Public reporting burden for this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0584). Do not return the completed form to this address.

OMB#: 0925-0584
Exp. xx/xx/xxxx

HCHS/SOL Physician Questionnaire

ID NUMBER: ☐☐☐☐☐☐☐☐

FORM CODE: PQE
VERSION:1, 1/15/2014

Contact Occasion 0 ☐

SEQ # ☐☐

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐
month may year

0b. Staff ID: ☐☐☐

Instructions: Please complete the following questions to the best of your ability by filling in the appropriate bubbles or writing the answer in the blank provided. Please return completed forms in the self addressed stamped envelope provided to the local HCHS/SOL field center.

DETAILS OF DEATH

1. Are you familiar with the events surrounding the decedent's death?

No 0 ☐
Yes 1 ☐

2. Did you witness the death?

No 0 ☐
Yes 1 ☐

If informant answered "Yes" *to one or both of Items 1 and 2, please skip to Item 4.*

3. If you answered "No" to both Questions, are you aware of another physician who could provide information regarding the death?

No 0 ☐ Please sign and date the bottom of this form
Yes 1 ☐

3a. Provide contact information. Please then sign and date the bottom of this form.

Name of physician: _____

Address: _____

_____

_____

CIRCUMSTANCES SURROUNDING DEATH

4. What do you believe to be the underlying cause of death?

Acute Myocardial Infarction	1 ☐	
Other Ischemic Heart Disease	2 ☐	
Cerebrovascular Disease	3 ☐	
Other Cardiovascular Disease	4 ☐	
Emphysema, chronic bronchitis or chronic obstructive pulmonary disease (COPD)	5 ☐	
Pneumonia	6 ☐	
Asthma	7 ☐	
Other Lung Disease	8 ☐	specify: _____
Non Cardio - Pulmonary Disease	9 ☐	specify: _____

5. Please specify the time between the onset of the acute episode of symptoms and death. (We are defining death as the point where spontaneous breathing ceased and the patient never recovered.) Please check the appropriate time period.

Less than 5 minutes	1 ☐
5 minutes to 1 hour	2 ☐
1 hour to 24 hours	3 ☐
More than 24 hours	4 ☐
1 day to 3 days	5 ☐
More than 3 days	6 ☐
Unknown	9 ☐

6. Was there an acute episode of pain in the chest, left arm or jaw during the last 72 hours prior to death?

No	0 ☐
Yes	1 ☐
Unknown	9 ☐

7. Was there an acute episode of shortness of breath during the 72 hours prior to death?

No	0 ☐
Yes	1 ☐
Unknown	9 ☐

8. Was there an acute episode of wheezing during the 72 hours prior to death?

No	0 ☐
Yes	1 ☐
Unknown	9 ☐

9. Did the decedent take or was s/he given nitrates or nitroglycerin at the time of the acute episode?

No 0 ☐
Yes 1 ☐
Unknown 9 ☐

MEDICAL HISTORY

10. Are you familiar with the decedent's medical history?

No 0 ☐ End questionnaire
Yes 1 ☐

11. Did the decedent have a medical history of any of the following conditions prior to the acute event which led to death?

11a. Myocardial Infarction (MI)?

No 0 ☐ Skip to 11b
Yes 1 ☐
Unknown 9 ☐ Skip to 11b

i. Date of most recent MI: ☐☐/ ☐☐/ ☐☐☐☐
month day year

11b. Angina Pectoris, Coronary Insufficiency or Other Chronic Ischemic Heart Disease?

No 0 ☐ Skip to 11c
Yes 1 ☐
Unknown 9 ☐ Skip to 11c

i. Date of first diagnosis: ☐☐/ ☐☐/ ☐☐☐☐
month day year

11c. Congestive Heart Failure (CHF) or Congestive Cardiomyopathy?

No 0 ☐ Skip to 11d
Yes 1 ☐
Unknown 9 ☐ Skip to 11d

i. Date of first exacerbation: ☐☐/ ☐☐/ ☐☐☐☐
month day year

11d. Stroke (CVA)?

No 0 ☐ Skip to 11e
Yes 1 ☐
Unknown 9 ☐ Skip to 11e

i. Date of most recent CVA: ☐☐/ ☐☐/ ☐☐☐☐
month day year

11e. Transient Ischemic Attack (TIA)?

No 0 ☐ Skip to 11f
Yes 1 ☐
Unknown 9 ☐ Skip to 11f

i. Date of first diagnosis: ☐☐/ ☐☐/ ☐☐☐☐
month day year

11f. Intermittent Claudication or Other Peripheral Arterial Disease (PAD)?

No 0 ☐ Skip to 11g
Yes 1 ☐
Unknown 9 ☐ Skip to 11g

11g. Lower Extremity Bypass, Angioplasty or Amputation Secondary to PAD?

No 0 ☐ Skip to 11h
Yes 1 ☐
Unknown 9 ☐ Skip to 11h

11h. Coronary Bypass Surgery?

No 0 ☐
Yes 1 ☐
Unknown 9 ☐

11i. Coronary Angioplasty?

No 0 ☐
Yes 1 ☐
Unknown 9 ☐

11j. Emphysema, chronic bronchitis, or Chronic Obstruction Pulmonary Disease (COPD)?

No 0 ☐ Skip to 11k
Yes 1 ☐
Unknown 9 ☐ Skip to 11k

i. Date of first exacerbation (or onset): ☐☐/ ☐☐/ ☐☐☐☐
month day year

11k. Asthma?

No 0 ☐
Yes 1 ☐
Unknown 9 ☐

i. Approximate age asthma first started: ☐☐

12. If you saw the participant within one month of death, please fill out the following for the most recent visit:

12a. Date of visit: ☐☐/ ☐☐/ ☐☐☐☐
month day year

12b. Chief Complaint:_____

_____

12c. Primary Diagnosis:_____

_____

12d. Changes in Medical Management:_____

_____

_____

Form completed by: _____ Date: _____