OMB #: 0925–0216
Expiration Date: xx/xxxx

# Numerical Data (Anthropometry)

|__| Check here if whole page is blank. Reason why_____

|__|__|__| **Technician Number**.

## Basic Information

*Check **Protocol Modification** ONLY if there was one and document it in Comment section*

| | | |
|---|---|---|
| |__| | **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.) *if not Exam date* |
| |__|__|*|__|__| | **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:

_____

_____

_____

_____

**TECH01**

OMB #: 0925–0216
Expiration Date: xx/xxxx

|__| Check here if whole page is blank. Reason why_____

|__|__|__| **Technician Number**.

## EXAM 32 Procedures Sheet

| | | |
|---|---|---|
| |__| | **ECG** | |
| |__| | **Physician Medical History (Tech. Medical History, off-site)** | |
| |__| | **Observed Physical Performance** | 0=No |
| |__| | **CES-D, 10-item** | |
| |__| | **MMSE** | 1=Yes |
| |__| | **Physical function: Katz, Rosow-Breslau, Nagi, IADL** | |
| |__| | **Leisure Time Cognitive and Physical Activities** | 9=Unk. |
| |__| | **Height** 8=not done due to offsite visit | |
| |__| | **Weight** | |
| |__| | **Socio-demographic, Nursing (Community) Services Use** | |

## Adverse Events

|__|__|__| **Technician ID#**

|__| **Was there an adverse event in clinic/offsite exam that does not require further medical evaluation?** (0=No, 1=Yes, 9=Unk.)
**Comments:**_____

|__| **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

|__|__|__| **Technician ID**

| | | | |
|---|---|---|---|
| | |__| | **Procedure Sheet Review** | 0=No |
| | |__| | **Referral Sheet Review** | |
| | |__| | **Left Clinic with all belongings** 8=n/a, offsite | 1=Yes |
| | |__| | **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**

OMB #: 0925–0216
Expiration Date: xx/xxxx

# Observed performance. Part 1 Technician Administered

| | |
|---|---|
| \|__\| Check here if whole page is blank. Reason why_____ | |
| \|__\|__\|__\| | **Technician Number** |

| **HAND GRIP TEST** *Measured to the nearest kilogram* | | |
|---|---|---|
| **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. | |

| **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 2=Refused | 3=Other _____write in 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 2=Refused | 3=Other _____write in 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 2=Refused | 3=Other _____write in 9=Unk. | \|__\| |

**TECH03**

OMB #: 0925–0216
Expiration Date: xx/xxxx

# Observed performance. Part 2 Technician Administered

|__| Check here if whole page is blank. Reason why_____

| |__|__|__| | **Technician Number** |
|---|---|

## Repeated Chair Stands

| | |
|---|---|
| **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.) | |__|__|*|__|__| |
| |__| **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. | |

## Measured Walks

| | | |
|---|---|---|
| **Course in meters.** *OFFSITE ONLY* *(check one)* | |__| **3m** | |__| **4m** |
| **Walking aid used: (0=No aid, 1=Cane, 2=Walker, 3=Other, 9=Unk.)** | |__| | |

### First Walk

| | |
|---|---|
| **Walk time** (in seconds, 99.99=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.) | |

### Second Walk

| | |
|---|---|
| **Walk time** (in seconds, 99.99=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.) | |

### Quick Walk

| | |
|---|---|
| **Walk time** (in seconds, 99.99=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.) | |

**TECH04**

OMB #: 0925–0216
Expiration Date: xx/xxxx

# 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.** *(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**

OMB #: 0925–0216
Expiration Date: xx/xxxx

# Mini-Mental State Exam

|__| Check here if whole page is blank. Reason why_____

| SCORE CORRECT<br>No Try=6, Unk.=9 | Write all responses on exam form.<br>(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,<br>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**

OMB #: 0925–0216
Expiration Date: xx/xxxx

# Mini-Mental State Exam

## Sentence and Design Handout for Participant

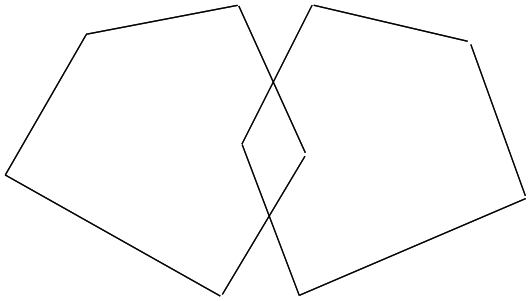
PLEASE WRITE A SENTENCE

_____

_____

_____

PLEASE COPY THIS DESIGN



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# Socio-demographics

|__| Check here if whole page is blank. Reason why_____

| | |
|---|---|
| |__|__|__| | **Technician Number** for Socio-demographics |

## Socio-demographics

| | | | |
|---|---|---|---|
| |__| **Where do you live?** (0=Private residence, 1=Nursing home, 2=Other institution, such as: assisted living or retirement community, 9=Unk.) | |
| |__| **Does anyone live with you?** (0=No, 1=Yes, 9=Unk.)<br>Code Nursing Home Residents as NO to these questions | |
| **If Yes ☛**<br>**If 0 or 9, skip down** | |__| Spouse | 0=No<br>1=Yes<br>9=Unk. |
| | |__| Children | |
| | |__| Other Relatives | |
| |__| **Are you Currently doing volunteer or community work?** (0=No, 1=Yes.) | |
| |__| **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 ***** |
| |__| | **In general, how is your health now**: (1=Excellent, 2=Good, 3=Fair, 4=Poor, 9=Unk) |
| |__| | **Compare your health to most people your own age:**<br>(1=Better, 2=About the same, 3=Worse than most people your own age, 9=Unk.) |
| |__| | **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**

OMB #: 0925–0216
Expiration Date: xx/xxxx

# 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**

OMB #: 0925–0216
Expiration Date: xx/xxxx

# Self-Reported Physical Function.

|__| 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.*

| | |
|---|---|
| |__|__|__| | **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.

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

## Rosow-Breslau Questions

| | | |
|---|---|---|
| |__| | **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<br>1=Yes, able<br>2=Does not do<br>9=Unk. |
| |__| | **Are you able to walk half a mile without help?** (About 4-6 blocks) | |
| **if NO then ☞** | |__| | **Are you able to walk a quarter of a mile without help?** (About 2-3 blocks) | |
| |__| | **Are you able to walk up and down stairs to the second floor without any help?** | |
| **if NO then ☞** | |__| | **Are you able to climb up 10 steps without help?** | |
| |__| | **Do you drive now?** (0=No, 1=Yes, 9=Unk) | |
| **if NO then ☞** | |__| | **Reason for not driving now** (1=Health, 2=Other non-health reason, 3=never licensed, 9=Unk.) | |

**TECH09**

OMB #: 0925–0216
Expiration Date: xx/xxxx

# Self-Reported Physical Function.

|__| Check here if whole page is blank. Reason why_____

| | |
|---|---|
| |__|__|__| | **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.)

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

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# Activities Questions.

|__| Check here if whole page is blank. Reason why_____

|__|__|__| **Technician Number** for Activities Questions

## Use of Nursing and Community Services

|__| **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.)

|__| **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☞**

- |__| **Home health aides**
- |__| **Homemaker visits**
- |__| **Visiting Nurses**
- |__| **Other** (write in)_____

|__| **Are you in bed or a chair for most or all of the day (on the average)?**
(0=No, 1=Yes, 9=Unk.)

|__| **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?**

- |__| **Cane or walking stick**
- |__| **Wheelchair**
- |__| **Walker**
- |__| **Other** (Write in )_____

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

**TECH11**

OMB #: 0925–0216
Expiration Date: xx/xxxx

# 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?** *(code as no if during sports activity)* (0=No, 1=Yes, 2=Maybe, 9=Unk)

**if yes, fill ☞**

|__|__| **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?** (0=No, 1=Yes, 2=Maybe, 9=Unk.)

**If 1 or 2, fill ☞**

|__|__| **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**

OMB #: 0925–0216
Expiration Date: xx/xxxx

# 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?

| ***Questions to be answered*** ***Circle best answer for each question*** | **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**

OMB #: 0925–0216
Expiration Date: xx/xxxx

# 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.

| | Circle best answer for each question | | | |
|---|---|---|---|---|
| **DURING THE PAST WEEK** | **Rarely or none of the time (less than 1 day)** | **Some or a little of the time (1-2 days)** | **Occasionally or moderate amount of time (3-4 days)** | **Most 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**

OMB #: 0925–0216
Expiration Date: xx/xxxx

# Proxy form

| | |
|---|---|
| \|__\| | **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** _____ |
| | \|__\| **Relationship** (1=1st Degree Relative(spouse, child), 2=Other Relative, 3=Friend, 4=Health Care Professional, 5=Other, 9=Unk. |
| | \|__\|__\|*****\|__\|__\| **How long have you known the participant?** (Years, months; 99.99=Unk) example: 3m=00*03 |
| | \|__\| **Are you currently living in the same household with the participant?** (0=No, 1=Yes, 9=Unk) |
| | \|__\| **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** _____ |
| | \|__\| **Relationship** (1=1st Degree Relative(spouse, child), 2=Other Relative, 3=Friend, 4=Health Care Professional, 5=Other, 9=Unk. |
| | \|__\|__\|*****\|__\|__\| **How long have you known the participant?** (Years, months; 99.99=Unk) example: 3 m=00*03 |
| | \|__\| **Are you currently living in the same household with the participant?** (0=No, 1=Yes, 9=Unk) |
| | \|__\| **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**

OMB #: 0925–0216
Expiration Date: xx/xxxx

**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.*

OMB #: 0925–0216
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# 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)*. | |
|---|---|---|
| |__| | **Blood Pressure**<br>**result** _____/_____ mmHg<br>_____/_____ mmHg | SBP or DBP<br>Phone call ≥ 200 or ≥110<br>Expedite ≥ 180 or ≥100<br>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**

OMB #: 0925–0216
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# 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** (*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.) |
| \|__\|__\| \|__\|__\| \|__\|__\|__\|__\| 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 |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**MD01**

OMB #: 0925–0216
Expiration Date: xx/xxxx

# Medical History—Medications

| Since your last exam (0=No, 1=Yes, now, 2=Yes, not now, 9=Unk.) | |
|---|---|
| |__| | **Have you taken medication for the treatment of hypertension? (high blood pressure)** |
| |__| | **Have you taken medication for the treatment of high blood cholesterol or high triglycerides?** |
| |__| | **Have you taken medication for the treatment of high blood sugar or diabetes?** |

## Aspirin use

|__| **Take aspirin regularly**? (0=No, 1=Yes, 9=Unk)

**If yes, fill ☞**

| | | |
|---|---|---|
| |__|__| | **Number of aspirins taken regularly** (99=Unk.) | |
| |__| | **Aspirin frequency**- number taken regularly (0=Never, 1=Day, 2=Week 3=Month, 4=Year, 9=Unk) | |
| **|__|__|__|** | **Usual dose** (write in mgs, 999=Unk.) | Examples: 081=baby,160=half dose, 250= like in Excedrin , 325=usual dose, 500=extra strength |

**MD02**

OMB #: 0925–0216
Expiration Date: xx/xxxx

# 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) # | **Number per** (circle one) day/week/month/year 1 / 2 / 3 / 4 | **PRN** 0=no, 1=yes,9=Unk. | **Check if OTC med** |
|---|---|---|---|---|---|---|
| **EXAMPLE:** S A M P L E D R U G N A M E | 100 mg | 1 | 1 | D W M Y | 0 | ☐ |
| | | | | D W M Y | | ☐ |
| | | | | D W M Y | | ☐ |
| | | | | D W M Y | | ☐ |
| | | | | D W M Y | | ☐ |
| | | | | D W M Y | | ☐ |
| | | | | D W M Y | | ☐ |
| | | | | D W M Y | | ☐ |
| | | | | D W M Y | | ☐ |
| | | | | D W M Y | | ☐ |
| | | | | D W M Y | | ☐ |

**Continue on the next page⇢**

OMB #: 0925–0216
Expiration Date: xx/xxxx

# 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) # | **Number per** (circle one) day/week/month/year 1 / 2 / 3 / 4 | **PRN** 0=no, 1=yes, 9-Unk | **Check if OTC med.** |
|---|---|---|---|---|---|---|
| **EXAMPLE:** SAMPLE DRUG NAME | 100 mg | 1 | 1 | D W M Y | 0 | ☐ |
| | | | | D W M Y | | ☐ |
| | | | | D W M Y | | ☐ |
| | | | | D W M Y | | ☐ |
| | | | | D W M Y | | ☐ |
| | | | | D W M Y | | ☐ |
| | | | | D W M Y | | ☐ |
| | | | | D W M Y | | ☐ |
| | | | | D W M Y | | ☐ |
| | | | | D W M Y | | ☐ |
| | | | | D W M Y | | ☐ |
| | | | | D W M Y | | ☐ |
| | | | | D W M Y | | ☐ |
| | | | | D W M Y | | ☐ |
| | | | | D W M Y | | ☐ |
| | | | | D W M Y | | ☐ |

**MD04**

OMB #: 0925–0216
Expiration Date: xx/xxxx

# Medical History–Blood Pressure, Smoking

| **Blood Pressure** (first reading) | |
|---|---|
| **Systolic** | **BP cuff size** |
| \|__\|__\|__\| to nearest 2 mm Hg 999=Unk. | \|__\| 0=pediatric,1=regular adult, 2=large adult, 3= thigh, 9=Unk. |
| **Diastolic** | **Protocol modification** |
| \|__\|__\|__\| to nearest 2 mm Hg 999=Unk. | \|__\| 0=No, 1=Yes, 9=Unk. write in _____ |

| **Smoking** | | |
|---|---|---|
| \|__\| | **Have you smoked cigarettes regularly since your last exam?** | 0=No, 1=Yes, now, 2=Yes, not now, 9=Unk. |
| **if yes fill** ☞ | \|__\|__\| **How many cigarettes do/did you smoke a day?** (01=one or less, 99=Unk.) | |

**MD05**

OMB #: 0925–0216
Expiration Date: xx/xxxx

## 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.) | |
|---|---|
| |__| | **Beer** |
| |__| | **Wine** |
| |__| | **Liquor/spirits** |

**What is your average number of servings in a typical week or month since your last exam?**
(999=Unk.)
*Code alcohol intake as EITHER weekly OR monthly as appropriate.*

| Beverage | Per week | Per month |
|---|---|---|
| **Beer** (12oz bottle, glass, can) | |__|__|__| | |__|__|__| |
| **Wine** (red or white, 4oz glass) | |__|__|__| | |__|__|__| |
| **Liquor/spirits** (1oz cocktail/highball) | |__|__|__| | |__|__|__| |

|__| **Check if over past year participant drinks less than one alcoholic drink of any type per month.**

**MD06**

OMB #: 0925–0216
Expiration Date: xx/xxxx

# 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**

OMB #: 0925–0216
Expiration Date: xx/xxxx

# Medical History—Respiratory Symptoms. Part 2

## Nocturnal chest symptoms (0=No, 1=Yes, 9=Unk.)

**In the past 12 months…**

|__| **Have you been awakened by shortness of breath?**

|__| **Have you been awakened by a wheezing/whistling in your chest?**

|__| **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.)

|__| **Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill?**

**if yes, fill all☞**

|__| **Do you have to walk slower than people of your age on level ground because of shortness of breath?**

|__| **Do you have to stop for breath when walking at your own pace on level ground?**

|__| **Do you have to stop for breath after walking 100 yards (or after a few minutes) on level ground?**

|__| **Do you/have you needed to sleep on two or more pillows to help you breathe (Orthopnea)?**

|__| **Have you since last exam had swelling in both your ankles (ankle edema)?**

|__| **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.

|__| **Have you been hospitalized for heart failure?**

**if yes, fill ☞**

**Name of hospital** _____

**Date of visit** |__|__|*|__|__|*|__|__|__|__| 99/99/9999=Unk.

## Examiner Opinion

|__| **First examiner believes CHF** 0=No,1=Yes 2=Maybe, 9=Unk.

**Comments**_____

_____

OMB #: 0925–0216
Expiration Date: xx/xxxx

# Medical History—Heart

| | | | | |
|---|---|---|---|---|
| |__| | **Any chest discomfort since last exam or medical history update?** (0=No, 1=Yes, 2=Maybe, 9=Unk.) *(please provide narrative comments in addition to checking the appropriate boxes)* | | |
| **if yes, fill☞ and below** | |__| | **Chest discomfort with exertion or excitement** | (0=No, 1=Yes, 2=Maybe, 9=Unk.) |
| | |__| | **Chest discomfort when quiet or resting** | (0=No, 1=Yes, 2=Maybe, 9=Unk.) |

## Chest Discomfort Characteristics *(must have checked box at top of table)*

| | | |
|---|---|---|
| |__|__|*|__|__|__|__| | **Date of onset** | mo/yr, 99/9999=Unk. |
| |__|__|__| | **Usual duration (min)** | 1=1 min or less, 900=15 hrs or more, 999=Unk. |
| |__|__|__| | **Longest duration (min)** | 1=1 min or less, 900=15 hrs or more, 999=Unk. |
| |__| | **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. |
| |__| | **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. |
| |__|__|__| | **Frequency (number in past month)** | 999=Unk. |
| |__|__|__| | **Frequency (number in past year)** | 999=Unk. |
| |__| | **Type** | 1=Pressure, heavy, vise, 2=Sharp, 3=Dull, 4=Other, 9=Unk |

| | | |
|---|---|---|
| |__| | **Relief by Nitroglycerine in <15 minutes** | 0=No 1=Yes, 8=Not tried 9=Unk. |
| |__| | **Relief by Rest in <15 minutes** | |
| |__| | **Relief Spontaneously in <15 minutes** | |
| |__| | **Relief by Other cause in <15 minutes** | |

**MD09**

OMB #: 0925–0216
Expiration Date: xx/xxxx

# Medical History—Heart (Continued)

| | |
|---|---|
| |__| | **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. |
| |__| | **Have you been hospitalized for heart attack?** |
| **if yes, fill ☞** | **Name of hospital** _____ |
| | **Date of visit** |__|__|*|__|__|*|__|__|__|__| 99*99*9999=Unk. |

## CHD First Opinions

|__| **Angina pectoris in interim**

|__| **Angina pectoris since revascularization procedure**

|__| **Coronary insufficiency in interim**

|__| **Myocardial infarct in interim**

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

**Comments**_____

_____

_____

_____

**MD10**

OMB #: 0925–0216
Expiration Date: xx/xxxx

# Medical History—Atrial Fibrillation/Syncope

|__| **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** ☞

|__|__|*|__|__|*|__|__|__|__| **Date of first episode** (99/99/9999=Unk.)

|__| **ER/hospitalized or saw M.D.** (0=No, 1=Hosp/ER, 2=Saw M.D., 9=Unk.)

**Hospitalized at**:_____

**M.D. seen:** _____

|__| **Have you fainted or lost consciousness since your last exam?**
*(If due to stroke skip to screen 11)*
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** ☞

|__|__|__| 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.)

|__| Did you have any injury caused by the event? (0=No, 1=Yes, 2=Maybe, 9=Unk.)

**if yes, fill** ☞ |__| 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

|__| **Syncope** (0=No, 1=Yes, 2=Maybe, 3=Presyncope, 9=Unk.)

|__| **Cardiac syncope**

|__| **Vasovagal syncope**

|__| **Other-Specify: _____**

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

|__| **Seizure Disorder** (0=No, 1=Yes, 2=Maybe,, 9=Unk.)

Comments _____

_____

_____

_____

_____

**MD11**

OMB #: 0925–0216
Expiration Date: xx/xxxx

# Medical History—Cerebrovascular Disease

## Cerebrovascular Episodes in Interim

| | | |
|---|---|---|
| |__| **Sudden muscular weakness** | 0=No, 1=Yes, 2=Maybe, 9=Unk. |
| |__| **Sudden speech difficulty** | |
| |__| **Sudden visual defect** | |
| |__| **Sudden double vision** | |
| |__| **Sudden loss of vision in one eye** | |
| |__| **Sudden numbness, tingling** | |
| **if yes, fill ☞** | |__| Numbness and tingling is positional | |
| |__| **Head CT scan *OTHER THAN FOR THE FHS*** | 0=No,1=Yes, 2= Maybe,9=Unk. |
| **if yes, fill ☞** | |__|__| * |__|__| * |__|__|__|__| **Date** | 99/99/9999=Unk. |
| | _____ **Place** | |
| |__| **Head MRI scan *OTHER THAN FOR THE FHS*** | 0=No,1=Yes, 2= Maybe,9=Unk. |
| **if yes, fill ☞** | |__|__| * |__|__| * |__|__|__|__| **Date** | 99/99/9999=Unk. |
| | _____ **Place** | |

| | | |
|---|---|---|
| |__| **Seen by neurologist**(write in who and when below) _____ | 0=No, 1=Yes, 2=Maybe, 9=Unk. |
| |__| **Have you been told by a doctor you had a stroke or TIA (transient ischemic attack, mini-stroke)?** | |
| |__| **Have you been told by a doctor you have Parkinson Disease?** | |
| |__| **Have you been told by a doctor you have memory problems, dementia or Alzheimer's disease?** | |
| |__| **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:**_____

_____

_____

**MD12**

OMB #: 0925–0216
Expiration Date: xx/xxxx

# 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**

|__| **Dementia**

|__| **Parkinson Disease**

|__| **Other, Specify: _____**

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

**Comments**_____

_____

_____

_____

**MD13**

OMB #: 0925–0216
Expiration Date: xx/xxxx

# Medical History--Peripheral Arterial Disease

## Peripheral Arterial Disease

| | | | | |
|---|---|---|---|---|
| |__| **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) | | |
| |__| **Do you get discomfort in either leg on walking?** (0=No, 1=Yes, 9=Unk.) | | |
| **if yes, fill ☞** | |__| **Does this discomfort ever begin when you are standing still or sitting? (0=no, 1=yes, 9=Unk)** | |
| | |__|__| **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* | |
| | **Left** | **Right** | **Claudication symptoms** | 0=No, 1=Yes, 9=Unk. |
| | |__| | |__| | **Discomfort in calf while walking** | |
| | |__| | |__| | **Discomfort in lower extremity (not calf) while walking**<br>**Write in site of discomfort**_____ | |
| | | |__| | **Occurs with first steps (code worse leg)** | |
| | | |__| | **After walking a while.** | |
| | | |__| | **Do you get the discomfort when you walk up hill or hurry?** | |
| | | |__| | **Does the discomfort ever disappear while you are still walking?** | |
| | | | **What do you do if you get discomfort when you are walking?**<br>*Check ONLY ONE box below* | |
| | | ☐ 1=stop | ☐ 2=slow down ☐ 3=continue at same pace ☐ 9=Unk. | |
| | | |__|__|__| | **Time for discomfort to be relieved by stopping (minutes)**<br>(000=No relief with stopping, 999=Unk.) | |
| | | |__|__| | **Number of days/month of lower limb discomfort**<br>(1=1 day/month or less, 99=Unk.) | |

**MD14**

OMB #: 0925–0216
Expiration Date: xx/xxxx

# Medical History--Peripheral Arterial Disease Continued

| | |
|---|---|
| \|__\| | **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** \|__\|__\|*\|__\|__\|*\|__\|__\|__\|__\| |
| \|__\| | **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 | | |
|---|---|---|
| \|__\| | **Intermittent Claudication** | 0=No, 1=Yes, 2=Maybe, 9=Unk. |

**Comments**_____

_____

_____

**MD15**

OMB #: 0925–0216
Expiration Date: xx/xxxx

# Venous Disease and Second Blood Pressure

| Venous Disease | | |
|---|---|---|
| \|__\| | **Since your last exam have you had a Deep Vein Thrombosis (blood clots in legs or arms)** | 0=No, 1=Yes, 9=Unk. |
| \|__\| | **Since your last exam have you had a Pulmonary Embolus (blood clots in lungs)** | |

| Blood Pressure (second reading) | |
|---|---|
| **Systolic** | **BP cuff size** |
| \|__\|__\|__\| to nearest 2 mm Hg 999=Unk. | \|__\| 0=pediatric,1=regular adult, 2=large adult, 3= thigh, 9=Unk. |
| **Diastolic** | **Protocol modification** |
| \|__\|__\|__\| to nearest 2 mm Hg 999=Unk. | \|__\| 0=No, 1=Yes, 9=Unk. write in _____ |

Comments on Protocol modification

_____

_____

_____

**MD16**

OMB #: 0925–0216
Expiration Date: xx/xxxx

# 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)* |
|---|---|
| \|__\| | **Heart Valvular Surgery** |
| if yes fill☞ | \|__\|__\|__\|__\| Year done (9999=Unk) |
| \|__\| | **Exercise Tolerance Test** |
| if yes fill☞ | \|__\|__\|__\|__\| Year done (9999=Unk) |
| \|__\| | **Coronary arteriogram** |
| if yes fill ☞ | \|__\|__\|__\|__\| Year done (9999=Unk) |
| \|__\| | **Coronary artery angioplasty or stent** |
| if yes fill☞ | \|__\|__\|__\|__\| Year done (9999=Unk) |
| \|__\| | **Coronary bypass surgery** |
| if yes fill☞ | \|__\|__\|__\|__\| Year done (9999=Unk) |
| \|__\| | **Permanent pacemaker insertion** |
| if yes fill ☞ | \|__\|__\|__\|__\| Year done (9999=Unk) |
| \|__\| | **Carotid artery surgery or stent** |
| if yes fill ☞ | \|__\|__\|__\|__\| Year done (9999=Unk) |
| \|__\| | **Thoracic aorta surgery** |
| if yes fill ☞ | \|__\|__\|__\|__\| Year done (9999=Unk) |
| \|__\| | **Abdominal aorta surgery** |
| if yes fill ☞ | \|__\|__\|__\|__\| Year done (9999=Unk) |
| \|__\| | **Femoral or lower extremity surgery** |
| if yes fill ☞ | \|__\|__\|__\|__\| Year done (9999=Unk) |
| \|__\| | **Lower extremity amputation** |
| if yes fill ☞ | \|__\|__\|__\|__\| Year done (9999=Unk) |
| \|__\| | **Other Cardiovascular Procedure (write in below)** |
| if yes fill ☞ | \|__\|__\|__\|__\| Year done (9999=Unk) Description_____ |

**Comments:**_____

_____

**MD17**

OMB #: 0925–0216
Expiration Date: xx/xxxx

# 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 | | |
| |__| | **Esophagus** | | |__| | |__| | |__| | | |
| |__| | **Stomach** | | |__| | |__| | |__| | | |
| |__| | **Colon** | | |__| | |__| | |__| | | |
| |__| | **Rectum** | | |__| | |__| | |__| | | |
| |__| | **Pancreas** | | |__| | |__| | |__| | | |
| |__| | **Larynx** | | |__| | |__| | |__| | | |
| |__| | **Trachea/Bronchus/ Lung** | | |__| | |__| | |__| | | |
| |__| | **Leukemia** | | |__| | |__| | |__| | | |
| |__| | **Skin** | | |__| | |__| | |__| | | |
| |__| | **Breast** | | |__| | |__| | |__| | | |
| |__| | **Cervix/Uterus** | | |__| | |__| | |__| | | |
| |__| | **Ovary** | | |__| | |__| | |__| | | |
| |__| | **Prostate** | | |__| | |__| | |__| | | |
| |__| | **Bladder** | | |__| | |__| | |__| | | |
| |__| | **Kidney** | | |__| | |__| | |__| | | |
| |__| | **Brain** | | |__| | |__| | |__| | | |
| |__| | **Lymphoma** | | |__| | |__| | |__| | | |
| |__| | **Other/Unk.** _____ | | |__| | |__| | |__| | | |

|__| **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**

OMB #: 0925–0216
Expiration Date: xx/xxxx

# 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)<br>**3 = 2nd degree AV block, Mobitz I (Wenckebach)**<br>**4 = 2nd degree AV block, Mobitz II**<br>**5 = 3rd degree AV block / AV dissociation**<br>**6 = Atrial fibrillation / atrial flutter**<br>**7 = Nodal**<br>**8 = Paced**<br>**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**

OMB #: 0925–0216
Expiration Date: xx/xxxx

# Electrocardiograph-Part II

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

OMB #: 0925–0216
Expiration Date: xx/xxxx

# Clinical Diagnostic Impression.

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

**Comments CDI Other Diagnoses**_____

_____

_____

_____

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**Continue Comments on the next page→**

**MD21**

**Continue from MD21**

**Comments CDI Other Diagnoses**_____

_____

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**MD22**