participant returns to finish their clinic exam on a date other than the original exam date, then fill in the date they return here. Otherwise leave entire page completely blank)
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Keys: if Second Exam Date is not filled and page is blank' then leave the page all blank.

Fill in with 1=yes if procedure was done on the Second Exam Date and 0=no if procedure was not done on the Second Exam Date. Note that informed consent from first visit will cover the second visit.

Procedures Sheet		
0=No, 1=Yes, 8=Offsite visit		
<input type="checkbox"/>	Type of Exam	1=Complete exam, 2=Split exam(exam completed in 2 visits), 3=short exam (incomplete exam), 8=offsite
<input type="checkbox"/>	Urine Specimen	
<input type="checkbox"/>	Blood Draw	
<input type="checkbox"/>	Mini-Mental Status Exam	
<input type="checkbox"/>	Anthropometry	
<input type="checkbox"/>	Sociodemographic Questions (self administered)	
<input type="checkbox"/>	SF-12 Health Survey	
<input type="checkbox"/>	CES-D Scale	
<input type="checkbox"/>	NAGI, Rosow-Breslau, Katz	
<input type="checkbox"/>	Exercise Questionnaire	
<input type="checkbox"/>	ECG	
<input type="checkbox"/>	P Wave Signal Averaged ECG	
<input type="checkbox"/>	If not performed why: 1=AF, 2=Pacemaker, 3=Pat. ran out of time, 4=Pat. couldn't lie flat, 5=equipment malfunction, 6=other	
<input type="checkbox"/>	Observed performance (Timed walk, hand grip, chair stands)	
<input type="checkbox"/>	Tonometry	
<input type="checkbox"/>	Ankle-brachial blood pressure by Doppler. (Participants ≥ 40 years)	
<input type="checkbox"/>	Spirometry	0=Not Done, 1=Done, 2=Attempted, not finished, 3= Attempted, tech aborted ,4=Other
<input type="checkbox"/>	Reason Spirometry not done	1=Medical exclusion, 2=Refused, 3=equipment problems 4=Other
<input type="checkbox"/>	Post Albuterol Spirometry	0=Not Done, 1=Done, 2=Attempted, not finished, 3= Attempted, tech aborted ,4=Other
<input type="checkbox"/>	Reason Post Alb. Spir. not done	1=Medical exclusion, 2=Refused, 3=equipment problems 4=Other 5=Do not qualify
<input type="checkbox"/>	Diffusion Capacity	0=Not Done, 1=Done, 2=Attempted, not finished, 3= Attempted, tech aborted ,4=Other
<input type="checkbox"/>	Reason Diffusion not done	1=Medical exclusion, 2=Refused, 3=equipment problems 4=Other
<input type="checkbox"/>	Accelerometer	

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TECH03

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Check here if whole page is blank. Reason why _____

Exit Interview

____ Technician Number

Procedure sheet reviewed

0=No

Referral sheet reviewed

1=Yes

8=Offsite

Left clinic w/ belongings

9=Unk.

Dietary questionnaire provided 1=Brought to exam completed or filled out in clinic, 2=Given in clinic to complete at home and send back, 3=Other, 8=Offsite, 9=Unk.

Left clinic with accelerometer 0=No, refused, 1=Yes, 2=it will be mailed to them, 8=Offsite, 9=Unk.

Feedback 0=No feedback, 1=Positive feedback, 2=Negative feedback, 3=Other, 9=Unk.

Comments _____

CLINIC visit only

____ Technician Number

Was there an adverse event in clinic that does not require further medical evaluation?
 (0=No, 1=Yes, 9=Unk.)

Comments: _____

OFFSITE visit only

____ Technician Number

Was a FHS physician contacted during the examination due to adverse exam finding?
 (0=No, 1=Yes, 9=Unk.)

Comments: _____

____ Technician who reviewed TECH portion of exam

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.

Offspring Exam9, Omni1 Exam4

«IDType»-«ID»

«LName», «FName»

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TECH04

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MMSE-Cognitive Function-Part I

Check here if whole page is blank. Reason why _____

I'm going to start by asking 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	Write all responses on exam form 0=incorrect, 1-3=score 1 point for each correct response, 6=item administered, Participant doesn't answer, 9=Unk.
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? (Town, county, state, correct score=3)
0 1 6 9	What Is the Name of this Place? (any appropriate answer all right, for instance my 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. Are you ready? Apple, Table, Penny. Could you repeat the three items for me Remember what they are because I will ask you to name them again in a few minutes.
____	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. (Letters Are Entered and Scored Later)
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

MMSE-Cognitive Function -Part II

Check here if whole page is blank. Reason why _____

SCORE	<i>Write all responses on exam form</i> 0=incorrect, 1-3=score 1 point for each correct response, 6=item administered, Participant doesn't answer, 9=Unk.	
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 (<i>performed=1, code 6 if low vision</i>)	
0 1 6 9	Please Write a Sentence (<i>code 6 if low vision</i>)	
0 1 6 9	Please Copy this Drawing (<i>code 6 if low vision</i>)	
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 (<i>score 1 for each correctly performed act, code 6 if low vision</i>)	

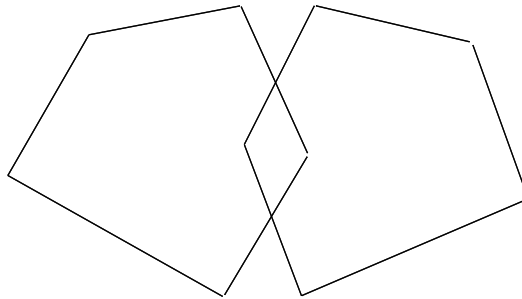
No Yes Maybe Unk. (coding for below)	Factor Potentially Affecting Mental Status Testing	
0 1 2 9	Not fluent in English	
0 1 2 9	Poor eyesight	
0 1 2 9	Poor hearing	
0 1 2 9	Other, write in _____	

TECH06

Sentence and Design Handout for Participant

PLEASE WRITE A SENTENCE

PLEASE COPY THIS DESIGN



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Socio-demographic Questionnaire (Tech-administered)

<input type="checkbox"/>	Check here if whole page is blank.	Reason why _____
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_ _ _	Technician Number
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Socio-demographics																		
_	Where do you live? (0=Private residence, 1=Nursing home, 2=Other, setting (no longer able to live independently) such as assisted living, 9=Unk.)																	
_	Does anyone live with you? (0=No, 1=Yes, 9=Unk.) <i>Code Nursing Home Residents as NO</i>																	
If Yes, fill ☞	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; text-align: center;"> _ </td> <td style="width: 60%;">Spouse</td> <td style="width: 30%;">0=No</td> </tr> <tr> <td style="text-align: center;"> _ </td> <td>Significant Other</td> <td></td> </tr> <tr> <td style="vertical-align: top; padding: 5px;">If 0 or 9, skip to next table</td> <td style="padding: 5px;"> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; text-align: center;"> _ </td> <td style="width: 60%;">Children</td> <td style="width: 30%;">1=Yes, more than 3 months per year</td> </tr> <tr> <td style="text-align: center;"> _ </td> <td>Friends</td> <td>2=Yes, less than 3 months per year</td> </tr> <tr> <td style="text-align: center;"> _ </td> <td>Relatives</td> <td>9=Unk.</td> </tr> </table> </td> </tr> </table>	_	Spouse	0=No	_	Significant Other		If 0 or 9, skip to next table	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; text-align: center;"> _ </td> <td style="width: 60%;">Children</td> <td style="width: 30%;">1=Yes, more than 3 months per year</td> </tr> <tr> <td style="text-align: center;"> _ </td> <td>Friends</td> <td>2=Yes, less than 3 months per year</td> </tr> <tr> <td style="text-align: center;"> _ </td> <td>Relatives</td> <td>9=Unk.</td> </tr> </table>	_	Children	1=Yes, more than 3 months per year	_	Friends	2=Yes, less than 3 months per year	_	Relatives	9=Unk.
_	Spouse	0=No																
_	Significant Other																	
If 0 or 9, skip to next table	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; text-align: center;"> _ </td> <td style="width: 60%;">Children</td> <td style="width: 30%;">1=Yes, more than 3 months per year</td> </tr> <tr> <td style="text-align: center;"> _ </td> <td>Friends</td> <td>2=Yes, less than 3 months per year</td> </tr> <tr> <td style="text-align: center;"> _ </td> <td>Relatives</td> <td>9=Unk.</td> </tr> </table>	_	Children	1=Yes, more than 3 months per year	_	Friends	2=Yes, less than 3 months per year	_	Relatives	9=Unk.								
_	Children	1=Yes, more than 3 months per year																
_	Friends	2=Yes, less than 3 months per year																
_	Relatives	9=Unk.																

Use of Nursing and Community Services		
_	Have you been admitted to a nursing home (or skilled facility) in the past year?	0=No
_	In the past year, have you been visited by a nursing service, or used home, community, or adult day care programs? (examples: home health aide, visiting nurses, etc)	1=Yes 9=Unk.

Nagi Questions (Tech-administered)

Check here if whole page is blank. Reason why _____

____| **Technician Number**

Nagi Questions

For each activity 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 Physician or Health Care Provider Orders
- (6) Don't Know
- (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 <i>(like a bag of potatoes)</i>
<input type="checkbox"/>	Lifting or carrying weights over 10 pounds <i>(like a very heavy bag of groceries)</i>

TECH08

Rosow-Breslau Scale and Katz Activities of Daily Living (Tech-administered)

<input type="checkbox"/>	Check here if whole page is blank.	Reason why _____
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_ _ _	Technician Number
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Rosow-Breslau Questions	
_	Are you able to do heavy work around the house, like shoveling snow or washing windows, walls, or floors without help?
_	Are you able to walk half a mile without help? (About 4-6 blocks)
_	Are you able to walk up and down one flight of stairs without help?

0=No
 1=Yes
 9=Unk.

Katz ADLs	
<p><u>During the Course of a Normal Day</u>, 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=Does not do during a normal day, 9=Unk.</p>	
_	<p>Dressing (undressing and redressing) <i>Devices such as: velcro, elastic laces</i></p>
_	<p>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></p>
_	<p>Eating <i>Devices such as: rocking knife, spork, long straw, plate guard.</i></p>
_	<p>Transferring(getting in and out of a chair) <i>Devices such as: sliding board, grab bars, special seat</i></p>
_	<p>Toileting Activities (using bathroom facilities and handle clothing) <i>Devices such as: special toilet seat, commode</i></p>

TECH09

Fractures

<input type="checkbox"/>	Check here if whole page is blank.	Reason why _____
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_ _ _	Technician Number
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Fractures	
_	Since Your Last Clinic Visit Have You Broken Any Bones? (0=No, 1=Yes, 2=Maybe, 9=Unk.)
If Yes, fill ☞	_ _ Location of fracture:
	_ _ Location of second fracture (if more than one):
	_ _ Location of third fracture (if more than two):
Code for Location (<i>code Unk. as 99</i>)	
1= Clavicle (collar bone)	
2=Upper arm (humerus) or elbow	
3=Forearm or wrist	
4=Hand	
5=Back (<i>If disc disease only, code as no</i>)	
6=Pelvis	
7=Hip	
8=Leg	
9=Foot	
10=Other, specify _____	

TECH10

Physical Activity Questionnaire Part 1--Framingham Heart Study Tech-administered

Check here if whole page is blank. Reason why _____

____ Technician Number

Rest and Activity for a Typical Day over the past year (A typical day = most days of the week) (Activities must equal 24 hours)	Number of hours
Sleep - Number of hours that you typically sleep?	_____
Sedentary - Number of hours typically sitting? Such as reading, watching TV, using the computer, doing handcrafts	_____
Slight Activity - Number of hours with activities such as standing, walking?	_____
Moderate Activity - Number of hours with activities such as housework (vacuum, dust, yard chores, climbing stairs; light sports such as bowling, golf)?	_____
Heavy Activity - Number of hours with activities such as heavy household work, heavy yard work such as stacking or chopping wood, exercise such as intensive sports--jogging, swimming etc.?	_____
Total number of hours (should be the total of above items)	24

Over the past 7 days, how often did you participate in SITTING ACTIVITIES such as reading, watching TV, using the computer, or doing handcrafts?

0 = Never
 1 = Seldom/1-2 days
 2 = Sometimes/3-4 days
 3 = Often/5-7 days
 8 = refused
 9 = Don't know/Unknown

Over the past 7 days, how many hours per day did you engage in these sitting activities?

1 = less than 1 hour
 2 = 1 hour but less than 2 hours
 3 = 2-4 hours
 4 = more than 4 hours
 8 = refused
 9 = Don't know/Unknown

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Physical Activity Questionnaire Part 2--Framingham Heart Study Tech-administered

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

I am going to read a list of activities. Please tell me which activities you have done in the past year.

_	During the past year did you (do)? 0=No, 1=Yes, 8=Refused, 9=Unk.	In a typical 2 week period of time, how often do you (<i>name of activity</i>)	Average time/session		Number months/year 0-12
			hours	minutes	
_	Walk (<i>walking to work, walking the dog, walking in the mall</i>)	_ _	_ _	_ _	_ _
_	Calisthenics/general exercise (<i>yoga, pilates</i>)	_ _	_ _	_ _	_ _
_	Exercise cycle, ski or stair machine (<i>treadmill, elliptical, stair master, etc.</i>)	_ _	_ _	_ _	_ _
_	Exercises to increase muscle strength or endurance -Weight training (<i>free weights, machines</i>)	_ _	_ _	_ _	_ _
_	Moderate/strenuous household chores (<i>vacuuming, scrubbing floors, washing windows, carrying wood</i>)	_ _	_ _	_ _	_ _
_	Jog	_ _	_ _	_ _	_ _
_	Bike	_ _	_ _	_ _	_ _
_	Dance	_ _	_ _	_ _	_ _
_	Aerobics	_ _	_ _	_ _	_ _
_	Swim	_ _	_ _	_ _	_ _
_	Tennis	_ _	_ _	_ _	_ _
_	Golf (no cart)	_ _	_ _	_ _	_ _
_	Lawn work or yard care* (<i>Mowing the lawn, snow or leaf removal</i>)	_ _	_ _	_ _	_ _
_	Outdoor Gardening	_ _	_ _	_ _	_ _
_	Hike	_ _	_ _	_ _	_ _
_	Light sport or recreational activities (<i>bowling, golf with a cart, shuffleboard, fishing, ping-pong</i>)	_ _	_ _	_ _	_ _
_	Other*, write in _____ _____	_ _	_ _	_ _	_ _

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TECH12

CES-D Scale
Tech-administered

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

The questions below ask about your feelings. For each statement, please say how often 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 did not feel like eating; my appetite was poor.	0	1	2	3
I felt that I could not shake off the blues, even with help from my family and friends.	0	1	2	3
I felt that I was just as good as other people.	0	1	2	3
I had trouble keeping my mind on what I was doing.	0	1	2	3
*I felt depressed.	0	1	2	3
I felt that everything I did was an effort.	0	1	2	3
I felt hopeful about the future.	0	1	2	3
I thought my life had been a failure.	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 talked less than usual.	0	1	2	3
I felt lonely.	0	1	2	3
People were unfriendly.	0	1	2	3
I enjoyed life.	0	1	2	3
I had crying spells.	0	1	2	3
I felt sad.	0	1	2	3
I felt that people disliked me	0	1	2	3
I could not "get going"	0	1	2	3

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** Indicates that the technician should preface the statement with "During the past week"*

TECH13

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Proxy form

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

TECH014

Offspring Exam9, Omni1 Exam4 «IDType»-«ID» «LName», «FName» 27

Offspring Exam9, Omni1 Exam4 <IDType>-<ID> <LName>, <FName>

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Observed performance Part 1 Technician Administered

Check here if whole page is blank. Reason why _____

_ _ _	Technician Number
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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.	_ _

Check if this test not completed or not attempted.

|_| **If not attempted or completed, why not?**
 1=Physical limitation, 2=Refused, 3=Other _____ write in, 9=Unk.

Protocol modification for Hand Grip , Chair stands and Walk testing
<input type="checkbox"/> Check for Protocol modification

Comments: _____

TECH15

Offspring Exam9, Omni1 Exam4

«IDType»-«ID»

«LName», «FName»

Observed performance Part 2
Technician Administered

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

Repeated Chair Stands (5)	
Time to complete five stands in seconds (99.99=Unk.)	_ _ * _ _
If less than five stands, enter the number (9=Unk.)	_
IF OFFSITE visit, Chair height (in inches, 99*99=Unk.)	_ _ * _ _
<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	
Walking aid used: 0=No aid, 1=Cane, 2=Walker, 3=Wheelchair, 4=Other, 9=Unk.	_
First Walk	
Walk time (in seconds, 99.99=Unk.)	_ _ * _ _
Laser walk time (in seconds, 99.99=Unk.)	_ _ * _ _
<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.)	_ _ * _ _
Laser walk time (in seconds, 99.99=Unk.)	_ _ * _ _
<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.)	_ _ * _ _
Laser walk time (in seconds, 99.99=Unk.)	_ _ * _ _
<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.)	

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TECH16

Offspring Exam9, Omni1 Exam4 «IDType»-«ID» «LName», «FName» 32

Ankle Brachial Blood Pressure Measurements. Participants ≥ 40 years

<input type="checkbox"/> Check here if whole page is blank	Reason why _____
. Technician Number for Doppler Ankle Brachial Blood Pressure.	

<input type="checkbox"/>	Have you had any problems with blood clots in your legs?	0=No
If yes, fill ☞	<i>do NOT proceed with testing in the extremity with the blood clot</i>	1=Yes
<input type="checkbox"/>	Are you being treated for this problem now?	

<input type="checkbox"/>	Cuff size, arm	0= pediatric, 1= regular adult
<input type="checkbox"/>	Cuff size, ankle	2= large adult, 3= thigh

	Right arm	
	Right ankle	300= \geq 300 mmHg
	Left ankle	888= Not Done
	Left arm	999= Unk.

REPEAT SYSTOLIC BLOOD PRESSURE MEASUREMENTS (reverse order)

	Left arm	
	Left ankle	300= \geq 300 mmHg
	Right ankle	888= Not Done
	Right arm	999= Unk.

THIRD SYSTOLIC BLOOD PRESSURE MEASUREMENT (order as in repeat SBP). To be obtained if initial and repeat SBP at any site differ by more than 10 mmHg. For site that differs.

	Right arm	
	Right ankle	300= \geq 300 mmHg
	Left ankle	888= Not Done
	Left arm	999= Unk.

<input type="checkbox"/>	Right Ankle blood pressure site	0= posterior tibial (ankle)
<input type="checkbox"/>	Left Ankle blood pressure site	1= dorsalis pedis (foot), 8=Not Done

EXCLUSIONS:

Enter exclusion **ONLY** if there is an 888 above

Right	Left	
		Lower Extremity Exclusions 1= venous stasis ulceration, or DVT 2= amputation, 3= other _____
		Upper Extremity Exclusions 1=Mastectomy, 3= Other _____
<input type="checkbox"/> Check if Protocol modification, write in _____		

Offspring Exam9, Omni Exam4 «IDType»-«ID» «LName», «FName» 33

Comments

TECH17

Offspring Exam9, Omni1 Exam4 «IDType»-«ID» «LName», «FName»

Respiratory Disease Questionnaire Part 1 Technician Administered

DATE of last exam «Lexam»

DATE of last medical history update «Lupdate»

Check here if whole page is blank. Reason why _____

____ Technician Number

Respiratory Diagnoses

Have you ever had asthma? (0=No, 1=Yes, 9=Unk.)

If yes, fill **Do you still have it?**

Was it diagnosed by a doctor or other health care professional?

At what age did it start? (Age in years 88=N/A, 99=Unk.)

If you no longer have it, at what age did it stop? (Age in years) 88=still have it, 99=Unk.

Have you received medical treatment for this in the past 12 months?

Have you ever had hay fever (allergy involving the nose and/or eyes)? (0=No, 1=Yes, 9=Unk.)

If yes, fill **Do you still have it?** (0=No, 1=Yes, 9=Unk.)

Have you ever had any of the following conditions diagnosed by a doctor or other health care professional? (0=No, 1=Yes, 9=Unk.)

Chronic Bronchitis

Emphysema

COPD (Chronic obstructive pulmonary disease)

Sleep Apnea

Pulmonary Fibrosis

Inhaler Use (0=No, 1=Yes)

Do you take inhalers or bronchodilators?

If yes, fill **Do you take any of the inhaled medications?**- albuterol, ProAir, Proventil, Ventolin, pirbuterol, Maxair, levalbuterol, Xopenex, metaproterenol, Alupent, or ipratropium, Atrovent, Combivent

If yes, fill How many hours ago did you last use the medication, either by inhaler or nebulizer? *if last used >48 hrs ago code 88, 99= Unk.* **Time in hours 1-48**

Do you take any of the following inhaled medications? salmeterol, Serevent, Advair, formoterol, Foradil, Symbicort, arformoterol, Brovana, tiotropium, or Spiriva,

If yes, fill How many hours ago did you last use the medication, either by inhaler or nebulizer? *if last used >48 hrs ago code 88, 99=Unk.* **Time in hours 1-48**

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TECH18

Respiratory Disease Questionnaire Part 2 Technician Administered

Check here if whole page is blank. Reason why _____

Acute Respiratory Illnesses Since Last Exam

Since your last exam or medical history update

Have you been hospitalized because of breathing trouble or wheezing? (0=No, 1=Yes, 9=Unk.)

If yes, fill **How many times has this occurred?**

Were any of these hospitalizations due to a lung or bronchial problem, for example COPD, asthma, bronchitis, emphysema, or pneumonia? (0=No, 1=Yes, 9=Unk.)

Have you required an emergency room visit or an unscheduled visit to a doctor's office or clinic because of breathing trouble or wheezing? (0=No, 1=Yes, 9=Unk.)

If yes, fill **How many times has this occurred?**

Were any of these emergency room or unscheduled visits due to a lung or bronchial problem, for example COPD, asthma, bronchitis, emphysema, or pneumonia? (0=No, 1=Yes, 9=Unk.)

Have you had pneumonia (including bronchopneumonia)? (0=No, 1=Yes, 9=Unk.)

If yes, fill **How many times have you had pneumonia?**

The following questions are about problems which occur when you **DO NOT** have a cold or the flu. Please list problems that occurred IN THE PAST 12 MONTHS only

Have you had a problem with sneezing or a runny or blocked nose when you DID NOT have a cold or the flu? (0=No, 1=Yes, 9=Unk.)

If yes, fill **Has this nose problem been accompanied by itchy-watery eyes?** (0=No, 1=Yes, 9=Unk.)

In which of the months did this nose problem occur? (0=No, 1=Yes) *Fill in ALL months.*

<input type="checkbox"/> January	<input type="checkbox"/> July
<input type="checkbox"/> February	<input type="checkbox"/> August
<input type="checkbox"/> March	<input type="checkbox"/> September
<input type="checkbox"/> April	<input type="checkbox"/> October
<input type="checkbox"/> May	<input type="checkbox"/> November
<input type="checkbox"/> June	<input type="checkbox"/> December

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TECH19

Sociodemographic questions.
Self-administered (Offsite - tech-administered)

_ _ _	Technician Number for OFFSITE visit ONLY
-------	---

What is your current marital status? (check ONE)	
<input type="checkbox"/> 1	single/never married
<input type="checkbox"/> 2	married/living as married/living with partner
<input type="checkbox"/> 3	separated
<input type="checkbox"/> 4	divorced
<input type="checkbox"/> 5	widowed
<input type="checkbox"/> 9	prefer not to answer
Please choose which of the following best describes your current employment status? (check ONE)	
<input type="checkbox"/> 0	homemaker, not working outside the home
<input type="checkbox"/> 1	employed (or self-employed) full time
<input type="checkbox"/> 2	employed (or self-employed) part time
<input type="checkbox"/> 3	employed, but on leave for health reasons
<input type="checkbox"/> 4	employed, but temporarily away from my job
<input type="checkbox"/> 5	unemployed or laid off
<input type="checkbox"/> 6	retired from my usual occupation and not working
<input type="checkbox"/> 7	retired from my usual occupation but working for pay
<input type="checkbox"/> 8	retired from my usual occupation but volunteering
<input type="checkbox"/> 9	prefer not to answer
<input type="checkbox"/> 10	unemployed due to disability

What is your current occupation?	
Write in _____	
_ _	Using the occupation coding sheet choose the code that best describes your occupation.

<input type="checkbox"/> YES	<input type="checkbox"/> NO	Do you have some form of health insurance?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Do you have prescription drug coverage?

Medication Questionnaire Self-administered (Offsite - tech-administered)

Check if NO medication taken and leave the page BLANK

This questionnaire refers to medication recommended to you by your doctor or health care provider. For the question below, please check YES or NO

<input type="checkbox"/> YES	<input type="checkbox"/> NO	Did you ever forget to take your medicine?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Are you careless at times about taking your medicine?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	When you feel better do you stop taking your medicine?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Sometimes if you feel worse when you take the medicine, do you stop taking it?

How often do you forget to take your medicine? (Circle only ONE)	
1.	Never
2.	More than once per week
3.	Once per week
4.	More than once per month
5.	Once per month
6.	Less than once per month.

SF-12® Health Survey (Standard) Self-administered

This questionnaire asks for your views about your health. This information will help you keep track of how you feel and how well you are able to do your usual activities.

Please answer every question by marking one box. If you are unsure about how to answer a question, please give the best answer you can.

1. In general, would you say your health is:

Excellent	Very good	Good	Fair	Poor
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
2. Moderate activities , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Climbing several flights of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	Yes	No
4. Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>
5. Were limited in the kind of work or other activities	<input type="checkbox"/>	<input type="checkbox"/>

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	Yes	No
6. Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>
7. Didn't do work or other activities as carefully as usual	<input type="checkbox"/>	<input type="checkbox"/>

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**SF-12® Health Survey (Standard)
Self-administered**

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

Not at all	A little bit	Moderately	Quite a bit	Extremely
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks...

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
9. Have you felt calm and peaceful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Did you have a lot of energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you felt downhearted and blue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Sleep Questionnaire. Part 1
Self-administered

What is the chance that you would doze off or fall asleep (not just "feel tired") in each of the following situations? (Circle one response for each situation. If you are never or rarely in the situation, please give your best guess for that situation)

	None	Slight	Moderate	High
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (such as theater or a meeting)	0	1	2	3
Riding as a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped in traffic for a few minutes	0	1	2	3

TECH24

Sleep Questionnaire Part 2 Self-administered

During the past month...	
when have you usually gone to bed at night?	_ _ : _ _ _ _ hours : min AM PM
how long has it usually taken you to fall asleep each night?	_ _ : _ _ hours : min
when have you usually gotten up in the morning?	_ _ : _ _ _ _ hours : min AM PM
how much <i>actual sleep</i> did you get at night?	_ _ : _ _ hours : min

When you experience the following situations, how likely is it for you to have difficulty sleeping?
 Circle an answer even if you have not experienced these situations recently.

	Not likely	Somewhat likely	Moderately likely	Very likely
Before an important meeting the next day	0	1	2	3
After a stressful experience during the day	0	1	2	3
After a stressful experience in the evening	0	1	2	3
After getting bad news during the day	0	1	2	3
After watching a frightening movie or TV show	0	1	2	3
After having a bad day at work	0	1	2	3
After an argument	0	1	2	3
Before having to speak in public	0	1	2	3
Before going on vacation the next day	0	1	2	3

<input type="checkbox"/>	On average over the past year, how often do you snore?	0= Never 1= Less than 1 night per week 2= 1-2 nights per week 3= 3-5 nights per week 4= 6-7 nights per week 9= Don't know
<input type="checkbox"/>	On average over the past year, how often do you have times when you stop breathing while you are asleep?	

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TECH25

Sleep Questionnaire Part 3 Self-administered

One hears about “morning” and “evening” types of people. Which ONE of these types do you consider yourself to be? Please **check ONE box** below

- 1 **Definitely a “morning” type**
- 2 **Rather more a “morning” than an “evening” type**
- 3 **Neither a “morning” nor an “evening” type**
- 4 **Rather more an “evening” than a “morning” type**
- 5 **Definitely an “evening” type**

hour min AM PM

Considering only your “feeling best” rhythm, at what time would you get up if you were entirely free to plan your day?

hour min AM PM

Considering only your “feeling best” rhythm, at what time would you go to bed if you were entirely free to plan your evening?

Have you ever been told by a doctor or other health professional that you have any of the following?

(Circle one response for each item)	No	Yes	Don't know
Sleep apnea or obstructive sleep apnea	0	1	9
if yes, Do you wear a mask (“CPAP”) or other device fill at night to treat sleep apnea?	0	1	9
Insomnia	0	1	9
Restless legs	0	1	9

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Framingham Study Vascular Function Participant Worksheet

(circle one)

Keyer 1: _____

Keyer 2:

0 1 9

Have you had any caffeinated drinks in the last 6 hours?
 (0=No, 1=Yes, 9=Unk.)

**if yes
fill** ☞

____|

How many cups? (99=Unk.)

0 1 9

Have you eaten anything else including a fat free cereal bar this morning?
 (0=No, 1=Yes, 9=Unknown)

0 1 9

Have you smoked cigarettes in the last 6 hours? (0=No, 1=Yes, 9=Unk.)

**if yes
fill** ☞

____|:____|

If yes, how many hours and minutes since your last cigarette?
 (99:99=Unk.)

Tonometry

____|/____|/____|

Date of Tonometry scan? (99/99/9999=Unk.)

____|

Tonometry Sonographer ID

____|-____|

Tonometry CD number

0 1

Was Tonometry done?

0= No, test was not attempted or done

1= Yes, test was done, even if all 4 pulses could not be acquired and recorded.

If no fill ☞

Reason why: *(Check all that apply)*

Subject refusal

Subject discomfort

Time constraint

Equipment problem, specify _____

Other, specify _____

Not for Data Entry.

Distances:

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_____Carotid(mm) _____Brachial(mm) _____Radial(mm) _____Femoral(mm)

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Date of exam

____/____/____

Framingham Heart Study

Summary Sheet to Personal Physician

Blood Pressure	First Reading	Second Reading
Systolic		
Diastolic		

ECG Diagnosis _____

The following tests are done on a routine basis: Blood Glucose, Blood Lipids, Pulmonary Function Test (results enclosed).

Summary of Findings _____

1. No history or physical exam findings to suggest cardiovascular disease
(check box if applicable)

Examining Physician

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

Offspring Exam9, Omni1 Exam4 <IDType>-<ID> <LName>, <FName>

Referral Tracking

Check here if whole page is blank. Reason why _____

<input type="checkbox"/>	Was further medical evaluation recommended for this participant? 0=No, 1=Yes, 9=Unk.	
if yes fill below		
RESULT	Reason for further evaluation: <i>(Check ALL that apply).</i>	
<input type="checkbox"/>	Blood Pressure result _____/_____ mmHg result _____/_____ mmHg	SBP or DBP Phone call ≥ 200 or ≥ 110 Expedite ≥ 180 or ≥ 100 Elevated ≥ 140 or ≥ 90
<i>Write in abnormality</i>		
<input type="checkbox"/>	Abnormal laboratory result _____	
<input type="checkbox"/>	ECG abnormality _____	
<input type="checkbox"/>	Clinic Physician identified medical problem _____	
<input type="checkbox"/>	Other _____	

Method used to inform participant of need for further medical evaluation <i>(Check ALL that apply)</i>	
<input type="checkbox"/>	Face-to-face in clinic
<input type="checkbox"/>	Phone call
<input type="checkbox"/>	Result letter
<input type="checkbox"/>	Other

Method used to inform participant's personal physician of need for further medical evaluation <i>(check ALL that apply)</i>	
<input type="checkbox"/>	Phone call
<input type="checkbox"/>	Result letter mailed
<input type="checkbox"/>	Result letter FAX'd <i>(inform staff if Fax needed)</i>
<input type="checkbox"/>	Other

Date referral made: ____/____/____

ID number of person completing the referral: _____

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

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Medical History—Hospitalizations, ER Visits, MD Visits

DATE _____

DATE of last exam *«Lexam»*

DATE of last medical history update *«Lupdate»*

Health Care

Since your last exam or medical history update

|_|_|_|

1st Examiner ID _____ 1st Examiner Name

|_0_|

1st Examiner Prefix (0=MD, 1=Tech. for OFFSITE visit)

|_|

Hospitalizations (*not just E.R.*) (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.)

|_|

Have you had a fever or infection in past two weeks? (0=No, 1=Yes, 9=Unk.)


|_|_| |_|_| |_|_|_|_|_|
 MM DD YYYY

Date of this FHS exam (*Today's date - See above*)

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

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MD01

Medical History—Medications

<input type="checkbox"/>	Do you take aspirin regularly? (0=No, 1=Yes, 9=Unk.)	
If yes,	<input type="text"/>	Number of aspirins taken regularly (99=Unk.)
fill 	<input type="text"/>	Frequency per (1=Day, 2=Week 3=Month, 4=Year, 9=Unk.)
<input type="text"/>	Usual dose (write in mgs, 999=Unk.)	<u>Examples:</u> 081=baby, 160=half dose, 250= like in Excedrin, 325=usual dose, 500=extra strength

Since your last exam	
(0=No, 1=Yes, 9=Unk.)	
<input type="checkbox"/>	Have you been told by doctor you have high blood pressure or hypertension?
<input type="checkbox"/>	Have you taken medication for high blood pressure or hypertension?
<input type="checkbox"/>	Have you been told by doctor you have high blood cholesterol or high triglycerides?
<input type="checkbox"/>	Have you taken medication for high blood cholesterol or high triglycerides?
<input type="checkbox"/>	Have you been told by doctor you have high blood sugar or diabetes?
<input type="checkbox"/>	Have you taken medication for high blood sugar or diabetes?
<input type="checkbox"/>	Have you taken medication for cardiovascular disease? (for example angina/chest pain, heart failure, atrial fibrillation/heart rhythm abnormality, stroke, leg pain when walking, peripheral artery disease)

MD02

Offspring Exam9, Omni1 Exam4 <IDType>-<ID> <LName>, <FName>

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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 or bottles/packs brought to exam? (0=No 1=Yes) ****List medications taken regularly in past month/ongoing medications****
Code ASPIRIN ONLY on screen MD02.

Check if NO medication taken

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"/>

Continue on the next page →

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MD03

Offspring Exam9, Omni1 Exam4 <IDType>-<ID> <LName>, <FName>

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 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"/>
				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"/>

Medical History–Female Reproductive History Part 1

Check here if Male Participant (and skip to Smoking Questions page 48/MD08)

<Meno> Check here if definitely menopausal (and skip to Female History Part 3 page 47)
(preloaded from previous exam)

Since your last exam have you taken or used birth control pills, shots, or hormone implants for birth control or medical indications (not post menopausal hormone replacement)?
(0=no, 1=yes, now, 2=yes, not now, 9=Unk.)

Have you been pregnant since last exam? (0=No, 1=Yes, 9=Unk.)

If yes, Number of pregnancies?

fill in number

fill Number of live births?

During any of these pregnancies, were you told you had high blood pressure or hypertension?

0=No

During any of these pregnancies, were you told you had eclampsia, pre-eclampsia (toxemia)?

1=Yes

During any of these pregnancies, were you told you had high blood sugar or diabetes?

9=Unk.

MD05

Medical History—Female Reproductive History Part 2

What is the best way to describe your periods? Check the BEST answer – only one

Not stopped

Periods stopped due to pregnancy, breastfeeding, or hormonal contraceptive (for example: depo-provera, progestin releasing IUD, extended release birth control pill)

Periods stopped due to low body weight, heavy exercise, or due to medication or health condition such as thyroid disease, pituitary tumor, hormone imbalance, stress,
 Write in cause _____

Periods stopped for less than 1 year (perimenopausal)
 |__| |__| **Number of months since last period** 99=Unk.

Periods stopped for 1 year or more

Periods stopped, but now have periods induced by hormones.
 |__| |__| **Number months stopped before hormones started.** 99=Unk.

|__| |__| * |__| |__| * |__| |__| |__| |__| |__| |__| **When was the first day of your last menstrual period?** 99/99/9999=Unk.
 88/88/8888= periods stopped for more than 1 year or using postmenopausal hormones
 If periods stopped due to pregnancy, breastfeeding, hormonal contraception or health condition code date of last menstrual period

|__| |__| **Age when periods stopped** (00=not stopped, 99=Unk.)
 If periods now induced by hormones, code age when periods naturally stopped.
 If periods stopped due to pregnancy, breastfeeding, or hormonal contraception code as 0=not stopped

|__| **Was your menopause natural or the result of surgery, chemotherapy, or radiation?**
 (0=still menstruating, 1=natural, 2=surgical, 3=chemo/radiation, 4=other, 9=Unk.)
 If periods stopped due to pregnancy, breast feeding, or hormonal contraception code as 0=still menstruating

MD06

Medical History–Female Reproductive History Part 3

Surgery History

Since your last exam have you had a hysterectomy (uterus/womb removed)?
(0=No, 1=Yes, 9=Unk.)

If yes,
fill

Age at hysterectomy? 99=Unk.

* **Date of surgery (mo/yr)** 99/9999=Unk.

Since last exam have you had an operation to remove one or both of your ovaries?
(0=No, 1=Yes, 9=Unk.)

If yes,
fill

Age when ovaries removed? *If more than one surgery, use age at last surgery* 99=Unk.

Number of ovaries removed? (check one)

1=one ovary

2=two ovaries

3= unknown number of ovaries

4= part of an ovary

Have you since your last exam taken hormone replacement therapy (estrogen/progesterone) or a selective estrogen receptor modulator (such as evista or raloxifene)?
(0=No, 1=Yes, now, 2=Yes, not now, 9=Unk.)

Comments _____

MD07

Medical History--Smoking

Cigarettes	
<input type="checkbox"/>	Since your last exam have you smoked cigarettes regularly? (0=No, 1=Yes, 9=Unk.)
If yes, fill <input type="checkbox"/>	Have you smoked cigarettes regularly in the last year? (<i>No means less than 1 cigarette a day for 1 year.</i>) (0=No, 1=Yes, 9=Unk.)
<input type="checkbox"/>	Do you now smoke cigarettes (as of 1 month ago)? (0=No, 1=Yes, 9=Unk.)
<input type="text"/>	How many cigarettes do you smoke per day now? (99=Unk.)
Questions below refer to "since your last exam"	
<input type="text"/>	During the time you were smoking, on average how many cigarettes per day did you smoke (99=Unk.)
<input type="text"/>	If you have stopped smoking cigarettes completely, how old were you when you stopped? (Age stopped, 00=Not stopped, 99=Unk.)
<input type="checkbox"/>	When you were smoking, did you ever stop smoking for >6 months? (0=No, 1=Yes, 9=Unk.)
If yes, fill <input type="text"/>	For how many years in total did you stop smoking cigarettes (01=6 months - 1 year, 99=Unk.)

Pipes or Cigars		
<input type="checkbox"/>	Since your last exam, have you regularly smoked a pipe or cigar?	0=No 1=Yes 9=Unk.
If yes, fill <input type="checkbox"/>	Do you smoke a pipe or cigar now	

Comments: _____

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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	
If yes, what is your average number of servings in a typical week or month over past year? (999=Unk.) <i>Code alcohol intake as EITHER weekly OR monthly as appropriate.</i>		
Beverage	Per week	Per month
Beer (12oz bottle, glass, can)	<input type="text"/>	<input type="text"/>
Wine (red or white, 4oz glass)	<input type="text"/>	<input type="text"/>
Liquor/spirits (1oz cocktail/highball)	<input type="text"/>	<input type="text"/>

<input type="text"/>	At what age did you stop drinking alcohol? (0= Not stopped, 888=Never drank, 999=Unk.)
----------------------	---

<input type="checkbox"/>	Over the past year, on average on how many days per week did you drink an alcoholic beverage of any type? (0=No drinks, 1=1 or less, 9=Unk.)
<input type="text"/>	Over the past year, on a typical day when you drink, how many drinks do you have? (0=No drinks, 1=1 or less, 99=Unk.)
<input type="text"/>	What was the maximum number of drinks you had in 24 hr. period during the past month? (0=No drinks, 1=1 or less, 99=Unk.)
<input type="checkbox"/>	Since last exam has there been a time when you drank 5 or more alcoholic drinks of any kind almost daily? (0=No, 1=Yes, 9=Unk.)

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

Comments: _____

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MD09

Medical History—Respiratory Symptoms Part I

Cough (0=No, 1=Yes, 9=Unk.)	
<input type="checkbox"/>	Do you usually have a cough? <i>(Exclude clearing of the throat)</i>
<input type="checkbox"/>	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:	
<input type="checkbox"/>	Do you cough like this on most days for three consecutive months or more during the past year?
<input type="checkbox"/>	How many years have you had this cough? (# of years)
	1=1 year or less 99=Unk.

Phlegm (0=No, 1=Yes, 9=Unk.)	
<input type="checkbox"/>	Do you usually bring up phlegm from your chest?
<input type="checkbox"/>	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:	
<input type="checkbox"/>	Do you bring up phlegm from your chest on most days for three consecutive months or more during the year?
<input type="checkbox"/>	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...	
<input type="checkbox"/>	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.
<input type="checkbox"/>	Have you had this wheezing or whistling in the chest when you had a cold?
<input type="checkbox"/>	Have you had this wheezing or whistling in the chest apart from colds?
<input type="checkbox"/>	Have you had an attack of wheezing or whistling in the chest that had made you feel short of breath?

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Medical History—Respiratory Symptoms Part II

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.)	
Since your last exam...	
<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? (Provide details on MD01-Health Care page 41)

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

Comments _____

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MD11

Physical Exam—Blood Pressure

Physician Blood Pressure	
First reading	
Systolic	BP cuff size
□□□□ to nearest 2 mm Hg	□ 0=pedi, 1=reg.adult, 2=large adult, 3= thigh, 9=Unk.
Diastolic	Protocol modification
□□□□ to nearest 2 mm Hg	□ 0=No, 1=Yes, 9=Unk.

Comments for Protocol modification _____

MD12

Medical History—Chest pain

<input type="checkbox"/>	Since your last exam have you experienced any chest discomfort? <i>(please provide narrative comments in addition to completing the appropriate boxes)</i>	0=No, 1=Yes, 2=Maybe, 9=Unk.
if yes, fill and below	<input type="checkbox"/> Chest discomfort with exertion or excitement	
	<input type="checkbox"/> Chest discomfort when quiet or resting	
Chest Discomfort Characteristics		
	<input type="text"/> * <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Date of onset <i>(mo/yr)</i>	99/9999=Unk.
	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Usual duration <i>(minutes)</i>	1=1 min or less, 900=15 hrs or more, 999=Unk.
	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Longest duration <i>(minutes)</i>	1=1 min or less, 900=15 hrs or more, 999=Unk.
	<input type="text"/> Location	0=No, 1=Central sternum and upper chest, 2=L Up Quadrant, 3=L Lower ribcage, 4=R Chest, 5=Other, 6=Combination, 9=Unk.
	<input type="text"/> 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="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Number of episodes of chest pain in past month	999=Unk.
	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Number of episodes of chest pain in past year.	999=Unk.
	<input type="text"/> Type	1=Pressure, heavy, vise, 2=Sharp, 3=Dull, 4=Other, 9=Unk.
	<input type="text"/> Relief by Nitroglycerin in <15 minutes	0=No,
	<input type="text"/> Relief by Rest in <15 minutes	1=Yes,
	<input type="text"/> Relief Spontaneously in <15 minutes	8= <i>Not tried</i>
	<input type="text"/> Relief by Other cause in <15 minutes	9=Unk.

<input type="checkbox"/>	Since your last exam have you been told by a doctor you had a heart attack or myocardial infarction?	0=No, 1=Yes, 2=Maybe, 9=Unk.
if yes, fill	Name of doctor _____	
	Date of visit <input type="text"/> * <input type="text"/> * <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> _____	99/99/9999=Unk.

CHD First Examiner Opinions		
<input type="checkbox"/>	Angina pectoris	0=No, 1=Yes, 2=Maybe, 8=No revascularization 9=Unk.
if yes,fill	<input type="checkbox"/> Angina pectoris since revascularization procedure	
	<input type="checkbox"/> Coronary insufficiency	
	<input type="checkbox"/> Myocardial infarct	

Comments _____

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MD13

Medical History—Atrial Fibrillation/Syncope

Since your last exam or medical history update...				
<input type="checkbox"/>	Have you been told you have/had atrial fibrillation?			0=No, 1=Yes, 2=Maybe, 9=Unk.
if yes, fill ☞	_ _ * _ _ * _ _ _ _	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.
if yes, fill ☞	_____ Name of the Hospital (write Unk. if unknown)			
	_____ Name of M.D. (write Unk. if unknown)			
<hr/>				
<input type="checkbox"/>	Do you have a family history of a heart rhythm problem called atrial fibrillation?			0=No, 1=Yes, 9=Unk
if yes, fill ☞	Mother	Father	Siblings	Children
	_ _	_ _	_ _	_ _
				0=No, 1=Yes, 9=Unk.
<hr/>				
<input type="checkbox"/>	Have you fainted or lost consciousness?			0=No, 1=Yes, 2=Maybe, 9=Unk..
	<i>(If event immediately preceded by head injury or accident code 0=No)</i>			
if yes, fill all ☞	_ _ _	Number of episodes in the past two years		999=Unk.
	_ _ * _ _ _ _	Date of first episode (mo/yr)		99/9999=Unk.
	_ _ _	Usual duration of loss of consciousness (minutes)		999=Unk., 1=1 min or less
<input type="checkbox"/>	Did you have any injury caused by the event?			0=No, 1=Yes, 2=Maybe, 9=Unk.
<input type="checkbox"/>	ER/hospitalized or saw M.D.			0=No, 1=Hosp/ER, 2=Saw M.D., 9=Unk.
if yes, fill ☞	_____ Name of the Hospital (write Unk.. if unknown)			
	_____ Name of M.D. (write Unk. if unknown)			
<hr/>				
<input type="checkbox"/>	Have you had a head injury with loss of consciousness?			0=No, 1=Yes, 2=Maybe, 9=Unk.
if yes, fill ☞	_ _ * _ _ * _ _ _ _	Date of serious head injury with loss of consciousness		99/99/9999=Unk.
<hr/>				
<input type="checkbox"/>	Have you had a seizure?			0=No, 1=Yes, 2=Maybe, 9=Unk.
if yes, fill ☞	_ _ * _ _ * _ _ _ _	Date of most recent seizure		99/99/9999=Unk.
<input type="checkbox"/>	Are you being treated for a seizure disorder?			0=No, 1=Yes, 2=Maybe, 9=Unk.

Syncope First Examiner Opinion			
<input type="checkbox"/>	Syncope (0=No, 1=Yes, 2=Maybe, 3=Presyncope, 9=Unk.) <i>needs second opinion</i>		
if yes, fill ☞	_ _	Cardiac syncope	0=No,
	_ _	Vasovagal syncope	1=Yes,
	_ _	Other-Specify: _____	2=Maybe,
			9=Unk.

Comments: _____

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MD14

Medical History—Cerebrovascular Diseases

Since your last exam or medical history update have you had...		
<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,
<input type="checkbox"/>	Sudden loss of vision in one eye	9=Unk.
<input type="checkbox"/>	Sudden numbness, tingling	9=Unk.
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"/> <input type="text"/> <input type="text"/> <input type="text"/> Date	99/99/9999=Unk.
	_____ Place	
<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"/> <input type="text"/> <input type="text"/> <input type="text"/> Date	99/99/9999=Unk.
	_____ Place	
<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,
<input type="checkbox"/>	Have you been told by a doctor you have Parkinson Disease?	1=Yes,
<input type="checkbox"/>	Have you been told by a doctor you have memory problems, dementia or Alzheimer's disease?	2=Maybe,
<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?	9=Unk.
<input type="checkbox"/>	Do you feel like your memory is becoming worse?	

Cerebrovascular Disease First Examiner Opinion		
<input type="checkbox"/>	TIA or stroke took place	0=No, 1=Yes,2=Maybe, 9=Unk.
if yes or maybe fill	<input type="text"/> * <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Date (mo/yr, 99/9999=Unk.)	
	<input type="text"/> * <input type="text"/> * <input type="text"/> Observed by _____	
	<input type="text"/> * <input type="text"/> * <input type="text"/> Duration (use format days/hours/mins, 99/99/99=Unk.)	
<input type="checkbox"/>	Hospitalized or saw M.D. (0=No, 1=Hosp.,2=Saw M.D, 9=Unk.)	
	Name _____	
	Address _____	

Comments _____

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MD15

Medical History--Venous and Peripheral Arterial Disease

Venous Disease		
Since your last exam or medical history update have you had...		
<input type="checkbox"/>	Deep Vein Thrombosis - DVT (blood clots in legs or arms)	0=No,1=Yes,
<input type="checkbox"/>	Pulmonary Embolus – PE (blood clot in lungs)	2=Maybe, 9=Unk.

Peripheral Arterial Disease		
Since your last exam have you had...		
<input type="checkbox"/>	Do you get discomfort in either leg on walking? (0=No, 1=Yes, 9=Unk.)	
<input type="checkbox"/>	Does this discomfort ever begin when you are standing still or sitting? (0=no, 1=yes, 9=Unk.)	
<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.) where 10 blocks=1 mile, code as no if more than 98 blocks required to develop symptoms	
<input type="checkbox"/>	<input type="checkbox"/>	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"/>	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?	
<input type="checkbox"/>	What do you do if you get discomfort when you are walking? (1=stop, 2=slow down, 3=continue at same pace, 9=Unk.)	
<input type="checkbox"/>	Time for discomfort to be relieved by stopping (minutes) (000=No relief with stopping, 999=Unk.)	
<input type="checkbox"/>	Number of days/month of lower limb discomfort (1=1 day/month or less, 99=Unk.)	
<input type="checkbox"/>	Since your last exam have you been told by a doctor you have intermittent claudication or peripheral artery disease? (0=No, 1=Yes, 9=Unk.)	
<input type="checkbox"/>	Name of doctor _____	
<input type="checkbox"/>	Date of visit <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> * <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> *	99/99/9999=Unk.
<input type="checkbox"/>	Since your last exam have you been told by a doctor you have spinal stenosis? (0=No, 1=Yes, 9=Unk.)	

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

Comments

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MD16

Medical History-- CVD Procedures

Since your last exam or medical history update did you have any of the following cardiovascular procedures?	
0=No, 1=Yes 2=Maybe, 9=Unk.	Cardiovascular Procedures <i>(if procedure was repeated code only first and provide narrative)</i>
<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"/>	AICD
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_____

Write in other procedures, year done, and location if more than one.

Comments: _____

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MD17

Physical Exam—Blood Pressure

Physician 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	<input type="text"/> 0=pedi, 1=reg.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	<input type="text"/> 0=No, 1=Yes, 9=Unk.

Comments for Protocol modification _____

History of Kidney Disease	
<input type="text"/>	Have you had a kidney stone in the past 10 years? (0=No, 1=Yes, 9=Unk.)
if yes, fill	<input type="text"/> ER/hospitalized or saw M.D. (0=No, 1=Hosp/ER, 2=Saw M.D., 9=Unk.)
if yes, fill	_____ Name of the Hospital (write Unk.. if unknown)
	_____ Name of M.D. (write Unk. if unknown)

Offspring Exam9, Omni1 Exam4 «IDType»-«ID» «LName», «FName» 88
MD18

Cancer Site or Type

Since your last exam or medical history update have you had a cancer or a tumor?
 (0=No and skip to next page MD20; 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/State 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)

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MD19

Physical Exam—Respiratory, Heart, Abdomen

OFFSITE VISIT – leave page BLANK

Respiratory		
<input type="checkbox"/>	Wheezing on auscultation	0=No,
<input type="checkbox"/>	Rales	1=Yes,
<input type="checkbox"/>	Abnormal breath sounds	2=Maybe,
		9=Unk.

Heart		
<input type="checkbox"/>	S3 Gallop	0=No,
<input type="checkbox"/>	S4 Gallop	1=Yes,
<input type="checkbox"/>	Systolic Click	2=Maybe,
<input type="checkbox"/>	Neck vein distention at 90 degrees (sitting upright)	9=Unk.

Systolic murmur(s)				
<input type="checkbox"/> if yes, fill below				0=No, 1=Yes, 2=Maybe, 9=Unk.
Murmur Location	Grade	Type	Radiation	Origin
	0=No sound 1 to 6 for grade of sound heard 9=Unk.	0=None 1=Ejection 2=Regurgitant 3=Other 9=Unk.	0=None 1=Axilla 2=Neck 3=Back 4=Rt. chest 9=Unk.	0=None, indet. 1=Mitral 2=Aortic 3=Tricuspid 4=Pulm 9=Ukn.
Apex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Left Sternum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Base	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diastolic murmur(s)				
<input type="checkbox"/> if yes, fill	<input type="checkbox"/>	Valve of origin for diastolic murmur(s) (1=Mitral, 2=Aortic, 3=Both, 4=Other, 8=N/A, 9=Unk)		0=No, 1=Yes, 2=Maybe, 9=Unk.

Abdominal Abnormalities		
<input type="checkbox"/>	Liver enlarged	0=No,
<input type="checkbox"/>	Surgical scar	1=Yes,
<input type="checkbox"/>	Abdominal aneurysm	2=Maybe,
<input type="checkbox"/>	Abdominal bruit	9=Unk.

Comments _____

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Physical Exam--Peripheral Vessels—Veins and Arterial pulses

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Left	Right	Lower Extremity Abnormalities
<input type="checkbox"/>	<input type="checkbox"/>	Stem varicose veins (Do not code reticular or spider varicosities) (0=No abnormality 1=Yes 9=Unk.)
<input type="checkbox"/>	<input type="checkbox"/>	Ankle edema (0=No, 1=Yes, 2=Maybe, 8=absent due to amputation 9=Unk.)
<input type="checkbox"/>	<input type="checkbox"/>	Amputation level (0=No, 1=Toes only, 2=Foot, 3=below Knee, 4=above Knee, 5= Other, write in _____, 9=Unk.)

Artery	Pulse		Bruit	
	(0=Normal, 1=Abnormal, 9=Unk.)		(0=Normal, 1=Abnormal, 9=Unk.)	
	Left	Right	Left	Right
Femoral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Popliteal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post Tibial	<input type="checkbox"/>	<input type="checkbox"/>		
Dorsalis Pedis	<input type="checkbox"/>	<input type="checkbox"/>		

Comments _____

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Physical Exam--Neurological Exam

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Neurological Exam		
Left	Right	
<input type="checkbox"/>	<input type="checkbox"/>	Carotid Bruit
	<input type="checkbox"/>	Speech disturbance
	<input type="checkbox"/>	Disturbance in gait
	<input type="checkbox"/>	Other neurological abnormalities on exam
	<input type="checkbox"/>	Specify _____

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

Comments _____

Electrocardiograph--Part I

OFFSITE ONLY		
<input style="width: 100%;" type="text"/>	MD Id#	ID Name

Rates and Intervals		
<input style="width: 100%;" type="text"/>	Ventricular rate per minute	(999=Unk.)
<input style="width: 100%;" type="text"/>	P-R Interval (milliseconds)	(999=Fully Paced, Atrial Fib, or Unk.)
<input style="width: 100%;" type="text"/>	QRS interval (milliseconds)	(999=Fully Paced, Unk.)
<input style="width: 100%;" type="text"/>	Q-T interval (milliseconds)	(999=Fully Paced, Unk.)
<input style="width: 100%;" type="text"/>	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	
<input style="width: 100%;" type="text"/>	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		
<input style="width: 100%;" type="text"/>	IV Block	(0=No, 1=Yes, 9=Fully paced or Unk.)
if yes, fill	<input style="width: 100%;" type="text"/> Pattern	(1=Left, 2=Right, 3=Indeterminate, 9=Unk.)
	<input style="width: 100%;" type="text"/> Complete (QRS interval=.12 sec or greater)	(0=No, 1=Yes, 9=Unk.)
	<input style="width: 100%;" type="text"/> Incomplete (QRS interval = .10 or .11 sec)	(0=No, 1=Yes, 9=Unk.)
<input style="width: 100%;" type="text"/>	Hemiblock	(0=No, 1=Left Ant, 2=Left Post, 9=Fully paced or Unk.)
<input style="width: 100%;" type="text"/>	WPW Syndrome	(0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unk.)

Arrhythmias		
<input style="width: 100%;" type="text"/>	Atrial premature beats	(0=No, 1=Atr, 2=Atr Aber, 9=Unk.)
<input style="width: 100%;" type="text"/>	Ventricular premature beats	(0=No, 1=Simple, 2=Multifoc, 3=Pairs, 4=Run, 5=R on T, 9=Unk.)
<input style="width: 100%;" type="text"/>	Number of ventricular premature beats in 10 seconds (see 10 second rhythm strip)	

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Electrocardiograph-Part II

Myocardial Infarction Location		
<input type="checkbox"/>	Anterior	0=No,
<input type="checkbox"/>	Inferior	1=Yes,
<input type="checkbox"/>	True Posterior	2=Maybe,
		9=Fully paced or Unk.

Left Ventricular Hypertrophy Criteria		
<input type="checkbox"/>	R > 20mm in any limb lead	0=No,
<input type="checkbox"/>	R > 11mm in AVL	1=Yes,
<input type="checkbox"/>	R in lead I plus S in lead III ≥ 25mm	9=Fully paced, Complete LBBB or Unk.
Measured Voltage		
* <input type="checkbox"/>	R AVL in mm (at 1 mv = 10 mm standard) Be sure to code these voltages	
* <input type="checkbox"/>	S V3 in mm (at 1 mv = 10 mm standard) Be sure to code these voltages	
R in V5 or V6-----S in V1 or V2		
<input type="checkbox"/>	R ≥ 25mm	0=No,
<input type="checkbox"/>	S ≥ 25mm	
<input type="checkbox"/>	R or S ≥ 30mm	1=Yes,
<input type="checkbox"/>	R + S ≥ 35mm	
<input type="checkbox"/>	Intrinsicoid deflection ≥.05 sec	9=Fully paced, Complete LBBB or Unk.
<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 OR LBBB 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 _____

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Clinical Diagnostic Impression--Part I

Heart Diagnoses		
<input type="checkbox"/>	Rheumatic Heart Disease	0=No,
<input type="checkbox"/>	Aortic Valve Disease	1=Yes,
<input type="checkbox"/>	Mitral Valve Disease	2=Maybe,
<input type="checkbox"/>	Arrhythmia	
<input type="checkbox"/>	Other Heart Disease (includes congenital)	9=Unk.
(Specify)_____		

Peripheral Vascular Disease		
<input type="checkbox"/>	Other Peripheral Vascular Disease	0=No,
<input type="checkbox"/>	Other Vascular Diagnosis	1=Yes,
		2=Maybe,
		9=Unk.
(Specify)_____		

Neurological Disease		
<input type="checkbox"/>	Stroke/ TIA	0=No,
<input type="checkbox"/>	Dementia	
<input type="checkbox"/>	Parkinson's Disease	1=Yes,
<input type="checkbox"/>	Adult Seizure Disorder	2=Maybe,
<input type="checkbox"/>	Migraine	
<input type="checkbox"/>	Other Neurological Disease	9=Unk.
(Specify)_____		

Comments _____

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Clinical Diagnostic Impression--Part II. Non Cardiovascular Diagnoses

Endocrine		
<input type="checkbox"/>	Thyroid Disease	0=No, 1=Yes, 2=Maybe, 9=Unk.
<input type="checkbox"/>	Diabetes Mellitus	
<input type="checkbox"/>	Other endocrine disorders, specify _____	
GU/GYN		
<input type="checkbox"/>	Renal disease, specify _____	0=No, 1=Yes, 2=Maybe, 8=male/female 9=Unk.
<input type="checkbox"/>	Prostate disease	
<input type="checkbox"/>	Gynecologic problems, specify _____	
Pulmonary		
<input type="checkbox"/>	Emphysema	0=No, 1=Yes, 2=Maybe, 9=Unk.
<input type="checkbox"/>	Pneumonia	
<input type="checkbox"/>	Asthma	
<input type="checkbox"/>	Other pulmonary disease, specify _____	
Rheumatologic Disorders		
<input type="checkbox"/>	Gout	0=No, 1=Yes, 2=Maybe, 9=Unk.
<input type="checkbox"/>	Degenerative joint disease	
<input type="checkbox"/>	Rheumatoid arthritis	
<input type="checkbox"/>	Other musculoskeletal or connective tissue disease, specify _____	
GI		
<input type="checkbox"/>	Gallbladder disease	0=No, 1=Yes, 2=Maybe, 9=Unk.
<input type="checkbox"/>	GERD/ulcer disease	
<input type="checkbox"/>	Liver disease	
<input type="checkbox"/>	Other GI disease, specify _____	
Blood		
<input type="checkbox"/>	Hematologic disorder	0=No, 1=Yes, 2=Maybe, 9=Unk.
<input type="checkbox"/>	Bleeding disorder	
Infectious Disease		
<input type="checkbox"/>	Infectious Disease	0=No, 1=Yes, 2=Maybe, 9=Unk.
if yes ☞	specify _____	
Mental Health		
<input type="checkbox"/>	Depression	0=No, 1=Yes, 2=Maybe, 9=Unk.
<input type="checkbox"/>	Anxiety	
<input type="checkbox"/>	Psychosis	
<input type="checkbox"/>	Other Mental health, specify _____	
Other		
<input type="checkbox"/>	Eye	0=No, 1=Yes, 2=Maybe, 9=Unk.
<input type="checkbox"/>	ENT	
<input type="checkbox"/>	Skin	
<input type="checkbox"/>	Other, specify _____	

Comments

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Second Examiner Opinions
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_ _ _	2nd Examiner ID number _____	2nd Examiner Last Name _____
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Coronary Heart Disease			
(Provide initiators, qualities, radiation, severity, timing, presence after procedures done)			
Item requires 2nd opinion <i>Check ALL that apply.</i>	2nd opinion		
<input type="checkbox"/>	_	Congestive Heart Failure	0=No,
<input type="checkbox"/>	_	Cardiac Syncope	1=Yes,
<input type="checkbox"/>	_	Angina Pectoris	2=Maybe,
<input type="checkbox"/>	_	Coronary Insufficiency	9=Unk.
<input type="checkbox"/>	_	Myocardial Infarct	

Comments about heart disease _____

Intermittent Claudication			
(Provide initiators, qualities, radiation, severity, timing, presence after procedures done)			
Item requires 2nd opinion <i>Check ALL that apply.</i>	2nd opinion		
<input type="checkbox"/>	_	Intermittent Claudication	0=No, 1=Yes, 2=Maybe, 9=Unk.

Comments about peripheral artery disease _____

Cerebrovascular Disease			
(Provide initiators, qualities, severity, timing, presence after procedures done)			
Item requires 2nd opinion <i>Check ALL that apply.</i>	2nd opinion		
<input type="checkbox"/>	_	Stroke	0=No, 1=Yes,
<input type="checkbox"/>	_	TIA	2=Maybe, 9=Unk.

Comments about possible cerebrovascular disease _____

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