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# A01 Participant Information

FHS\_IDTYPE\_ID

*Gen 3, NOS, Omni 2 Cohort Exam 3*

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## Participant Information

**Name: [lastname], [firstname]DOB: [dob]Age: [age] Sex: [sex] Date of last exam: [lastexamdate]**

**Date of last medical health update: [lastmhudate]**

Date of this FHS exam (today's date)

Year of this FHS exam

Site Heart Study

Nursing home Residence Other

## Imported Validated Information

IDTYPE 2 - NOS

3 - Gen 3

72 - Omni Gen 2 (FHS idtype)

ID

(FHS ID (4-digit))

Participant's last name

Participant's first name

Date of birth

Year of birth

Age (in years)

Sex Male

Female

Date of last exam

Year of last exam

Date of last medical health update

Date of last medical information:

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## Additional Comments

Participant Information

# M01 Medical Encounters

FHS\_IDTYPE\_ID

*Gen3 Exam3 12-3-15*

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## Medical Encounters

**Name: [lastname], [firstname]DOB: [dob]Age: [age] Sex: [sex] Date of last exam: [lastexamdate]**

**Date of last medical health update: [lastmhudate]**

1st Examiner ID

Since you last provided medical information ([lastmedinfodate]) have you had any of the following?

Hospitalizations (not just E.R.)? No

Yes Unknown

If "Yes"

Hospitalization #1 Reason

Year

(9999 = Unknown)

DATE details (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Name of hospital

Location of hospital

Have you had another hospitalization? No Yes

Unknown

Hospitalization #2 Reason

Year

(9999 = Unknown)

DATE details (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Name of hospital

Location of hospital

Have you had another hospitalization? No Yes

Unknown

Hospitalization #3 Reason

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Year

(9999 = Unknown)

DATE details (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Name of hospital

Location of hospital

Have you had another hospitalization? No Yes

Unknown

Hospitalization #4 Reason

Year

(9999 = Unknown)

DATE details (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Name of hospital

Location of hospital

If participant has had more than 4 hospitalizations, provide details in "Additional comments" below.

E.R. visits only? No

Yes Unknown

If "Yes"

E.R. Visit #1 Reason

Year

(9999 = Unknown)

DATE details (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Name of hospital

Location of hospital

Have you had another E.R. visit? No

Yes Unknown

E.R. Visit #2 Reason

Year

(9999 = Unknown)

DATE details (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Name of hospital

Have you had another E.R. visit? No

Yes Unknown

E.R. Visit #3 Reason

Year

(9999 = Unknown)

DATE details (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Name of hospital

Location of hospital

Have you had another E.R. visit? No

Yes Unknown

E.R. Visit #4 Reason

Year

(9999 = Unknown)

DATE details (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Name of hospital

Location of hospital

If participant has had more than 4 E.R. visits, provide details in "Additional comments" below.

Day surgery? No

Yes Unknown

If "Yes"

Day Surgery #1 Reason

Year

(9999 = Unknown)

DATE details (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Name of hospital/doctor

Location of hospital/doctor

Have you had another day surgery? No Yes

Unknown

Day Surgery #2

Year

(9999 = Unknown)

DATE details (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Name of hospital/doctor

Location of hospital/doctor

Have you had another day surgery? No Yes

Unknown

Day Surgery #3 Reason

Year

(9999 = Unknown)

DATE details (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Name of hospital/doctor

Location of hospital/doctor

Have you had another day surgery? No Yes

Unknown

Day Surgery #4 Reason

Year

(9999 = Unknown)

DATE details (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Name of hospital/doctor

Location of hospital/doctor

If participant has had more than 4 day surgeries, provide details in "Additional comments" below.

Major illness with visit to doctor? No

Yes Unknown

If "Yes"

Major Illness #1 Reason

Year

(9999 = Unknown)

DATE details (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Name of doctor

Location of doctor

Have you had another major illness with visit to No

doctor? Yes

Unknown

Major Illness #2 Reason

Year

(9999 = Unknown)

DATE details (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Name of doctor

Location of doctor

Have you had another major illness with visit to No

doctor? Yes

Unknown

Major Illness #3 Reason

Year

(9999 = Unknown)

DATE details (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Name of doctor

Location of doctor

Have you had another major illness with visit to No

doctor? Yes

Unknown

Major Illness #4 Reason

Year

(9999 = Unknown)

DATE details (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Name of doctor

Location of doctor

If participant has had more than 4 major illnesses, provide details in "Additional comments" below.

Check up by doctor or other health care provider? No Yes

Unknown

If "Yes"

Check Up #1 Reason

Year

(9999 = Unknown)

DATE details (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Name of doctor

Location of doctor

Have you had another check up by doctor or other No

health care provider? Yes

Unknown

Check Up #2 Reason

Year

(9999 = Unknown)

DATE details (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Name of doctor

Location of doctor

Have you had another check up by doctor or other No

health care provider? Yes

Unknown

Check Up #3 Reason

Year

(9999 = Unknown)

DATE details (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Name of doctor

Location of doctor

Have you had another check up by doctor or other No

health care provider? Yes

Unknown

Check Up #4 Reason

Year

(9999 = Unknown)

DATE details (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Name of doctor

Location of doctor

If participant has had more than 4 check ups, provide details in "Additional comments" below.

## Additional Comments

Medical Encounters

*Gen 3, NOS, Omni 2 Cohort Exam 3*

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# M03 Aspirin Medication Treatment Questions

FHS\_IDTYPE\_ID

## Aspirin Name: [lastname], [firstname]DOB: [dob]Age: [age] Sex: [sex] Date of last exam: [lastexamdate]

**Date of last medical health update: [lastmhudate]**

Do you take aspirin REGULARLY? No Yes

Unknown

If "Yes" to taking aspirin REGULARLY

Usual dose of aspirin? 081mg Baby

160mg Half

250mg e.g. Excedrin 325mg Usual

500mg Extra strength Other

Unknown

If dose of Aspirin is 'Other'

(Dose in mg )

How many aspirin?

(99=unknown)

How often do you take [numaspirin] ([doseaspirin]) Day

aspirin? Week

Month Year Unk

## Medication Treatment Questions

High blood pressure or hypertension

Have you been TOLD by your doctor you have high blood No pressure or hypertension? Yes

Unknown

Are you CURRENTLY taking medication for high blood No

pressure or hypertension? Yes

Unknown

High blood cholesterol or high triglycerides

Have you been TOLD by doctor you have high blood No

cholesterol or high triglycerides? Yes Unknown

Are you CURRENTLY taking medication for high blood No

cholesterol or high triglycerides? Yes Unknown

High blood sugar or diabetes

*Page 2 of 2*

Have you been TOLD by doctor you have high blood No

sugar or diabetes? Yes

Unknown

Are you CURRENTLY taking medication for high blood No

sugar or diabetes? Yes

Unknown

Are you CURRENTLY taking medication for No

cardiovascular disease? (for example angina/chest Yes

pain, heart failure, atrial fibrillation/heart rhythm Unknown abnormality, stroke, leg pain when walking,

peripheral artery disease)

## Additional Comments

Additional comments for Aspirin and Medication Treatment Questions

*Gen3 Exam3 12-3-15*

*Page 1 of 2*

# M04 Prescription Andor Non Prescription Medication

FHS\_IDTYPE\_ID

## Prescription and Non-Prescription Medications in Last Month as Directed by Your Health Care Provider

**Name: [lastname], [firstname]DOB: [dob]Age: [age] Sex: [sex] Date of last exam: [lastexamdate]**

**Date of last medical health update: [lastmhudate]**

In the past month have you taken any prescription No

and/or non prescription as directed by HCP? Yes, as directed by HCP Unknown

Medication bag with medications brought to exam? No Yes

## Prescription and Non-Prescription Medications As Directed by Your Health Care Provider

Medication name #1

Medication name #2

Medication name #3

Medication name #4

Medication name #5

Medication name #6

Medication name #7

Medication name #8

Medication name #9

Medication name #10

## New prescription and/or non prescription directed by HCPMedications ADD medication if not on drop down list

Are there any medications that you could not find on No

the list? Yes

Medication (new) name #1

Medication (new) name #2

Medication (new) name #3

Medication (new) name #4

Medication (new) name #5

*Page 2 of 2*

Are you taking any over the counter products i.e. No

vitamins, supplements, plant extracts, alternatives? Yes Unknown

Check all OTC you are taking: Vitamins

Supplements Plant extracts Alternatives Other

Comment on vitamins

Comment on supplements

Comment on plant extracts

Comment on alternatives

Comment on other over the counter products

## Additional Comments

Additional comment for Prescription and Non-Prescription Medications in Last Month

**M05 Female Repro Pregnancy**

FHS\_IDTYPE\_ID

*Gen 3, NOS, Omni 2 Cohort Exam 3*

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### **Female Reproductive History**

**Name: [lastname], [firstname]DOB: [dob]Age: [age] Sex: [sex] Date of last exam: [lastexamdate]**

**Date of last medical health update: [lastmhudate]**

Participant is male. Select "Save and go to Next Form".

### **Pregnancy**

Since your last exam have you taken or used birth No

control pills, shots, or hormone implants for birth Yes, now

control or medical indications (not post menopausal Yes, not now

hormone replacement)? Unk.

Have you ever tried to become pregnant for >=1 year No without becoming pregnant? Yes

Unk.

Have you been pregnant since last exam? No Yes Unk.

If "Yes",

Number of pregnancies?

During any of these pregnancies, were you told you No

had high blood pressure or hypertension? Yes Unk.

During any of these pregnancies, were you told you No

had eclampsia, pre-eclampsia (toxemia)? Yes Unk.

During any of these pregnancies, were you told you No

had high blood sugar or diabetes? Yes Unk.

Have you had any births since your last exam? No Yes

If "Yes",

Number of live births since last exam

Now, I would like to ask you about how much each of your children weighed at birth and whether you breastfed.

### **Baby #1**

Full term? < 37 weeks

=>37 weeks Unk.

Birth weight (pounds)

Birth weight (ounces)

Did you breast feed ( include expressed breast milk)? No Yes Unk.

If yes, how long? < 6 weeks

6 to 11 weeks

3 to 6 months

>6 months Unk.

### **Baby #2**

Full term? < 37 weeks

=>37 weeks Unk.

Birth weight (pounds)

Birth weight (ounces)

Did you breast feed (include expressed breast milk)? No Yes Unk.

If yes, how long? < 6 weeks

6 to 11 weeks

3 to 6 months

>6 months Unk.

### **Baby #3**

**Baby #4**

Full term? < 37 weeks

=>37 weeks Unk.

Birth weight (pounds)

Birth weight (ounces)

Did you breast feed (include expressed breast milk)? No Yes Unk.

If yes, how long? < 6 weeks

6 to 11 weeks

3 to 6 months

>6 months Unk.

### **Baby #5**

Full term? < 37 weeks

=>37 weeks Unk.

Birth weight (pounds)

Birth weight (ounces)

Did you breast feed (include expressed breast milk)? No Yes Unk.

If yes, how long? < 6 weeks

6 to 11 weeks

3 to 6 months

>6 months Unk.

### **Baby #6**

### **Baby #7**

Full term? < 37 weeks

=>37 weeks Unk.

Birth weight (pounds)

Birth weight (ounces)

Did you breast feed (include expressed breast milk)? No Yes Unk.

If yes, how long? < 6 weeks

6 to 11 weeks

3 to 6 months

>6 months Unk.

### **Additional Comments**

Female Repro - Pregnancy

# M06 Female Repro Menopause

FHS\_IDTYPE\_ID

*Gen 3, NOS, Omni 2 Cohort Exam 3*

*Page 1 of 2*

## Menopause1

**Name: [lastname], [firstname]DOB: [dob]Age: [age] Sex: [sex] Date of last exam: [lastexamdate]**

**Date of last medical health update: [lastmhudate]**

Participant is male. Select "Save and go to Next Form".

What is the best way to describe your periods? 1=Not stopped

(Check the BEST answer - only one.) 2=Stopped due to pregnancy, breast feeding, hormonal contraceptive

3=Stopped due to low body weight, exercise, medication or health conditions

4=Stopped for less than 1 year (perimenopausal) 5=Stopped for 1 year or more

6=Stopped but now have periods induced by hormones (Check the BEST answer - only one.)

For option 3 above, write in cause.

For option 4 above, write in number of months since

last period. (99=Unknown)

For option 6 above, write in number of months period stopped before hormones started.

## Menopause2

When was the first day of your last menstrual period

* month ? (88=period stopped for more than 1 year or using postmenopausal hormones, 99=Unknown)

When was the first day of your last menstrual period

* day ? (99=Unknown, 88=period stopped for more than 1

year or using postmenopausal hormones)

When was the first day of your last menstrual period

* year ? (9999=Unknown, 8888=period stopped for more than 1 year or using postmenopausal hormones)

How many periods have you had in past 12 months?

(99=Unknown, 88=periods stopped for more than 1 year or using postmenopausal hormones)

Age when periods stopped. If periods now induced by hormones, code age when periods naturally stopped. (00=not stopped, 99=Unknown)

Was your menopause natural or the result of surgery, Still menstruating chemotherapy, or radiation? Natural

Surgical Chemo/radiation Other

Unknwon

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Have you since your last exam taken hormone No

replacement therapy (estrogen/progesterone) or a Yes, now selective estrogen receptor modulator (such as evista Yes, not now or raloxifene)? Unk.

## Surgery History

Since your last exam have you had a hysterectomy No

(uterus/womb removed)? Yes

Unk.

If yes, age at hysterectomy?

(99=Unknown)

If yes, date of surgery (month)

(99=Unk.)

If yes, date of surgery (year)

(9999=Unk.)

Since last exam have you had an operation to remove No one or both of your ovaries? Yes

Unk.

If yes, age when ovaries removed?

(If more than one surgery, use age at last surgery. 99=Unk )

If yes, number of ovaries removed? One ovary Two ovaries

Unknown number of ovaries Part of an ovary

(If more than one surgery, use age at last surgery. 99=Unk )

## Additional Comments

Female Repro - Menopause

# M07 Smoking

FHS\_IDTYPE\_ID

*Gen 3, NOS, Omni 2 Cohort Exam 3*

*Page 1 of 2*

## Smoking

**Name: [lastname], [firstname]DOB: [dob]Age: [age] Sex: [sex] Date of last exam: [lastexamdate]**

**Date of last medical health update: [lastmhudate]**

**Cigarettes**

Since your last exam have you smoked cigarettes No

regularly? Yes

Unknown

If "Yes"

Have you smoked cigarettes regularly in the last No

year? (No means less than 1 cigarette a day for 1 Yes

year.) Unknown

Do you smoke cigarettes (as of 1 month ago)? No Yes

Unknown

How many cigarettes do you smoke per day now?

(99 = Unknown)

Questions below refer to "whole lifetime"

On the average of the entire time you smoked, how

many cigarettes did you smoke per day? (99 = Unknown)

How old were you when you first started regular

cigarette smoking? (99 = Unknown)

If you have stopped smoking cigarettes completely,

how old were you when you stopped? (00 = Not stopped, 99 = Unknown)

When you were smoking, did you ever stop smoking No

for > 6 months? Yes

Unknown

If "Yes"

For how many years in total did you stop smoking

cigarettes? (1 = 6 months - 1 year, 99 = Unknown)

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## Pipes or Cigars

Since your last exam have you regularly smoked a pipe No or cigar? Yes

Unknown

If "Yes"

Do you smoke a pipe or cigar now? No Yes

Unknown

## E-cigarettes

E-cigarettes are battery-powered and produce vapor instead of smoke. Have you ever tried an e-cigarette? No

Yes

Refused to answer Don't know

If "Yes"

Have you ever been a regular user of e-cigarettes No

(at least once per week)? Yes

Refused to answer Don't know

If "Yes"

How long did you use e-cigarettes? (# of years)

(99 = Unknown)

How many days per week, on average, did you use

e-cigarettes while you were a regular user? (1 = 1 day or less per week, 9 = Unknown)

In the past 5 days, including today, on how many 0 days

days did you smoke an e-cigarette? 1 day 2 days

1. days
2. days
3. days

Refused to answer Don't know

## Additional Comments

Smoking

# M08 Alcohol Consumption

FHS\_IDTYPE\_ID

*Gen 3, NOS, Omni 2 Cohort Exam 3*

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## Alcohol Consumption

**Name: [lastname], [firstname]DOB: [dob]Age: [age] Sex: [sex] Date of last exam: [lastexamdate]**

**Date of last medical health update: [lastmhudate]**

Now I will ask you questions regarding your alcohol use.

Do you drink beer at least once a month? (serving 12 No

oz. bottle, glass, can) Yes

Unknown

If "Yes"

Do you drink beer at least once week? No Yes

Unknown

If "Yes"

Number of beers per week

(999 = Unknown)

If "No"

Number of beers per month

(999 = Unknown)

Do you drink wine at least once a month? (serving red No or white, 4oz. glass) Yes

Unknown

If "Yes"

Do you drink wine at least once a week? No Yes

Unknown

If "Yes"

Number of glasses of wine per week

(999 = Unknown)

If "No"

Number of glasses of wine per month

(999 = Unknown)

Do you drink liquor/ spirits at least once a month? No

(serving 1 oz. cocktail/ highball) Yes

Unknown

If "Yes"

Do you drink liquor/ spirits at least once per week? No Yes

Unknown

If "Yes"

*Page 2 of 2*

Number of drinks per week

(999 = Unknown)

If "No"

Number of drinks per month

(999 = Unknown)

At what age did you stop drinking alcohol?

(000 = Not stopped, 888 = Never drinker, 999 = Unknown)

Over the past year, on average, on how many days per

week did you drink an alcoholic beverage of any type? (0 = No days, 1 = 1 day or less, 9 = Unknown)

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 = Unknown)

What was the maximum number of drinks you had in a 24

hour period during the past month? (0 = No drinks, 1 = 1 or less, 99 = Unknown)

Since your last exam has there been a time when you No

drank 5 or more alcoholic drinks of any kind almost Yes

daily? Unknown

Over the past year, does participant drink less than No

one alcoholic drink of any type per month? Yes

## Additional Comments

Alcohol Consumption

# M09 Respiratory Symptoms

FHS\_IDTYPE\_ID

*Gen 3, NOS, Omni 2 Cohort Exam 3*

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## Respiratory Symptoms

**Name: [lastname], [firstname]DOB: [dob]Age: [age] Sex: [sex] Date of last exam: [lastexamdate]**

**Date of last medical health update: [lastmhudate]**

**Cough**

In the past 12 months . . .

Do you usually have a cough? (Exclude clearing of the No throat) Yes

Unknown

Do you usually have a cough at all on getting up or No

first thing in the morning? Yes

Unknown

If "Yes" to either of 2 questions directly above

Do you cough like this on most days for three No

consecutive months or more during the past year? Yes Unknown

How many years have you had this cough? (# of years)

(1 = 1 year or less, 99 = Unknown)

## Phlegm

In the past 12 months . . .

Do you usually bring up phlegm from your chest? No Yes

Unknown

Do you usually bring up phlegm at all on getting up No

or first thing in the morning? Yes

Unknown

If "Yes" to either of 2 questions directly above

Do you bring up phlegm from your chest on most days No for three consecutive months or more during the year? Yes

Unknown

How many years have you had trouble with phlegm? (# of years) (1 = 1 year or less, 99 = Unknown)

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## Wheeze

In the past 12 months . . .

Have you had wheezing or whistling in your chest at No

any time? Yes

Unknown

If "Yes"

How often have you had this wheezing or whistling? MOST days or nights

A few days or nights a WEEK

A few days or nights a MONTH A few days or nights a YEAR Unknown

Have you had this wheezing or whistling in the chest No

when you had a cold? Yes

Unknown

Have you had this wheezing or whistling in the chest No

apart from colds? Yes

Unknown

Have you had an attack of wheezing or whistling in No

the chest that made you feel short of breath? Yes Unknown

# M09b Sleep Apnea and CHF Opinion

FHS\_IDTYPE\_ID

*Gen 3, NOS, Omni 2 Cohort Exam 3*

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## Sleep Apnea and CHF Opinion

**Name: [lastname], [firstname]DOB: [dob]Age: [age] Sex: [sex] Date of last exam: [lastexamdate]**

**Date of last medical health update: [lastmhudate]**

**Sleep Related Symptoms (days/ nights)**

Since your last exam . . .

On average how many nights a week did you snore? Never

Rarely (1-2 nights/week)

Occasionally (3-4 nights/week) Frequently (5 or more nights/week) I don't know

Unknown

On average, how many nights a week do you snort, Never

gasp, or stop breathing while you are asleep? Rarely (1-2 nights/week) Occasionally (3-4 nights/week) Frequently (5 or more nights/week) I don't know

Unknown

On average, how many days a week have you had Never

excessive (too much) daytime sleepiness? Rarely (1-2 nights/week) Occasionally (3-4 nights/week) Frequently (5 or more nights/week) I don't know

Unknown

## Nocturnal Chest Symptoms

Since your last exam . . .

Have you been awakened by shortness of breath? No Yes

Unknown

Have you been awakened by a wheezing/ whistling in No

your chest? Yes

Unknown

Have you been awakened by coughing? No Yes

Unknown

If "Yes"

How often have you been awakened by coughing? MOST days or nights

A few days or nights a WEEK

A few days or nights a MONTH A few days or nights a YEAR Unknown

## Shortness of Breath

Since your last exam . . .

Are you troubled by shortness of breath when hurrying No on level ground or walking up a slight hill? Yes

Unknown

If "Yes"

Do you have to walk slower than people of your age No

on level ground because of shortness of breath? Yes Unknown

Do you have to stop for breath when walking at your No

own pace on level ground? Yes

Unknown

Do you have to stop for breath after walking 100 No

yards (or after a few minutes) on level ground? Yes Unknown

Do you/ have you needed to sleep on two or more No

pillows to help you breathe (Orthopnea)? Yes Unknown

Have you had swelling in both your ankles (ankle No

edema)? Yes

Unknown

Have you been told by your doctor that you had heart No

failure or congestive heart failure? Yes Unknown

If "Yes"

Have medical encounter details been entered on M01? No

Yes

If "No"

Name of doctor

Location of doctor

Date of visit - year

(9999 = Unknown)

DATE details (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Have you been to a hospital/ E.R. for heart failure? No Yes

Unknown

If "Yes"

Have medical encounter details been entered on M01? No

Yes

If "No"

Name of hospital

Location of hospital

Date of hospitalization - year

(9999 = Unknown)

DATE details (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

## CHF First Examiner Opinion

First Examiner believes CHF No

Yes Maybe Unknown

## Additional Comments

Sleep Apnea and CHF Opinion

## Blood Pressure 1st MD Reading

**Name: [lastname], [firstname]DOB: [dob]Age: [age] Sex: [sex] Date of last exam: [lastexamdate]**

**Date of last medical health update: [lastmhudate]**

Systolic (to nearest 2 mm Hg)

Diastolic (to nearest 2 mm Hg)

BP cuff size Pedi

Regular adult Large adult Thigh Unknown

Protocol modification No

Yes Unknown

If "Yes"

Comments for Protocol modification

## Additional Comments

Blood Pressure 1st MD Reading

## Chest Discomfort and CHD Opinion

**Name: [lastname], [firstname]DOB: [dob]Age: [age] Sex: [sex] Date of last exam: [lastexamdate]**

**Date of last medical health update: [lastmhudate]**

Since you last provided medical information No

([lastmedinfodate]) have you experienced any chest Yes

discomfort? (Please provide narrative comments in Maybe

addition to completing the appropriate questions.) Unknown If "Yes" or "Maybe"

Chest discomfort with exertion or excitement No Yes

Maybe Unknown

Chest discomfort when quiet or resting No Yes

Maybe Unknown

Chest Discomfort Characteristics

Date of onset - year

(2002-2021)

DATE details (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Usual duration (minutes)

(1 = 1 min or less, 900 = 15 hrs or more, 999 = Unknown)

Longest duration (minutes)

(1 = 1 min or less, 900 = 15 hrs or more, 999 = Unknown)

Location No

Central sternum and upper chest Left upper quadrant

Left lower ribcage Right chest

Other Combination Unknown

Radiation No

Left shoulder or left arm Neck

Right shoulder or right arm, Back

Abdomen Other Combination Unknown

Number of episodes of chest pain in past month

(999 = Unknown)

Number of episodes of chest pain in past year

(999 = Unknown)

Type Pressure, heavy, vise

Sharp Dull Other Unknown

Relief by nitroglycerin in < 15 minutes

No Yes Not tried Unknown

Relief by rest in < 15 minutes

Relief spontaneously in < 15 minutes

Relief by other cause in < 15 minutes

Since you last provided medical information No

([lastmedinfodate]) have you been told by a doctor Yes

you had a heart attack, myocardial infarction or Maybe

angina? Unknown

If "Yes" or "Maybe"

Have medical encounter details been entered on M01? No

Yes

If "No"

Name of doctor

Location of doctor

Date of visit - year

(2002-2021)

DATE details (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Since you last provided medical information No

([lastmedinfodate]) have you been to a hospital/ E.R. Yes

for a heart attack, myocardial infarction or angina? Maybe Unknown

If "Yes" or "Maybe"

Have medical encounter details been entered on M01? No

Yes

If "No"

Name of hospital

Location of hospital

Date - year

(2002-2021)

DATE details (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

## CHD First Examiner Opinions

Angina pectoris No

Yes Maybe Unknown

If "Yes" or "Maybe"

Angina pectoris since revascularization procedure No Yes

Maybe Unknown

Coronary insufficiency No

Yes Maybe Unknown

Myocardial infarct No

Yes Maybe Unknown

## Additional Comments

Chest Discomfort and CHD Opinion

*Gen 3, NOS, Omni 2 Cohort Exam 3*

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# M12 Atrial Fibrillation Syncope Syncope Opinion

FHS\_IDTYPE\_ID

## Atrial Fibrillation, Syncope & Syncope Opinion

**Name: [lastname], [firstname]DOB: [dob]Age: [age] Sex: [sex] Date of last exam: [lastexamdate]**

**Date of last medical health update: [lastmhudate]**

Atrial Fibrillation

Since your last exam or medical history update....

Have you been told you have/had atrial fibrillation? No Yes

Maybe Unknown

Have medical encounter details been entered on M01? Yes

No

If "No"

Date of first episode - year

DATE details (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

ER/hospitalized or saw M.D. No

Hosp/ER Saw M.D.

Unk.

Name of the hospital (write Unk. if unknown)

Name of M.D. (write Unk. if unknown)

Syncope

Have you fainted or lost consciousness? No Yes

Maybe Unknown

Number of episodes in the past two years

(999=Unknown)

Date of first episode (month)

(99=Unknown)

Date of first episode (year)

(9999=Unknown)

Usual duration of loss of consciousness (minutes)

(999=Unk., 1=1 min or less)

Did you have any injury caused by the event? No Yes

Maybe Unknown

(999=Unk., 1=1 min or less)

ER/hospitalized or saw M.D. No

Hosp/ER Saw M.D.

Unk.

(999=Unk., 1=1 min or less)

Name of the hospital (write Unk. if unknown)

Name of M.D. (write Unk. if unknown)

Have you had a head injury with loss of No

consciousness? Yes

Maybe Unknown

Have medical encounter details been entered on M01? Yes

No

If "No",

Date of serious head injury with loss of consciousn.

- year (9999=Unknown)

DATE details (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Have you had a seizure? No

Yes Maybe Unknown

Have medical encounter details been entered on M01? Yes

No

If "No",

Date of most recent seizure - year

(9999=Unknown)

Are you being treated for a seizure disorder? No Yes

Maybe Unknown

Syncope First Examiner Opinion

Syncope (needs second opinion) No

Yes Maybe

Presyncope Unk.

Cardiac syncope No

Yes Maybe Unknown

Vasovagal syncope No

Yes Maybe Unknown

Other syncope No

Yes Maybe Unknown

Specify:

## Additional Comments

Atrial Fibrillation Syncope Syncope Opinion

# M13 Cerebrovascular Disease and Opinion

FHS\_IDTYPE\_ID

*Gen 3, NOS, Omni 2 Cohort Exam 3*

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## Cerebrovascular Disease and Opinion

**Name: [lastname], [firstname]DOB: [dob]Age: [age] Sex: [sex] Date of last exam: [lastexamdate]**

**Date of last medical health update: [lastmhudate]**

**Cerebrovascular Disease**

Since you last provided medical information ([lastmedinfodate]) have you had . . .

Sudden muscular weakness Sudden speech difficulty Sudden visual defect Sudden double vision

Sudden loss of vision in one eye Sudden numbness, tingling

No Yes Maybe Unknown

If "Yes" or "Maybe"

Numbness and tingling is positional No Yes

Maybe Unknown

HEAD CT scan OTHER THAN FOR THE FHS No

Yes Maybe Unknown

If "Yes" or "Maybe"

Have medical encounter details been entered on M01? No

Yes

If "No"

Name of facility

Location of facility

Date - year

(2002-2021)

DATE details (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

HEAD MRI scan OTHER THAN FOR THE FHS No

Yes Maybe Unknown

If "Yes" or "Maybe"

Have medical encounter details been entered on M01? No

Yes

If "No"

Name of facility

Location of facility

Date - year

(2002-2021)

DATE details (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Seen by neurologist No

Yes Maybe Unknown

If "Yes" or "Maybe"

Have medical encounter details been entered on M01? No

Yes

If "No"

Name of neurologist

Location of neurologist

Date - year

(2002-2021)

DATE details (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Have you been told by a doctor you had a stroke or TIA (transient ischemic attack,

mini-stroke)?

No Yes Maybe Unknown

Have you been told by a doctor you have Parkinson's 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?

Do you feel your memory is becoming worse?

## Cerebrovascular Disease First Examiner Opinion

TIA or stroke took place No

Yes Maybe Unknown

If "Yes" or "Maybe"

Date of TIA or stroke - year

(2002-2021)

DATE details (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Observed by

Duration - number of days

(99 = Unknown)

Duration - number of hours

(0 - 23, 99 = Unknown)

Duration - number of minutes

(0 - 59, 99 = Unknown)

Hospitalized or saw MD No

Hosp/ER Saw MD Unknown

Have medical encounter details been entered on M01? No

Yes

If "No"

Name of hospital

Location of hospital

Name of doctor

Location of doctor

Date - Year

(2002-2021)

DATE details (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

## Additional Comments

Cerebrovascular Disease and Opinion

# M14 Venous and PAD and IC Opinion

FHS\_IDTYPE\_ID

*Gen 3, NOS, Omni 2 Cohort Exam 3*

*Page 1 of 3*

## Venous and Peripheral Arterial Disease and Intermittent Claudication Opinion Name: [lastname], [firstname]DOB: [dob]Age: [age] Sex: [sex]

**Date of last exam: [lastexamdate]**

**Date of last medical health update: [lastmhudate]**

**Venous Disease**

Since you last provided medical information ([lastmedinfodate]) have you had . . .

Deep vein thrombosis - DVT (blood clots in legs or No

arms) Yes

Maybe Unknown

Pulmonary embolus - PE (blood clot in lungs) No Yes

Maybe Unknown

## Peripheral Arterial Disease

Since you last provided medical information ([lastmedinfodate]) . . .

Do you get discomfort in either leg on walking? No Yes

Unknown

If "Yes"

Does this discomfort ever begin when you are No

standing still or sitting? Yes

Unknown

When walking at an ordinary pace on level ground,

how many city blocks until symptoms develop? (where (1 = 1 block or less, 99 = Unknown) 10 blocks = 1 mile. Code as No if more than 98

blocks required to develop symptoms)

Claudication Symptoms

Discomfort in calf while walking

* left

No Yes Unknown

Discomfort in calf while walking

* right

Discomfort in lower leg (not calf) while walking - left

Discomfort in lower leg (not calf) while walking - right

If discomfort in either left or right not calf "Yes" Write in site of discomfort

Occurs with first steps (code worse leg) No Yes

Unknown

Do you get the discomfort when you walk up a hill or No

hurry? Yes

Unknown

Does the discomfort ever disappear while you are No

still walking? Yes

Unknown

What do you do if you get discomfort when you are Stop

walking? Slow down

Continue at same pace Unknown

Time for discomfort to be relieved by stopping

(minutes) (000 = No relief with stopping, 999 = Unknown)

Number of days/month of lower limb discomfort

(1 = 1 day/month or less, 99 = Unknown)

Since your last exam have you been told by a doctor No

you have intermittent claudication or peripheral Yes

artery disease? Unknown

If "Yes"

Have medical encounter details been entered on M01? No

Yes

If "No"

Name of doctor

Location of doctor

Date of visit - year

(2002-2021)

DATE details (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Since your last exam have you been told by a doctor No

you have spinal stenosis? Yes

Unknown

## Intermittent Claudication First Examiner Opinion

Intermittent claudication No

Yes Maybe Unknown

## Additional Comments

Venous and Peripheral Arterial Disease and Intermittent Claudication Opinion

# M15 CVD Procedures

FHS\_IDTYPE\_ID

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## CVD Procedures

**Name: [lastname], [firstname]DOB: [dob]Age: [age] Sex: [sex] Date of last exam: [lastexamdate]**

**Date of last medical health update: [lastmhudate]**

Since you last provided medical information ([lastmedinfodate]) did you have any of the following cardiovascular procedures?

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

Heart valvular surgery No

Yes Maybe Unknown

If "Yes" or "Maybe"

Year done

(2002 - 2021, 9999 = Unknown)

Exercise tolerance test No

Yes Maybe Unknown

If "Yes" or "Maybe"

Year done

(2002 - 2021, 9999 = Unknown)

Coronary arteriogram No

Yes Maybe Unknown

If "Yes" or "Maybe"

Year done

(2002 - 2021, 9999 = Unknown)

Coronary artery angioplasty or stent No Yes

Maybe Unknown

If "Yes" or "Maybe"

Year done

(2002 - 2021, 9999 = Unknown)

Coronary bypass surgery No

Yes Maybe Unknown

If "Yes" or "Maybe"

Year done

(2002 - 2021, 9999 = Unknown)

Permanent pacemaker insertion No

Yes Maybe Unknown

If "Yes" or "Maybe"

Year done

(2002 - 2021, 9999 = Unknown)

Carotid artery surgery or stent No

Yes Maybe Unknown

If "Yes" or "Maybe"

Year done

(2002 - 2021, 9999 = Unknown)

Thoracic aorta surgery No

Yes Maybe Unknown

If "Yes" or "Maybe"

Year done

(2002 - 2021, 9999 = Unknown)

Abdominal aorta surgery No

Yes Maybe Unknown

If "Yes" or "Maybe"

Year done

(2002 - 2021, 9999 = Unknown)

Femoral or lower extremity surgery No Yes

Maybe Unknown

If "Yes" or "Maybe"

Year done

(2002 - 2021, 9999 = Unknown)

Lower extremity amputation No

Yes Maybe Unknown

If "Yes" or "Maybe"

Year done

(2002 - 2021, 9999 = Unknown)

Other cardiovascular procedure (specify below) No Yes

Maybe Unknown

If "Yes" or "Maybe"

Year done

(2002 - 2021, 9999 = Unknown)

Specify other cardiovascular procedure

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

## Additional Comments

CVD Procedures

## Blood Pressure 2nd MD Reading

**Name: [lastname], [firstname]DOB: [dob]Age: [age] Sex: [sex Date of last exam: [lastexamdate]**

**Date of last medical health update: [lastmhudate]**

Systolic (to nearest 2 mm Hg)

Diastolic (to nearest 2 mm Hg)

BP cuff size Pedi

Regular adult Large adult Thigh Unknown

Protocol modification No

Yes Unknown

If "Yes"

Comments for Protocol modification

## Additional Comments

Blood Pressure 2nd MD Reading

## Cancer

**Name: [lastname], [firstname]DOB: [dob]Age: [age] Sex: [sex] Date of last exam: [lastexamdate]**

**Date of last medical health update: [lastmhudate]**

Since your last provided medical information No

([lastmedinfodate]) have you had a cancer or tumor? Yes Maybe Unknown

If "Yes" or "Maybe"

Cancer or tumor - #1 Esophagus

Stomach Colon Hand Rectum Pancreas Larynx

Trachea?Bronchus/Lung Leukemia

Skin Breast

Cervix/Uteru Ovary Prostate Bladder Kidney

Brain Lymphoma Other

Cancer or tumor site for "Other" - #1 ([cancersite1])

Diagnosis - #1 ([cancersite1]) Cancer

Maybe cancer Benign

Have medical encounter details been entered on M01 - No

#1 ([cancersite1]) Yes

If "No"

Year first diagnosed - #1 ([cancersite1])

DATE details for diagnose - #1 ([cancersite1]) (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Name of MD for diagnose - #1 ([cancersite1])

Location of MD for diagnose - #1 ([cancersite1])

Was a diagnostic biopsy done? - #1 ([cancersite1]) No Yes

If "Yes"

Year of biopsy - #1 ([cancersite1])

DATE details for biopsy - #1 ([cancersite1])(e.g. 10/2, April, Summer, August-Nov., Unknown etc)

Name of MD for biopsy - #1 ([cancersite1])

Location of MD for biopsy - #1 ([cancersite1])

Have you had another cancer or tumor? No Yes

Maybe Unknown

If "Yes" or "Maybe"

Site of cancer or tumor - #2 Esophagus

Stomach Colon Hand Rectum Pancreas Larynx

Trachea?Bronchus/Lung Leukemia

Skin Breast

Cervix/Uteru Ovary Prostate Bladder Kidney

Brain Lymphoma Other

Cancer or tumor site for "Other" - #2 ([cancersite2])

Diagnosis - #2 ([cancersite2]) Cancer

Maybe cancer Benign

Have medical encounter details been entered on M02 - No

#2 ([cancersite2]) Yes

If "No"

Year first diagnosed - #2 ([cancersite2])

DATE details for diagnose - #2 ([cancersite2]) (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Name of MD for diagnose - #2 ([cancersite2])

Location of MD for diagnose - #2 ([cancersite2])

Was a diagnostic biopsy done? - #2 ([cancersite2]) No Yes

If "Yes"

Year of biopsy - #2 ([cancersite2])

DATE details for biopsy - #2 ([cancersite2])(e.g. 10/2, April, Summer, August-Nov., Unknown etc)

Name of MD for biopsy - #2 ([cancersite2])

Location of MD for biopsy - #2 ([cancersite2])

Have you had another cancer or tumor? No Yes

Maybe Unknown

If "Yes" or "Maybe"

Site of cancer or tumor - #3 Esophagus

Stomach Colon Hand Rectum Pancreas Larynx

Trachea?Bronchus/Lung Leukemia

Skin Breast

Cervix/Uteru Ovary Prostate Bladder Kidney

Brain Lymphoma Other

Cancer or tumor site for "Other" - #3 ([cancersite3])

Diagnosis - #3 ([cancersite3]) Cancer

Maybe cancer Benign

Have medical encounter details been entered on M01 - No

#3 ([cancersite3]) Yes

If "No"

Year first diagnosed - #3 ([cancersite3])

DATE details for diagnose - #3 ([cancersite3]) (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Name of MD for diagnose - #3 ([cancersite3])

Location of MD for diagnose - #3 ([cancersite3])

Was a diagnostic biopsy done? - #3 ([cancersite3]) No Yes

If "Yes"

Year of biopsy - #3 ([cancersite3])

DATE details for biopsy - #3 ([cancersite3])(e.g. 10/2, April, Summer, August-Nov., Unknown etc)

Name of MD for biopsy - #3 ([cancersite3])

Location of MD for biopsy - #3 ([cancersite3])

Have you had another cancer or tumor? No Yes

Maybe Unknown

If "Yes" or "Maybe"

Other

Cancer or tumor site for "Other" - #4 ([cancersite4])

Diagnosis - #4 ([cancersite4]) Cancer

Maybe cancer Benign

Have medical encounter details been entered on M01 - No

#4 ([cancersite4]) Yes

If "No"

Year first diagnosed - #4 ([cancersite4])

DATE details for diagnose - #4 ([cancersite4]) (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Name of MD for diagnose - #4 ([cancersite4])

Location of MD for diagnose - #4 ([cancersite4])

Was a diagnostic biopsy done? - #4 ([cancersite4]) No Yes

If "Yes"

Year of biopsy - #4 ([cancersite4])

DATE details for biopsy - #4 ([cancersite4])(e.g. 10/2, April, Summer, August-Nov., Unknown etc)

Name of MD for biopsy - #4 ([cancersite4])

Location of MD for biopsy - #4 ([cancersite4])

Have you had another cancer or tumor? No Yes

Maybe Unknown

If "Yes" or "Maybe"

Other

Cancer or tumor site for "Other" - #5 ([cancersite5])

Diagnosis - #5 ([cancersite5]) Cancer

Maybe cancer Benign

Have medical encounter details been entered on M01 - No

#5 ([cancersite5]) Yes

If "No"

Year first diagnosed - #5 ([cancersite5])

DATE details for diagnose - #5 ([cancersite5]) (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Name of MD for diagnose - #5 ([cancersite5])

Location of MD for diagnose - #5 ([cancersite5])

Was a diagnostic biopsy done? - #5 ([cancersite5]) No Yes

If "Yes"

Year of biopsy - #5 ([cancersite5])

DATE details for biopsy - #5 ([cancersite5])(e.g. 10/2, April, Summer, August-Nov., Unknown etc)

Name of MD for biopsy - #5 ([cancersite5])

Location of MD for biopsy - #5 ([cancersite5])

## Additional Comments

Cancer

# M18 ECG

FHS\_IDTYPE\_ID

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## ECG

**Name: [lastname], [firstname]DOB: [dob]Age: [age] Sex: [sex] Date of last exam: [lastexamdate]**

**Date of last medical health update: [lastmhudate]**

**OFFSITE ONLY**

MD ID#

MD Name

## Rhythm - predominant

Rhythm Normal sinus (including s. tach, s. brady, s.

arrhy, 1 degree AV block)

2nd degress AV block, Mobitz I (Wenckebach) 2nd degree AV block, Mobitz II

3rd degree AV block / AV dissociation Atrial fibrillation / atrial flutter

Nodal Paced

Other or combination of above (list)

If "Other or combination of above (list)" Specify combination

## Ventricular Conduction Abnormalities

IV block No

Yes

Fully paced or unknown

If "Yes"

Pattern Left

Right Indeterminate Unknown

IV block complete or incomplete Incomplete (QRS interval < .12 sec) Complete (QRS interval >= .12 sec) Unknown

Hemiblock No

Left ant. Left post.

Fully paced or unknown

*Page 2 of 3*

WPW syndrome No

Yes Maybe

Fully paced or unknown

## Arrhythmias

Atrial premature beats No

Atr.

Atr. aber. Unknown

Ventricular premature beats No

Simple Multifoc. Pairs Run

R on T Unknown

If "Simple", "Multifoc.", "Pairs', "Run" or "R on T"

Number of ventricular premature beats in 10 seconds (see 10 second rhythm strip)

## Myocardial Infarction Location

Anterior No

Yes Maybe

Fully paced or unknown

Inferior No

Yes Maybe

Fully paced or unknown

True posterior No

Yes Maybe

Fully paced or unknown

## Hypertrophy, Enlargement, and Other ECG Diagnoses

Nonspecific S-T segment abnormality No

S-T depression S-T flattening Other

Fully paced or unknown

Nonspecific T-wave abnormality No

T inversion T flattening Other

Fully paced or unknown

Left Right Both

Atrial fib. or unknown

RVH (If complete RBBB or LBBB present, code RVH = None

Unknown) Yes

Maybe

Fully paced or unknown

LVH (If complete LBBB present, code LVH = Unknown) None

LVH with strain

LVH with mild S-T segment abn. LVH by voltage only

Fully paced or unknown

## Additional Comments

ECG

# M19 Clinical Diagnostic Impression

FHS\_IDTYPE\_ID

*Gen 3, NOS, Omni 2 Cohort Exam 3*

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## Clinical Diagnostic Impression

**Name: [lastname], [firstname]DOB: [dob]Age: [age] Sex: [sex] Date of last exam: [lastexamdate]**

**Date of last medical health update: [lastmhudate]**

Have you ever been told you have . . .

## Heart Diagnoses

Aortic valve disease Mitral valve disease

No Yes Maybe Unknown

## Neurological Disease

Dementia/ TIA Parkinson's's Disease Adult seizure disorder Migraine

Other neurological disease

No Yes Maybe Unknown

Specify other neurological disease

Comments

## Endocrine

Thyroid disease Diabetes Mellitus

Other endocrine disorders

No Yes Maybe Unknown

Specify other endocrine disorders

## GU/ GYN

Renal disease

No Yes Maybe Unknown

Specify renal disease

Prostate disease Gynecological problems

No Yes Maybe Male/Female Unknown

Specify gynecological problems

## Pulmonary

Emphysema Pneumonia Asthma

Other pulmonary disease

No Yes Maybe Unknown

Specify other pulmonary disease

## Rheumatologic Disorders

Gout

Degenerative joint disease Rheumatoid arthritis

Other muscular or connective tissue disease

No Yes Maybe Unknown

Specify other muscular or connective tissue disease

## GI

Gallbladder disease GERD/ ulcer disease Liver disease

Other GI disease

No Yes Maybe Unknown

Specify other GI disease

## Blood

Hematologic disorder Bleeding disorder

No Yes Maybe Unknown

## Infectious Disease

Infectious disease

No Yes Maybe Unknown

Specify infectious disease

## Mental Health

Depression Anxiety

Other mental health

No Yes Maybe Unknown

Specify other mental health

## Other

Eye ENT

Skin Other

No Yes Maybe Unknown

Specify other

## Additional Comments

Clinical Diagnostic Impression

# M20 Second Examiner Opinions

FHS\_IDTYPE\_ID

*Gen 3, NOS, Omni 2 Cohort Exam 3*

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## Second Examiner Opinion

**Name: [lastname], [firstname]DOB: [dob]Age: [age] Sex: [sex] Date of last exam: [lastexamdate]**

**Date of last medical health update: [lastmhudate]**

This form is not completed for exams performed OFFSITE. Choose Save and go to Next Form to continue. No second opinions are required for this participant. Choose Save and go to Next Form to continue.

Check here to skip this form Yes

Reason why skipped

Second examiner ID number

## Coronary Heart Disease

Provide initiators, qualities, radiation, severity, timing, presence after procedures done 2nd opinion for congestive heart failure No

Yes Maybe Unknown

2nd opinion for cardiac syncope No

Yes Maybe Unknown

2nd opinion for angina pectoris No

Yes Maybe Unknown

2nd opinion for coronary insufficiency No Yes

Maybe Unknown

2nd opinion for myocardial infarct No Yes

Maybe Unknown

Comments about heart disease

*Page 2 of 2*

## Intermittent Claudication

Provide initiators, qualities, radiation, severity, timing, presence after procedures done 2nd opinion for intermittent claudication No

Yes Maybe Unknown

Comments about peripheral artery disease

## Cerebrovascular Disease

Provide initiators, qualities, severity, timing, presence after procedures done 2nd opinion for stroke No

Yes Maybe Unknown

2nd opinion for TIA No

Yes Maybe Unknown

Comments about possible cerebrovascular disease

## Additional Comments

Second Examiner Opinions

# M21 Referral Tracking

FHS\_IDTYPE\_ID

*Gen 3, NOS, Omni 2 Cohort Exam 3*

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## Referral Tracking

**Name: [lastname], [firstname]DOB: [dob]Age: [age] Sex: [sex] Date of last exam: [lastexamdate]**

**Date of last medical health update: [lastmhudate]**

**Further Medical Evaluation**

Was further medical evaluation recommended for this No

participant? Yes

Unknown

## Result

Blood pressure No

Yes

Result - Systolic (mmHg)

Result - Diastolic (mmHg)

Phone call if SBP >= 200 or DBP >= 110 Expedite if SBP >= 180 or DBP >= 100 Elevated if SBP >= 140 or DBP >= 90

ECG abnormality No

Yes

Specify abnormality

Clinic physician identified medical problem No Yes

Specify medical problem

Other No

Yes

Specify other

## Method used to inform . . . Participant

No Yes

*Page 2 of 2*

Face-to-face in clinic Phone call

Result letter Other

## Method used to inform . . . Participant's personal physician

Phone call

Result letter mailed

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

No Yes

Other

Date referral made

ID number of person completing referral

Notes documenting conversation with participant or participant's personal physician

For Omni participants only: Which language was English

primarily used in conversing with the participant? Spanish Mixed Unknown

## Additional Comments

Referral Tracking

*Gen 3, NOS, Omni 2 Cohort Exam 3*

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# S01 General Information Sociodemographic

FHS\_IDTYPE\_ID

## General Information (Sociodemographic)

**Name: [lastname], [firstname]DOB: [dob]Age: [age] Sex: [sex] Date of last exam: [lastexamdate]**

**Date of last medical health update: [lastmhudate]**

What is your current marital status?

Single or never married

Married or living as married/living with partner Separated

Divorced Widowed

Prefer not to answer

What is the HIGHEST degree or level of school you have completed? (if currently enrolled, mark the highest grade completed, degree received)

Grades 1-8

Grades 9-11

Completed high school (12th grade) or GED Some college but no degree

Technical school certificate

Associate degree (Junior college AA, AS) Bachelor's degree (BA, AB, BS)

Graduate or professional (master's, doctorate, MD etc.) Prefer not to answer

Please choose which of the following best describes your current employment status?

Homemaker, not working outside the home Employed (or self-employed) full time Employed (or self-employed) part time Employed, but on leave for health reasons Employed, but temporarily away from my job Unemployed or laid off

Retired from usual occupation and not working Retired from usual occupation but working for pay Retired from usual occupation but volunteering Pefer not to answer

Unemployed due to disability Full-time student

What is your current occupation?

Using the occupation coding sheet choose the code that best describes your occupation

High degree Medium degree Training required Entry level Other

*Page 2 of 2*

Please select which income group that best represents your combined family income for the past 12 months.

Under $20,000

$20,000 - $34,999

$35,000 - $54,999

$55,000 - $74,999

$75,000 - $100.000

Over $100,000 Prefer not to answer

How many people are supported by this income?

## Additional Comments

Additional comments for General Information (Sociodemographic)

# S02 Health Insurance and Medications

FHS\_IDTYPE\_ID

*Gen 3, NOS, Omni 2 Cohort Exam 3*

*Page 1 of 2*

## Health Insurance and Medications

**Name: [lastname], [firstname]DOB: [dob]Age: [age] Sex: [sex] Date of last exam: [lastexamdate]**

**Date of last medical health update: [lastmhudate]**

**Health Insurance**

Do you currently have health insurance? No Yes

Prefer not to answer Unknown

If "Yes"

HMO or other private insurance such as Blue Cross, No

Aetna, Harvard-Pilgrim, etc. Yes

Prefer not to answer Unknown

If "Yes"

Blue Cross Blue Shield Harvard-Pilgrim

Tufts Aetna

United Health Care Other

No Yes Unknown

Specify other health insurance

Medicare No

Yes

Prefer not to answer Unknown

Medicaid No

Yes

Prefer not to answer Unknown

Military or Veteran's Administration sponsored No Yes

Prefer not to answer Unknown

Other No

Yes

Prefer not to answer Unknown

*Page 2 of 2*

Do you have prescription drug coverage? No Yes

Prefer not to answer Unknown

If "Yes" (Check one, Joanne will find the most common prescription drug plans in MA)

## Medication

Do you take any medications? No

Yes Unknown

If "Yes"

The questions below refer to medication recommended to you by your doctor or health care provider.

Did you ever forget to take your medicine?

No Yes Unknown

Are you careless at times about taking your medicine?

When you feel better do you stop taking your medicine?

Sometimes if you feel worse when you take the medicine, do you stop taking it?

How often do you forget to take your medicine? Never

More than once per week Once per week

More than once per month Once per month

Less than once per month

## Health Survey (SF-12) part 1

**Name: [lastname], [firstname]DOB: [dob]Age: [age] Sex: [sex] Date of last exam: [lastexamdate]**

**Date of last medical health update: [lastmhudate]**

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: Poor Fair Good

Very Good Excellent

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?

1. Moderate activities, such as moving a table, No, not limited at all

pushing a vacuum cleaner, bowling, or playing golf Yes, limited a little Yes, limited a lot

1. Climbing several flights of stairs No, not limited at all Yes, limited a little Yes, limited a lot

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?

1. Accomplished less than you would like Yes No
2. Were limited in the kind of work or other Yes

activities No

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)?

1. Accomplished less than you would like Yes No
2. Didn't do work or other activities as carefully as Yes

usual No

Health Survey (SF-12) part 2

Name: [lastname], [firstname]DOB: [dob]Age: [age] Sex: [sex] Date of last exam: [lastexamdate]

Date of last medical health update: [lastmhudate]

## 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 (=0) A little Bit (=1) Moderately (=2) Quite a Bit (=3) Extremely (=4)

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...

1. Have you felt calm and peaceful?

All of the time (=5)

Most of the time (=4)

A good bit of the time (=3)

Some of the time (=2)

A little of the time (=1)

None of the time (=0)

1. Did you have a lot of energy?
2. Have you felt downhearted and blue?
3. During the past 4 weeks, how much of the time has All of the time your physical health or emotional problems interfered Most of the time with your social activities (like visiting friends, Some of the time

relatives, etc.)? A little of the time

None of the time

## Bleeding History

**Name: [lastname], [firstname]DOB: [dob]Age: [age] Sex: [sex] Date of last exam: [lastexamdate]**

**Date of last medical health update: [lastmhudate]**

These questions are being asked because in rare situations some people or families have clinical bleeding problems or abnormalities. Since we are conducting blood cell counts, measurements of blood RNA and biomarkers, and tests of blood platelet reactivity, it is helpful to know about any individual or family clinical bleeding history since this can help in interpretation and analysis of results.

Does your FAMILY have a history of bleeding problems No or complications? (EXAMPLES: frequent nosebleeds, Yes prolonged or excessive bleeding or bruising after

cuts/trauma, gum bleeding, excess bleeding after dental or other medical or surgical procedures, extreme bleeding with your period)

Have YOU ever experienced frequent (>=1week) No

nosebleeds in your lifetime? Yes

Had nosebleeds lasting longer than 5 minutes or which No required medical attention? Yes

Do YOU experience frequent or heavy bruising No

disproportionate to the size of trauma? Yes

Do YOU ever experience prolonged bleeding (>5minutes) No with minor cuts, or with bites to lip, cheek or Yes tongue?

Have YOU experienced prolonged bleeding at the No

dentist that delayed a procedure, or after leaving a Yes dentist's office?

Have YOU experienced bleeding that a No surgeon/physician termed abnormal, caused a delay in Yes discharge, or required supportive treatment (for

example: re-suturing, re-admission, transfusion, iron therapy)?

## Have YOU ever experienced or been told you have any of the following?

Skin bleeding/red spots (petechiae)

No Yes

Spontaneous Gum bleeding Vomiting blood (hematemesis) Black, tarry stools (melena)

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Blood stools (hematochezia)

Excess bleeding w/your period (menorrhagia)

Excess bleeding w/delivery requiring medical intervention (post-partum hemorrhage)

*Gen 3, NOS, Omni 2 Cohort Exam 3*

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# T01 Basic Information and Anthropometrics

FHS\_IDTYPE\_ID

## Basic Information and Anthropometrics

**Name: [lastname], [firstname]DOB: [dob]Age: [age] Sex: [sex] Date of last exam: [lastexamdate]**

**Date of last medical health update: [lastmhudate]**

Technician Number

Check here to skip this form Yes

Reason why skipped

## Basic Information

What state do you reside in? (If reside outside the AL = Alabama USA, code ZZZ, if plans to wear accelerometer while AK = Alaska visiting USA code state of visit) AZ = Arizona



AR = Arkansas CA = California CO = Colorado

CT = Connecticut DE = Delaware

FL = Florida GA = Georgia HI = Hawaii ID = Idaho

IL = Illinois IN = Indiana IA = Iowa

KS = Kansas KY = Kentucky LA = Louisiana ME = Maine

MD = Maryland

MA = Massachusetts MI = Michigan

MN = Minnesota MS = Mississippi MO = Missouri MT = Montana NE = Nebraska NV = Nevada

NH = New Hampshire NJ = New Jersey

NM = New Mexico NY = New York

NC = North Carolina ND = North Dakota OH = Ohio

OK = Oklahoma OR = Oregon

PA = Pennsylvania RI = Rhode Island SC = South Carolina SD = South Dakota TN = Tennessee

TX = Texas UT = Utah

VT = Vermont VA = Virginia

WA = Washington WV = West Virginia WI = Wisconsin

WY = Wyoming

ZZ = Outside United States

## Anthropometry

Weight (to nearest pound)

(400 = 400 or more, 888 = Refused, 999 = Not done or unknown)

Protocol modification - weight No

Yes

If "Yes"

Comments protocol modification - weight

Height (inches, to next lower 1/4 inch)

(88.88 = Refused, 99.99 = Not done or unknown)

Protocol modification - height No

Yes

If "Yes"

Comments protocol modification - height

Waist Girth at umbilicus (inches, to next lower 1/4

inch) (88.88 = Refused, 99.99 = Not done or unknown)

Protocol modification - waist girth No Yes

If "Yes"

Comments protocol modification - waist girth

Hip Girth (inches, to next lower 1/4 inch)

(88.88 = Refused, 99.99 = Not done or unknown)

Protocol modification - hip girth No

Yes

If "Yes"

Comments protocol modification - hip girth

## Additional Comments

Basic Information and Anthropometry Comments

# T02 CESD and Rosow Breslau Questions

FHS\_IDTYPE\_ID

*Gen 3, NOS, Omni 2 Cohort Exam 3*

*Page 1 of 3*

## CES-D and Rosow-Breslau Questions Name: [lastname], [firstname]DOB: [dob]Age: [age] Sex: [sex]

**Date of last exam: [lastexamdate]**

**Date of last medical health update: [lastmhudate]**

Technician Number

Check here to skip this form Yes

Reason why skipped

## CES-D

The questions below ask about your feelings. For each statement, please say how often you felt that way DURING THE PAST WEEK

I was bothered by things that don't usually bother Rarely or none of the time (less than 1 day) me. Some or a little of the time (1-2 days)

Occasionally or a moderate amount of the time (3-4 days)

Most or all of the time (5-7 days)

I did not feel like eating; my appetite was poor. Rarely or none of the time (less than 1 day)

Some or a little of the time (1-2 days)

Occasionally or a moderate amount of the time (3-4 days)

Most or all of the time (5-7 days)

I felt that I could not shake off the blues even with Rarely or none of the time (less than 1 day) the help of my family or friends. Some or a little of the time (1-2 days)

Occasionally or a moderate amount of the time (3-4 days)

Most or all of the time (5-7 days)

I felt that I was just as good as other people. Rarely or none of the time (less than 1 day) Some or a little of the time (1-2 days)

Occasionally or a moderate amount of the time (3-4 days)

Most or all of the time (5-7 days)

I had trouble keeping my mind on what I was doing. Rarely or none of the time (less than 1 day)

Some or a little of the time (1-2 days)

Occasionally or a moderate amount of the time (3-4 days)

Most or all of the time (5-7 days)

*Page 2 of 3*

I felt depressed. Rarely or none of the time (less than 1 day) Some or a little of the time (1-2 days)

Occasionally or a moderate amount of the time (3-4 days)

Most or all of the time (5-7 days)

I felt everything I did was an effort. Rarely or none of the time (less than 1 day) Some or a little of the time (1-2 days)

Occasionally or a moderate amount of the time (3-4 days)

Most or all of the time (5-7 days)

I felt hopeful about the future. Rarely or none of the time (less than 1 day) Some or a little of the time (1-2 days)

Occasionally or a moderate amount of the time (3-4 days)

Most or all of the time (5-7 days)

I thought my life had been a failure. Rarely or none of the time (less than 1 day) Some or a little of the time (1-2 days)

Occasionally or a moderate amount of the time (3-4 days)

Most or all of the time (5-7 days)

I felt fearful. Rarely or none of the time (less than 1 day)

Some or a little of the time (1-2 days)

Occasionally or a moderate amount of the time (3-4 days)

Most or all of the time (5-7 days)

My sleep was restless. Rarely or none of the time (less than 1 day) Some or a little of the time (1-2 days)

Occasionally or a moderate amount of the time (3-4 days)

Most or all of the time (5-7 days)

I was happy. Rarely or none of the time (less than 1 day) Some or a little of the time (1-2 days)

Occasionally or a moderate amount of the time (3-4 days)

Most or all of the time (5-7 days)

I talked less than usual. Rarely or none of the time (less than 1 day) Some or a little of the time (1-2 days)

Occasionally or a moderate amount of the time (3-4 days)

Most or all of the time (5-7 days)

I felt lonely. Rarely or none of the time (less than 1 day)

Some or a little of the time (1-2 days)

Occasionally or a moderate amount of the time (3-4 days)

Most or all of the time (5-7 days)

People were unfriendly. Rarely or none of the time (less than 1 day) Some or a little of the time (1-2 days)

Occasionally or a moderate amount of the time (3-4 days)

Most or all of the time (5-7 days)

I enjoyed life. Rarely or none of the time (less than 1 day) Some or a little of the time (1-2 days)

Occasionally or a moderate amount of the time (3-4 days)

Most or all of the time (5-7 days)

I felt sad. Rarely or none of the time (less than 1 day)

Some or a little of the time (1-2 days)

Occasionally or a moderate amount of the time (3-4 days)

Most or all of the time (5-7 days)

I felt that people disliked me. Rarely or none of the time (less than 1 day) Some or a little of the time (1-2 days)

Occasionally or a moderate amount of the time (3-4 days)

Most or all of the time (5-7 days)

I could not get "going". Rarely or none of the time (less than 1 day) Some or a little of the time (1-2 days)

Occasionally or a moderate amount of the time (3-4 days)

Most or all of the time (5-7 days)

Score:

## Rosow-Breslau Questions

Are you able to do heavy work around the house, like No

shoveling snow or washing windows, walls, or floors Yes

without help? Unknown

Are you able to walk half a mile without help? No

(About 4-6 blocks) Yes

Unknown

Are you able to walk up and down one flight of stairs No

without help? Yes

Unknown

## Additional Comments

Additional comments for CESD and Rosow-Breslau Questions

|  |  |  |  |
| --- | --- | --- | --- |
| **Physical Activity Index (PAI)**  **[firstname]DOB: [dob]Age: [age] Sex: [sex] Date of last exam: [lastexamdate]**  **Date of last medical health update: [lastmhudate]** |  |  | **Name: [lastname],** |
| Technician Number |  |  |  |
| Check here to skip this form |  | Yes |  |
| Reason why skipped |  |  |  |
| Rest and Activity for a Typical Day over the past year. (A typical day = most days of the week)  (Activities must equal 24 hours) |  |  |  |
| Sleep Number of hours that you typically sleep? |  |  |  |
| Sedentary Number of hours typically sitting? |  |  |  |
| 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) (Must add up to 24)

## Additional Comment

Additional comments for Physical Activity Index

## Physical Activity Questionnaire - Part 1

**Name: [lastname], [firstname]DOB: [dob]Age: [age] Sex: [sex] Date of last exam: [lastexamdate]**

**Date of last medical health update: [lastmhudate]**

Technician Number

Check here to skip this form Yes

Reason why skipped

Now I'll ask you about your Physical Activities. Only include the time spent actually doing the activity. For example, sitting by the pool does not count as time swimming; sitting in a chair lift does not count for skiing.

First I'll ask about vigorous activities. Vigorous activities increase your heart rate, or make you sweat doing them, or make your breathe hard, or raise your body temperature. If you do an activity but not vigorously, please include it later when I ask you about other non-strenuous activities.

For all estimates, round up to nearest whole number.

In the past 12 months for at least one hour total time in any month did you do the following activities? For example, you may have done three 20 minute sessions in the month.

Jog or run? No

Yes Unknown

If "Yes"

How many months did you do this activity?

(99 = Unknown)

How many times per month did you do this activity?

(99 = Unknown)

How long did you do this activity on average each

time? (# of minutes) (999 = Unknown)

Do vigorous racket sports? No

Yes Unknown

If "Yes"

How many months did you do this activity?

(99 = Unknown)

How many times per month did you do this activity?

(99 = Unknown)

How long did you do this activity on average each

time? (# of minutes) (999 = Unknown)

Bicycle faster than 10 miles/hour or exercise hard on No

an exercise bicycle? or other machine such as... Yes Unknown

if "Yes"

*Page 2 of 2*

How many months did you do this activity?

(99 = Unknown)

How many times per month did you do this activity?

(99 = Unknown)

How long did you do this activity on average each

time? (# of minutes) (999 = Unknown)

Swim? No

Yes Unknown

if "Yes"

How many months did you do this activity?

(99 = Unknown)

How many times per month did you do this activity?

(99 = Unknown)

How long did you do this activity on average each

time? (# of minutes) (999 = Unknown)

## Additional Comments

Physical Activity Questionnaire - Part 1

*Gen 3, NOS, Omni 2 Cohort Exam 3*

*Page 1 of 2*

# T05 Physical Activity Questionnaire - Part 2

FHS\_IDTYPE\_ID

## Physical Activity Questionnaire - Part 2

**Name: [lastname], [firstname]DOB: [dob]Age: [age] Sex: [sex] Date of last exam: [lastexamdate]**

**Date of last medical health update: [lastmhudate]**

Technician Number

Check here to skip this form Yes

Reason why skipped

In the past 12 months for at least one hour total time in any month did you...

Do a vigorous exercise class or vigorous dancing? No Yes

Unknown

if "Yes"

How many months did you do this activity?

(99 = Unknown)

How many times per month did you do this activity?

(99 = Unknown)

How long did you do this activity on average each

time? (# of minutes) (999 = Unknown)

Do any vigorous job activities such as lifting, No

carrying, or digging? Yes

Unknown

if "Yes"

How many months did you do this activity?

(99 = Unknown)

How many times per month did you do this activity?

(99 = Unknown)

How long did you do this activity on average each

time? (# of minutes) (999 = Unknown)

Do any home activities such as snow shoveling, moving No heavy objects, or weight lifting (including weight Yes

training)? Unknown

if "Yes"

How many months did you do this activity?

(99 = Unknown)

How many times per month did you do this activity?

(99 = Unknown)

How long did you do this activity on average each

time? (# of minutes) (999 = Unknown)

*Page 2 of 2*

Do other strenuous sports such as basketball, No

football, skating, skiing, etc.? Yes

Unknown

If "Yes"

How many months did you do this activity?

(99 = Unknown)

How many times per month did you do this activity?

(99 = Unknown)

How long did you do this activity on average each

time? (# of minutes) (999 = Unknown)

Now, I'd like to ask you about more leisurely activities.

In the past 12 months for at least one hour total time in any month did you... Do non-strenuous sports such as softball, shooting No

baskets, volleyball, ping pong, or leisurely jogging, Yes swimming or biking, which we haven't included above? Unknown

If "Yes"

How many months did you do this activity?

(99 = Unknown)

How many times per month did you do this activity?

(99 = Unknown)

How long did you do this activity on average each

time? (# of minutes) (999 = Unknown)

## Additional Comments

Physical Activity Questionnaire - Part 2

*Gen 3, NOS, Omni 2 Cohort Exam 3*

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# T06 Physical Activity Questionnaire - Part 3

FHS\_IDTYPE\_ID

## Physical Activity Questionnaire - Part 3

**Name: [lastname], [firstname]DOB: [dob]Age: [age] Sex: [sex] Date of last exam: [lastexamdate]**

**Date of last medical health update: [lastmhudate]**

Technician Number

Check here to skip this form Yes

Reason why skipped

In the past 12 months for at least one hour total time in any month did you...

Take walks or hikes or walk to work? No Yes

Unknown

if "Yes"

How many months did you do this activity?

(99 = Unknown)

How many times per month did you do this activity?

How long did you do this activity on average each time? (# of minutes)

Bowl or play golf? No

Yes Unknown

If "Yes"

How many months did you do this activity?

(99 = Unknown)

How many times per month did you do this activity?

(99 = Unknown)

How long did you do this activity on average each

time? (# of minutes) (999 = Unknown)

Do home exercise or calisthenics? No Yes

Unknown

If "Yes"

How many months did you do this activity?

(99 = Unknown)

How many times per month did you do this activity?

(99 = Unknown)

How long did you do this activity on average each

time? (# of minutes) (999 = Unknown)

*Page 2 of 2*

Do home maintenance or gardening, including No

carpentry, painting, raking, mowing, etc.? Yes Unknown

if "Yes"

How many months did you do this activity?

(99 = Unknown)

How many times per month did you do this activity?

(99 = Unknown)

How long did you do this activity on average each

time? (# of minutes) (999 = Unknown)

Do non-strenuous weight training including free No

weights or machines such as Nautilus? Yes Unknown

If "Yes"

How many months did you do this activity?

(99 = Unknown)

How many times per month did you do this activity?

(99 = Unknown)

How long did you do this activity on average each

time? (# of minutes) (999 = Unknown)

## Additional Comments

Physical Activity Questionnaire - Part 3

*Gen 3, NOS, Omni 2 Cohort Exam 3*

*Page 1 of 2*

# T07 Physical Activity Questionnaire - Part 4

FHS\_IDTYPE\_ID

## Physical Activity Questionnaire - Part 4

**Name: [lastname], [firstname]DOB: [dob]Age: [age] Sex: [sex] Date of last exam: [lastexamdate]**

**Date of last medical health update: [lastmhudate]**

Technician Number

Check here to skip this form Yes

Reason why skipped

Now I'm going to ask you some questions about your physical activity during the past year at WORK ONLY.

Do you work? No

Yes Unknown

if "Yes"

How many hours per week do you work? (number of hours)

(999 = Unknown) Please answer for the work you do most of the year if you are a seasonal worker.

At work do you SIT

At work do you STAND At work do you WALK

Never(0 hrs) Seldom Sometimes Often Always Do notrecall

My next question is about your leisure time.

In the past week, about how many hours per day did None or < 1 hour you sit and watch TV or videos? 1 hour

1. hours
2. hours
3. hours
4. hours or more Unknown

In the past week, about how many hours per day did None or < 1 hour you use a computer or play computer games or play 1 hour

video games? 2 hours

1. hours
2. hours
3. hours or more Unknown

*Page 2 of 2*

## Additional Comments

Physical Activity Questionnaire - Part 4

# T08 Respiratory Disease Questionnaire

FHS\_IDTYPE\_ID

*Gen 3, NOS, Omni 2 Cohort Exam 3*

*Page 1 of 2*

## Respiratory Disease Questionnaire

**Name: [lastname], [firstname]DOB: [dob]Age: [age] Sex: [sex] Date of last exam: [lastexamdate]**

**Date of last medical health update: [lastmhudate]**

Technician Number

Check here to skip this form Yes

Reason why skipped

## Respiratory Diagnoses

Since your last exam...

Have you had asthma? No

Yes Unknown

If "Yes"

Do you still have it? No

Yes Unknown

Was it diagnosed by a doctor or other health care No

professional? Yes

Unknown

If it started since your last exam, at what age did

it start? (Age in years) If it started before last (88 = N/A, 99 = Unknown) exam enter 88 = N/A

If you no longer have it, at what age did it stop?

(Age in years) (88 = Still have it, 99 = Unknown)

Have you received medical treatment for this in the No

past 12 months? Yes

Unknown

Have you had any of the following conditions diagnosed by a doctor or other health care professional? Chronic Bronchitis No

Yes Unknown

Emphysema No

Yes Unknown

COPD (Chronic Obstructive Pulmonary Disease) No Yes

Unknown

*Page 2 of 2*

Sleep Apnea No

Yes Unknown

Pulmonary Fibrosis No

Yes Unknown

## Additional Comments

Respiratory Disease Questionnaire

# T09 Fractures

FHS\_IDTYPE\_ID

*Gen 3, NOS, Omni 2 Cohort Exam 3*

*Page 1 of 4*

## Fractures

**Name: [lastname], [firstname]DOB: [dob]Age: [age] Sex: [sex] Date of last exam: [lastexamdate]**

**Date of last medical health update: [lastmhudate]**

Technician Number

Check here to skip this form Yes

Reason why skipped

If more than 1 fracture at one site on the same side, enter it as a separate fracture.

Since you last provided medical information No

([lastmedinfodate]) have you broken any bones? Yes Unknown

If "Yes"

Location of fracture - #1 Hip

Upper arm (Humerus) Forearm or wrist

Hand

Clavicle (Collar bone) Rib

Back or vertebra Pelvis

Leg Ankle Foot Other

Location of fracture - #1 ([fracture1])

Side of fracture - #1 ([fracture1]) Left Right N/A

Unknown (don't remember)

Year of fracture - #1 ([fracture1])

(9999 = Unknown)

DATE details - #1 ([fracture1])(e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Have medical encounter details been entered on M01? - No

#1 ([fracture1]) Yes

If "No"

Hosp/MD for fracture - #1 ([fracture1])

Location of Hosp/MD - #1 ([fracture1])

Have you broken any more bones? No Yes

Unknown

If "Yes"

Location of fracture - #2 Hip

Upper arm (Humerus) Forearm or wrist

Hand

Clavicle (Collar bone) Rib

Back or vertebra Pelvis

Leg Ankle Foot Other

Location of fracture - #2 ([fracture2])

Side of fracture - #2 ([fracture2]) Left Right N/A

Unknown (don't remember)

Year of fracture - #2 ([fracture2])

(9999 = Unknown)

DATE details - #2 ([fracture2])(e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Have medical encounter details been entered on M01? - No

#2 ([fracture2]) Yes

If "No"

Hosp/MD for fracture - #2 ([fracture2])

Location of Hosp/MD - #2 ([fracture2])

Have you broken any more bones? No Yes

Unknown

If "Yes"

Location of fracture - #3 Hip

Upper arm (Humerus) Forearm or wrist

Hand

Clavicle (Collar bone) Rib

Back or vertebra Pelvis

Leg Ankle Foot Other

Location of fracture - #3 ([fracture3])

Side of fracture - #3 ([fracture3]) Left Right N/A

Unknown (don't remember)

Year of fracture - #3 ([fracture3])

(9999 = Unknown)

DATE details - #3 ([fracture3])(e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Have medical encounter details been entered on M01? - No

#3 ([fracture3]) Yes

If "No"

Hosp/MD for fracture - #3 ([fracture3])

Location of Hosp/MD - #3 ([fracture3])

Have you broken any more bones? No Yes

Unknown

If "Yes"

Location of fracture - #4 Hip

Upper arm (Humerus) Forearm or wrist

Hand

Clavicle (Collar bone) Rib

Back or vertebra Pelvis

Leg Ankle Foot Other

Location of fracture - #4 ([fracture4])

Side of fracture - #4 ([fracture4]) Left Right N/A

Unknown (don't remember)

Year of fracture - #4 ([fracture4])

(9999 = Unknown)

DATE details - #4 ([fracture4])(e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Have medical encounter details been entered on M01? - No

#4 ([fracture4]) Yes

If "No"

Hosp/MD for fracture - #4 ([fracture4])

Location of Hosp/MD - #4 ([fracture4])

Have you broken any more bones? No Yes

Unknown

If "Yes"

Upper arm (Humerus) Forearm or wrist

Hand

Clavicle (Collar bone) Rib

Back or vertebra Pelvis

Leg Ankle Foot Other

Location of fracture - #5 ([fracture5])

Side of fracture - #5 ([fracture5]) Left Right N/A

Unknown (don't remember)

Year of fracture - #5 ([fracture5])

(9999 = Unknown)

DATE details - #5 ([fracture5])(e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Have medical encounter details been entered on M01? - No

#5 ([fracture5]) Yes

If "No"

Hosp/MD for fracture - #5 ([fracture5])

Location of Hosp/MD - #5 ([fracture5])

## Additional Comments

Fractures

## Hand Grip Test

**Name: [lastname], [firstname]DOB: [dob]Age: [age] Sex: [sex] Date of last exam: [lastexamdate]**

**Date of last medical health update: [lastmhudate]**

Technician Number

Check here to skip this form Yes

Reason why skipped

Right hand Measured to the nearest kilogram

Trial 1

(99 = Unknown)

Trial 2

(99 = Unknown)

Trial 3

(99 = Unknown)

Left hand Measured to the nearest kilogram

Trial 1

(99 = Unknown)

Trial 2

(99 = Unknown)

Trial 3

(99 = Unknown)

Was this test NOT completed or NOT attempted? No Yes

If "Yes"

If not attempted or completed, why not? Physical limitation Refused

Other Unknown

Other: Write in

## Additional Comments

Hand Grip Test

## Tonometry Worksheet

**Name: [lastname], [firstname]DOB: [dob]Age: [age] Sex: [sex] Date of last exam: [lastexamdate]**

**Date of last medical health update: [lastmhudate]**

**Tonometry Worksheet Questions**

Have you had any caffeinated drinks in the last 6 No

hours? Yes

Unknown

If "Yes"

How many cups?

(99 = Unknown)

Have you eaten anything else including a fat freee No

cereal bar this morning? Yes

Unknown

Have you smoked cigarettes in the last 6 hours? No Yes

Unknown

If "Yes"

How many hours since your last cigarette? - hour

portion (99 = Unknown)

How many minutes since your last cigarette? - minute portion (99 = Unknown)

## Tonometry Test

Tonometry Sonographer ID

Date of Tonometry scan?

Was Tonometry done? No, test was not attempted or done

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

If "No"

Subject refusal No

Yes

Subject discomfort No

Yes

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Time constraint No

Yes

Equipment problem No

Yes

If "Yes"

Specify equipment problem

Other No

Yes

If "Yes" Specify other

## Additional Comments

Tonometry Worksheet

# T12 Exiting

FHS\_IDTYPE\_ID

*Gen 3, NOS, Omni 2 Cohort Exam 3*

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## Exit Interview and Adverse EventsName: [lastname], [firstname]DOB: [dob]Age: [age] Sex: [sex]

**Date of last exam: [lastexamdate]**

**Date of last medical health update: [lastmhudate]**

Technician Number

Check here to skip this form Yes

Reason why skipped

Removed and shredded bar code bracelet No Yes

## Exit Interview

Procedure sheet reviewed No

Yes Unknown

Referral sheet reviewed No

Yes Unknown

Dietary questionnaire provided (if not completed in No

clinic) Yes

Unknown

Left clinic with accelerometer No

Yes Unknown

Left clinic w/ belongings No

Yes Unknown

Explanation of microbiome; agreed to participate No Yes

Unknown

Feedback No feedback

Positive feedback Negative feedback Other

Unknown

Comments for Exit Interview

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## Adverse Events

**(not requiring further medical evaluation)**

Technician Number

Was there an adverse event in clinic that does not No

require further medical evaluation? Yes Unknown

Comments

Technician who reviewed that all REDCap form questions were completed

## Additional Comments

Additional comments for Exit Interview and Adverse Events