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

Date

NAME
ADDRESS

ID#:

Dear

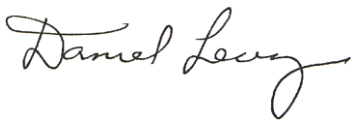
We would like to update the health information that we have on file for you at the Framingham Heart Study. As a participant in the Heart Study, it is important that we have information regarding diagnoses for any significant heart disease, vascular disease, stroke or cancer since we last examined you.

Please complete the enclosed medical history update form. Also, please sign and date the consent form. This procedure will give us permission to obtain the necessary information from the physicians and hospitals where you may have received care. Please inform us if there is any name, address or telephone number change.

If you have questions, please don't hesitate to call Mary Ann Crossen at 1-508-935-3430 or 1-800-854-7582, extension 430.

Thank you for your help.

Sincerely,



Daniel Levy, M.D.
Director
Framingham Heart Study

I hereby authorize _____
_____
_____

to release to the Framingham Heart Study
73 Mt. Wayte Avenue
Framingham, MA 01702

The following protected health information my medical record.

Date of Birth:

Address

Disclose the following information for dates from present.

- Face Sheet
- Discharge Summary
- ER Report
- Admission Notes
- Progress Notes
- Operative Report
- Pathology Report
- Chest X-Ray
- EKGs (All)
- Echocardiogram
- CT Scan (Head)
- MRI/MRA (Head/Neck)
- Lab Reports – Cardiac Enzymes
- Consults (Cardiac & Neuro)
- Cardiac Catheterization
- Exercise Tolerance Test
- Nursing Home Notes
- Notes near time of death
- Other _____
  _____

The purpose for this disclosure is research.

The information disclosed under this authorization **will not be redisclosed** to anyone but the researchers conducting this study, except as required by law.

I understand I may revoke this authorization at any time by requesting such of the above referenced physician/hospital in writing. If I do it will not have any effect on actions that the hospital/physician took before it received the revocation.

This authorization expires at the end of the research study.

Date: _____ Signed: _____

ID

FRAMINGHAM STUDY MEDICAL HISTORY UPDATE

For Office Use Only

TYPE |___|___| 1=TELEPHONE 2=MAILER 3=ONSITE BONE STUDY 4=ONSITE EBCT 88=OTHER

INTERVIEWER |___|___|___| DATA ENTRY |___|___|___|1 |___|___|___|2

ID

DATE OF LAST EXAM OR UPDATE

NAME

ADDRESS and PHONE (if changed since last exam/update) _____

_____

SOCIAL SECURITY NUMBER |___|___|___| - |___|___| - |___|___|___|___|

DATE COMPLETED |___|___| - |___|___| - |___|___|

1. a. First, please tell us who is completing this form:

- ☐ Framingham Heart Study (FHS) participant whose name is above **(Go to question 3)**
- ☐ Spouse
- ☐ Family member other than spouse (Relationship) _____
- ☐ Friend
- ☐ Health care provider for FHS participant
- ☐ Other _____

→ Go to 1.b.

If other than participant, please answer the following questions.

b. Name _____

c. How long have you known the participant?

|___|___| years |___|___| months

d. Are you currently living in the same household with the participant?

☐ yes ☐ no

ID

FRAMINGHAM STUDY MEDICAL HISTORY UPDATE

e. How often did you talk with the participant during the prior 11 months? Check one.

- ☐ Almost every day
- ☐ Several times a week
- ☐ Once a week
- ☐ 1 to 3 times per month
- ☐ Less than once a month
- ☐ Unknown / N/A

2. Have you noticed that he/she has had any memory problems or change in personality?

☐ yes ☐ no

Specifically: _____

If response to #2 "yes":

Has there been a diagnosis of dementia or Alzheimer's Disease made by a doctor?

☐ yes ☐ no

TO WHOM SHOULD WE SEND A CONSENT FORM TO BE SIGNED SO THAT WE CAN OBTAIN MEDICAL RECORDS?

NAME: _____

ADDRESS: _____

RELATIONSHIP: _____

Please go on to the next page

ID

FRAMINGHAM STUDY MEDICAL HISTORY UPDATE

3. Since the date of the last Framingham Heart Study exam or update on the first page of the Medical History Update form, have you seen a doctor or been hospitalized?

☐ yes ☐ no If yes, did you have any of the following problems?

a. Heart Problems, such as:

Yes	No	(Mark yes or no for each question)
☐	☐	Chest pain, angina or angina pectoris
☐	☐	Heart attack or myocardial infarction or MI
☐	☐	Heart failure or congestive heart failure or CHF
☐	☐	Atrial fibrillation or atrial flutter
☐	☐	Heart catheterization or cardiac catheterization
☐	☐	Heart bypass operation or coronary bypass surgery or CABG
☐	☐	Procedure to unblock narrowed blood vessels to your heart muscles (PTCA, coronary angioplasty, or coronary stent)
☐	☐	Other heart problem (pacemaker, valve problem, aortic surgery, ventricular tachycardia, other rhythm problem) Specify _____

b. Circulatory Problems, such as:

Yes	No	(Mark yes or no for each question)
☐	☐	Stroke, TIA (transient ischemic attack), sudden paralysis, vision loss, inability to speak
☐	☐	Procedure to unblock narrowed blood vessels in your neck (carotid endarterectomy, carotid angioplasty).
☐	☐	Poor blood circulation or blocked or narrowed blood vessels to the legs or feet, (claudication, peripheral arterial disease, gangrene)
☐	☐	Amputation of part of a leg or toes, because of poor circulation or gangrene.
☐	☐	Blood clot or embolism in leg or lung.
☐	☐	Other circulatory problem. Specify _____

ID

FRAMINGHAM STUDY MEDICAL HISTORY UPDATE

Since the date of the last Framingham Heart Study exam or update on the first page of the Medical History Update form, have you seen a doctor or been hospitalized for the following:

c. Other Neurological Problems

Yes	No	(Mark yes or no for each question)
☐	☐	Memory problems
☐	☐	Other neurological problems such as Parkinson's, multiple sclerosis, seizures, head injury. Specify problem_____
☐	☐	Have you had an MRI scan of your brain other than for the Framingham Heart Study? Name of MRI Facility _____ Date of MRI |___|___| - |___|___| - |___|___| Reason for MRI:_____

d. Other Problems

Yes	No	(Mark yes or no for each question)
☐	☐	Diabetes If yes, please list medications you take for diabetes _____
☐	☐	Cancer Specify type _____ Physician _____ Place where biopsy performed_____ _____ _____
☐	☐	Fracture, broken bone (Specify including hip, back, arm, leg, pelvis, collarbone, foot, toe and others)_____
☐	☐	Other Specify problem _____

Please go on to the next page

ID

FRAMINGHAM STUDY MEDICAL HISTORY UPDATE

4. Since the date of your last Framingham Heart Study exam or update on the first page of the Medical History Update form, have you been admitted to a **HOSPITAL** or gone to an **EMERGENCY ROOM** or seen a **PHYSICIAN** for other than a routine examination?

☐ yes (if yes, please give details) ☐ no (go to question 5 on the next page)

Date |___|___| - |___|___| - |___|___|

Type* _____ _____

Reason** _____ _____

Hospital Name _____ Doctor's Name _____

Address _____ Address _____

_____ _____

Date |___|___| - |___|___| - |___|___|

Type* _____ _____

Reason** _____ _____

Hospital Name _____ Doctor's Name _____

Address _____ Address _____

_____ _____

Date |___|___| - |___|___| - |___|___|

Type* _____ _____

Reason** _____ _____

Hospital Name _____ Doctor's Name _____

Address _____ Address _____

_____ _____

* Type

1. Overnight admission
2. Emergency room visit
3. Day Surgery/Procedure
4. M.D. visit

** Reason

1. Heart problems
2. Stroke or transient ischemic attack (TIA), sudden paralysis, vision loss, inability to speak
3. Broken, crushed or fractured bones
4. Cancer or malignant tumor
5. Circulation problem, or blood clots
6. Other reasons (Please specify)

ID

FRAMINGHAM STUDY MEDICAL HISTORY UPDATE

Nursing Home/Rehabilitation Admissions.

5. Have you stayed overnight as a patient in a nursing home, rehabilitation center or transitional care unit (TCU) since the date of your last Framingham Heart Study exam or update on the top of the first page of the Medical History Update form?

☐ yes ☐ no (if no, go to Question 8.)

6. Please list the name and location of the nursing home or rehabilitation center and the date you were admitted.

Nursing home/Rehab Center name: _____

Street address: _____

City/State/Zip Code _____

Date you entered the nursing home/rehabilitation center |___|___| - |___|___| - |___|___|

7. Were you an overnight patient in a nursing home, rehabilitation center or transitional care unit (TCU) at any **other** time since your last exam?

☐ yes ☐ no

Nursing home/Rehab Center name: _____

Street address: _____

City/State/Zip Code _____

Date you entered the nursing home/rehabilitation |___|___| - |___|___| - |___|___|

Marital Status.

8. What is your **current** marital status? Please check one

☐ married ☐ widowed ☐ divorced ☐ separated
☐ single, never married ☐ living with partner

ID

FRAMINGHAM STUDY MEDICAL HISTORY UPDATE

Health Status. (Questions 9 and 10 to be filled out only by the participant.)

9. In general, how is your health now?

- ☐ Excellent
- ☐ Fair
- ☐ Poor
- ☐ Good
- ☐ Don't know

10. Compare your health to most people your own age. Would you say your health is?

- ☐ Better
- ☐ Worse than most people
- ☐ About the same
- ☐ Don't know

Primary Care Physician

11. Please list the name and address of your primary care physician.

Name _____

Address _____

_____

YOU MIGHT BE SENT A CONSENT FORM TO SIGN SO THAT WE MAY OBTAIN YOUR MEDICAL RECORDS.