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A01 Participant Information

FHS_IDTYPE_ID _____

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: _____

Additional Comments

Participant Information

M01 Medical Encounters

FHS_IDTYPE_ID _____

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
- ◯ Ye
- ◯ s
- ◯ Unknown

Hospitalization

#3 Reason _____

Yea
r _____
(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
- ◯ Ye
- ◯ s
- Unknown

Hospitalization

#4 Reason _____

Yea
r _____
(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 _____

Yea
r _____
(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 _____

Yea
r

(9999 = Unknown)

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

Name of hospital

Location of _____

Have you had another E.R. visit?
- ◯ No
- ◯ Yes
- ◯ Unknown

E.R. Visit #3

Reason _____

Yea
r _____
(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 _____

Yea
r _____
(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 _____

Yea
r _____
(9999 = Unknown)

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

Name of hospital/doctor _____

Location of hospital/doctor _____

Location of
Have you had another day surgery?

_____

- ○ No
- ○ Ye
- ○ s
- ○ Unknown

Day Surgery #2

Reaso _____

Yea
r _____
(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
- ◯ Ye
- ◯ s
  Unknown

Day Surgery #3

Reason _____

Yea
r _____
(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
- ◯ Ye
- ◯ s
  Unknown

Day Surgery #4

Reason _____

Yea
r _____
(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

Reaso
Reason

_____

Yea
r

_____
(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 doctor?
- ◯ No
- ◯ 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 doctor?
- ◯ No
- ◯ 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 doctor?
- ◯ No
- ◯ 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
- ◯ Ye
- ◯ s

Unknown

If "Yes"

Check Up #1

Reason _____

Yea
r _____
(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 health care provider?
- ◯ No
- ◯ Yes
- ◯ Unknown

Check Up #2

Reason _____

Yea
r _____
(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 health care provider?
- ◯ No
- ◯ Yes
- ◯ Unknown

Check Up #3

Reason _____

Yea
r _____
(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 health care provider?
- ◯ No
- ◯ Yes
- ◯ Unknown

Check Up #4

Reason _____

Yea r

(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

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
- ◯ Ye
- ◯ s
- 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]) aspirin?
- ◯ Day
- ◯ Week
- ◯ Month
- ◯ Year
- ◯ Unk

Medication Treatment Questions

High blood pressure or hypertension

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

Are you CURRENTLY taking medication for high blood pressure or hypertension?
- ◯ No
- ◯ Yes
- ◯ Unknown

High blood cholesterol or high triglycerides

Have you been TOLD by doctor you have high blood cholesterol or high triglycerides?
- ◯ No
- ◯ Yes
- ◯ Unknow n

Are you CURRENTLY taking medication for high blood
- ◯ No
- ◯
- ◯

cholesterol or high triglycerides?	Yes Unknow n
High blood sugar or diabetes	

Have you been TOLD by doctor you have high blood sugar or diabetes?	◯ No ◯ Yes ◯ Unknown
Are you CURRENTLY taking medication for high blood sugar or diabetes?	◯ No ◯ Yes ◯ Unknown
Are you CURRENTLY taking medication for cardiovascular disease? (for example angina/chest pain, heart failure, atrial fibrillation/heart rhythm Unknown abnormality, stroke, leg pain when walking, peripheral artery disease)	◯ No ◯ Yes ◯

Additional Comments

Additional comments for Aspirin and Medication Treatment Questions

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 and/or non prescription as directed by HCP?
- ◯ No
- ◯ Yes, as directed by
- ◯ HCP Unknown

Medication bag with medications brought to exam?
- ◯ No
- ◯ Ye s

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 the list?
- ◯ No
- ◯ Yes

Medication (new) name #1 _____

Medication (new) name #2 _____

Medication (new) name #3 _____

Medication (new) name #4 _____

Medication (new) name #5 _____

Are you taking any over the counter products i.e. vitamins, supplements, plant extracts, alternatives?

- ◯ No
- ◯ Yes
- ◯ Unknow n

Check all OTC you are taking:

- ☐ Vitamins
- ☐ Supplement s 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 _____

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 control pills, shots, or hormone implants for birth control or medical indications (not post menopausal hormone replacement)?
- ◯ No
- ◯ Yes, now
- ◯ Yes, not now
- ◯ Unk.

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

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 had high blood pressure or hypertension?
- ◯ No
- ◯ Yes
- ◯ Unk
.

During any of these pregnancies, were you told you had eclampsia, pre-eclampsia (toxemia)?
- ◯ No
- ◯ Yes
- ◯ Unk
.

During any of these pregnancies, were you told you had high blood sugar or diabetes?
- ◯ No
- ◯ Yes
- ◯ Unk
.

Have you had any births since your last exam?
- ◯ No
- ◯ Ye
s

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

Full
- ◯ < 37 weeks
- ◯ =>37

Birth weight _____

Birth weight _____

Did you breast feed (include expressed
- ◯ No
- ◯ Yes
- ◯ Unk

If yes, how
- ◯ < 6 weeks
- ◯ 6 to 11 weeks
- ◯ 3 to 6 months

>6
months
Unk.

Baby #3

Full

◯ < 37
◯ weeks
◯ =>37

Birth weight

_____

Birth weight

_____

Did you breast feed (include expressed

◯ No
◯ Yes
◯ Unk

If yes, how

◯ < 6 weeks
◯ 6 to 11
◯ weeks
◯ 3 to 6
◯ months

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

Full
- ◯ < 37 weeks
- ◯ =>37

Birth weight _____

Birth weight _____

Did you breast feed (include expressed
- ◯ No
- ◯ Yes
- ◯ Unk

If yes, how
- ◯ < 6 weeks
- ◯ 6 to 11 weeks
- ◯ 3 to 6 months

>6
months
Unk.

Baby #6

Full

- ◯ < 37
- ◯ weeks
- ◯ =>37

Birth weight _____

Birth weight _____

Did you breast feed (include expressed

- ◯ No
- ◯ Yes
- ◯ Unk

If yes, how

- ◯ < 6 weeks
- ◯ 6 to 11
- ◯ weeks
- ◯ 3 to 6
- ◯ months

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 _____

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? (Check the BEST answer - only one.)

- ◯ 1=Not stopped
- ◯ 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. 99=Unknown)

_____ (00=not stopped,

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

- ◯ Still
- ◯ Natural
- ◯ Surgical
- ◯ Chemo/radiation
- ◯ Other
- ◯ Unknwon

Have you since your last exam taken hormone replacement therapy (estrogen/progesterone) or a selective estrogen receptor modulator (such as evista now or raloxifene)?

- ◯ No
- ◯ Yes, now
- ◯ Yes, not
- ◯ Unk.

Surgery History

Since your last exam have you had a hysterectomy (uterus/womb removed)?

- ◯ No
- ◯ 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 one or both of your ovaries?

- ◯ No
- ◯
- ◯

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 _____

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 regularly?
- ◯ No
- ◯ Yes
- ◯ Unknown

If "Yes"

Have you smoked cigarettes regularly in the last year? (No means less than 1 cigarette a day for 1 year.)
- ◯ No
- ◯ Yes
- ◯ Unknown

Do you smoke cigarettes (as of 1 month ago)?
- ◯ No
- ◯ Ye
- ◯ s
  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 for > 6 months?
- ◯ No
- ◯ Yes
- ◯ Unknown

If "Yes"

For how many years in total did you stop smoking cigarettes?
_____
(1 = 6 months - 1 year, 99 = Unknown)

Pipes or Cigars

Since your last exam have you regularly smoked a pipe or cigar?

- ◯ No
- ◯
- ◯
- Yes
- Unknown

If "Yes"

Do you smoke a pipe or cigar now?

- ◯ No
- ◯ Ye
- ◯ s
- 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 (at least once per week)?

- ◯ No
- ◯ 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 days did you smoke an e-cigarette?

- ◯ 0 days
- ◯ 1 day
- ◯ 2
- ◯ days
- ◯ 3 days
- ◯ 4 days
- ◯ 5 days
- ◯ Refused to answer
- Don't know

Additional Comments

Smoking

M08 Alcohol Consumption

FHS_IDTYPE_ID _____

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 oz. bottle, glass, can)
◯ No
◯ Yes
◯ Unknown

If "Yes"

Do you drink beer at least once week?
◯ No
◯ Ye
◯ s
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 or white, 4oz. glass)
◯ No
◯
◯

Yes
Unknown

If "Yes"

Do you drink wine at least once a week?
◯ No
◯ Ye
◯ s
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? (serving 1 oz. cocktail/ highball)
◯ No
◯ Yes
◯ Unknown

If "Yes"

Do you drink liquor/ spirits at least once per week?

- ◯ No
- ◯ Ye
- ◯ s
- Unknown

If "Yes"

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 drank 5 or more alcoholic drinks of any kind almost daily?

- ◯ No
- ◯ Yes
- ◯ Unknown

Over the past year, does participant drink less than one alcoholic drink of any type per month?

- ◯ No
- ◯ Yes

Additional Comments

Alcohol Consumption

M09 Respiratory Symptoms

FHS_IDTYPE_ID _____

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 throat)
◯ No
◯ Yes
◯ Unknown

Do you usually have a cough at all on getting up or first thing in the morning?
◯ No
◯ Yes
◯ Unknown

If "Yes" to either of 2 questions directly above

Do you cough like this on most days for three consecutive months or more during the past year?
◯ No
◯ 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 or first thing in the morning?
◯ No
◯ Yes
◯ Unknown

If "Yes" to either of 2 questions directly above

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

Unknown

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

Wheeze

In the past 12 months . . .

Have you had wheezing or whistling in your chest at any time?
- ◯ No
- ◯ 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 when you had a cold?
- ◯ No
- ◯ Yes
- ◯ Unknown

Have you had this wheezing or whistling in the chest apart from colds?
- ◯ No
- ◯ Yes
- ◯ Unknown

Have you had an attack of wheezing or whistling in the chest that made you feel short of breath?
- ◯ No
- ◯ Yes
- ◯ Unknow n

M09b Sleep Apnea and CHF Opinion

FHS_IDTYPE_ID _____

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, gasp, or stop breathing while you are asleep?
- ◯ 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 days a week have you had excessive (too much) daytime sleepiness?
- ◯ Never
- ◯ 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
- ◯ Ye
- ◯ s
  Unknown

Have you been awakened by a wheezing/ whistling in your chest?
- ◯ No
- ◯ Yes
- ◯ Unknown

Have you been awakened by coughing?
- ◯ No
- ◯ Ye
- ◯ s

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 on level ground or walking up a slight hill?

- ◯ No
- ◯
- ◯

Yes

Unknown

If "Yes"

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

- ◯ No
- ◯ Yes
- ◯ Unknow n

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

- ◯ No
- ◯ Yes
- ◯ Unknown

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

- ◯ No
- ◯ Yes
- ◯ Unknow n

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

- ◯ No
- ◯ Yes
- ◯ Unknow n

Have you had swelling in both your ankles (ankle edema)?

- ◯ No
- ◯ Yes
- ◯ Unknown

Have you been told by your doctor that you had heart failure or congestive heart failure?

- ◯ No
- ◯ Yes
- ◯ Unknow n

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
- ◯ Ye
- ◯ s
  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

M10 BP 1st MD

FHS_IDTYPE_ID _____

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

M11 Chest Discomfort and CHD

FHS_IDTYPE_I _____

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 ([lastmedinfodate]) have you experienced any chest discomfort? (Please provide narrative comments in addition to completing the appropriate questions.)

- ◯ No
- ◯ Yes
- ◯ Maybe
- ◯

Unknown If "Yes" or "Maybe"

Chest discomfort with exertion or excitement

- ◯ No
- ◯ Ye
- ◯ s
- ◯ Maybe
  Unknown

Chest discomfort when quiet or resting

- ◯ No
- ◯ Ye
- ◯ s
- ◯ 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
- ◯
- ◯

M11 Chest Discomfort and CHD

FHS_IDTYPE_I _____

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

	No	Yes	Not tried	Unknown
Relief by nitroglycerin in < 15 minutes	◯	◯	◯	◯
Relief by rest in < 15 minutes	◯	◯	◯	◯
Relief spontaneously in < 15 minutes	◯	◯	◯	◯
Relief by other cause in < 15 minutes	◯	◯	◯	◯

Since you last provided medical information ([lastmedinfodate]) have you been told by a doctor you had a heart attack, myocardial infarction or angina?
- ◯ No
- ◯ Yes
- ◯ Maybe
- ◯ 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 ([lastmedinfodate]) have you been to a hospital/ E.R. for a heart attack, myocardial infarction or angina?
- ◯ No
- ◯ Yes
- ◯ 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

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
- ◯ Ye
- ◯ s
- ◯ 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
- ◯ Ye
- ◯ s
- ◯ 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
- ◯ Ye
- ◯ s
- ◯ 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 consciousness?

- ◯ No
- ◯ 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
- ◯ Unknow n

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
- ◯ Ye
- ◯ s
- ◯ Maybe
- ◯ Unknown

Syncope First Examiner Opinion

Syncope (needs second opinion)

- ◯ No
- ◯ Yes
- ◯ Maybe
- ◯ Presyncop
- ◯ e Unk.

Cardiac syncope

- ◯ No
- ◯ Yes
- ◯ Maybe
- ◯ Unknow n

Vasovagal syncope

- ◯ No
- ◯ Yes
- ◯ Maybe
- ◯ Unknow n

Other syncope

- ◯ No
- ◯ Yes
- ◯ Maybe
- ◯ Unknown

Specify: _____

Additional Comments

Atrial Fibrillation Syncope Syncope Opinion

M13 Cerebrovascular Disease and Opinion

FHS_IDTYPE_ID _____

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 . . .

	No	Yes	Maybe	Unknown
Sudden muscular weakness	○			
Sudden speech difficulty	○			
Sudden visual defect		○	○	○
Sudden double vision	○	○	○	○
Sudden loss of vision in one eye	○	○	○	○
Sudden numbness, tingling	○	○	○	○
	○	○	○	○

If "Yes" or "Maybe"

Numbness and tingling is positional
○ No
○ Ye
○ s
○ Maybe
Unknown

HEAD CT scan OTHER THAN FOR THE FHS
○ No
○ Yes
○ Maybe
○ Unknow
n

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.) _____

	No	Yes	Maybe	Unknown
Have you been told by a doctor you had a stroke or TIA (transient ischemic attack, mini-stroke)?	◯	◯	◯	◯
Have you been told by a doctor you have Parkinson'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 _____

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 arms)
- ◯ No
- ◯ Yes
- ◯ Maybe
- ◯ Unknown

Pulmonary embolus - PE (blood clot in lungs)
- ◯ No
- ◯ Ye
- ◯ s
- ◯ Maybe
- Unknown

Peripheral Arterial Disease

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

Do you get discomfort in either leg on walking?
- ◯ No
- ◯ Ye
- ◯ s
- Unknown

If "Yes"

Does this discomfort ever begin when you are standing still or sitting?
- ◯ No
- ◯ 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
◯ Ye
◯ s
Unknown

Do you get the discomfort when you walk up a hill or hurry?
◯ No
◯ Yes
◯ Unknown

Does the discomfort ever disappear while you are still walking?
◯ No
◯ Yes
◯ Unknown

What do you do if you get discomfort when you are walking?
◯ Stop
◯ Slow down
◯ Continue at same pace
◯ Unknown

Time for discomfort to be relieved by stopping (minutes) Unknown)
_____
(000 = No relief with stopping, 999 =

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 you have intermittent claudication or peripheral artery disease?
◯ No
◯ 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
_____
(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 you have spinal stenosis?
◯ No
◯ 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 _____

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
Unknow
n

If "Yes" or "Maybe"

Year
done

_____
(2002 - 2021, 9999 = Unknown)

Permanent pacemaker insertion

◯ No
◯ Yes
◯ Maybe
◯ Unknow n

If "Yes" or "Maybe"

Year done _____ (2002 - 2021, 9999 = Unknown)

Carotid artery surgery or stent

◯ No
◯ Yes
◯ Maybe
◯ Unknow n

If "Yes" or "Maybe"

Year done _____ (2002 - 2021, 9999 = Unknown)

Thoracic aorta surgery

◯ No
◯ Yes
◯ Maybe
◯ Unknow n

If "Yes" or "Maybe"

Year done _____ (2002 - 2021, 9999 = Unknown)

Abdominal aorta surgery

◯ No
◯ Yes
◯ Maybe
◯ Unknow n

If "Yes" or "Maybe"

Year done _____ (2002 - 2021, 9999 = Unknown)

Femoral or lower extremity surgery

◯ No
◯ Ye
◯ s
◯ Maybe
Unknown

If "Yes" or "Maybe"

Year done _____ (2002 - 2021, 9999 = Unknown)

Lower extremity amputation

◯ No
◯ Yes
◯ Maybe
◯ Unknow n

If "Yes" or "Maybe"

Year done _____ (2002 - 2021, 9999 = Unknown)

Other cardiovascular procedure (specify below)

◯ No
◯ Ye
◯
◯

s
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

M16 BP 2nd MD

FHS_IDTYPE_ID _____

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

M17

FHS_IDTYPE_I _____

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 ([lastmedinfodate]) have you had a cancer or tumor?
- ◯ No
- ◯ 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 - #1 ([cancersite1])
- ◯ No
- ◯ 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])

M17

FHS_IDTYPE_I _____

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
- ◯ Ye
- ◯ s
- ◯ Maybe
- Unknown

If "Yes" or "Maybe"

Site of cancer or tumor - #2

- ◯ Esophagus
- ◯ Stomac
- ◯ h Colon
- ◯ Hand
- ◯ Rectum
- ◯ Pancrea
- ◯ s
- ◯ Larynx
- ◯ Trachea?Bronchus/Lung
- ◯ Leukemia
- ◯ Skin
- ◯ Breast
- ◯ Cervix/Uteru
- ◯ Ovary
- ◯ Prostate
- ◯ Bladder
- ◯ Kidney
- ◯ Brain
- ◯ Lymphom
- a Other

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

_____

Diagnosis - #2 ([cancersite2])

- ◯ Cancer
- ◯ Maybe
- ◯ cancer
- Benign

Have medical encounter details been entered on M02 - #2 ([cancersite2])

- ◯ No
- ◯ 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
- ◯ Ye
- s

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
- ◯ Ye
- ◯ s
- ◯ Maybe
- Unknown

If "Yes" or "Maybe"

Site of cancer or tumor - #3

- ◯ Esophagus
- ◯ Stomac
- ◯ h Colon
- ◯ Hand
- ◯ Rectum
- ◯ Pancrea
- ◯ s
- ◯ Larynx
- ◯ Trachea?Bronchus/Lung
- ◯ Leukemia
- ◯ Skin
- ◯ Breast
- ◯ Cervix/Uteru
- ◯ Ovary
- ◯ Prostate
- ◯ Bladder
- ◯ Kidney
- ◯ Brain
- ◯ Lymphom
- a Other

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

Diagnosis - #3 ([cancersite3])

- ◯ Cancer
- ◯ Maybe
- ◯ cancer
- Benign

Have medical encounter details been entered on M01 - #3 ([cancersite3])

- ◯ No
- ◯ 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
- ◯ Ye
- s

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
- ◯ Ye
- ◯ s
- ◯ Maybe
- Unknown

If "Yes" or "Maybe"

Site of cancer or tumor

- ◯ Esophagus
- ◯ Stomach
- ◯ Colon
- ◯ Hand
- ◯ Rectum
- ◯ Pancreas
- ◯ Larynx
- ◯ Trachea?Bronchus/ Lung Leukemia
- ◯ Skin
- ◯ Breast
- ◯ Cervix/ Uterus
- ◯ Ovary
- ◯ Prostate
- ◯ Bladder
- ◯ Kidney
- ◯ Other

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

Diagnosis - #4 ([cancersite4])

- ◯ Cancer
- ◯ Maybe cancer
- ◯ Benign

Have medical encounter details been entered on M01 - #4 ([cancersite4])

- ◯ No
- ◯ 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
- ◯

Site of cancer or tumor

- ◯ Esophagus
- ◯ Stomach
- ◯ Colon
- ◯ Hand
- ◯ Rectum
- ◯ Pancreas
- ◯ Larynx
- ◯ Trachea?Bronchus/Lung Leukemia
- ◯ Skin
- ◯ Breast
- ◯ Cervix/Uterus
- ◯ Ovary
- ◯ Prostate
- ◯ Bladder
- ◯ Kidney
- Maybe
- Unknown

If "Yes" or "Maybe"

Site of cancer or tumor

- ◯ Esophagus
- ◯ Stomach
- ◯ Colon
- ◯ Hand
- ◯ Rectum
- ◯ Pancreas
- ◯ Larynx
- ◯ Trachea?Bronchus/ Lung Leukemia
- ◯ Skin
- ◯ Breast
- ◯ Cervix/ Uterus
- ◯ Ovary
- ◯ Prostate
- ◯ Bladder
- ◯ Kidney
- ◯ Other

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

Diagnosis - #5 ([cancersite5])

- ◯ Cancer
- ◯ Maybe
- ◯ cancer Benign

Have medical encounter details been entered on M01 - #5 ([cancersite5])

- ◯ No
- ◯ 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]) _____

Site of cancer or tumor

- ◯ Esophag
- ◯ us
- ◯ Stomach
- ◯ Colon
- ◯ Hand
- ◯ Rectum
- ◯ Pancreas
- ◯ Larynx
- ◯ Trachea?Bronchus/
- ◯ Lung Leukemia
- ◯ Skin
- ◯ Breas
- ◯ t
- ◯ Cervix/
- ◯ Uteru
- ◯ Ovary
- ◯ Prostate
- ◯ Bladder
- ◯ Kidney

Additional Comments

Cancer

M18
ECG

FHS_IDTYPE_ID _____

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
- ◯
- ◯

Indetermina
te 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

WPW syndrome

- ◯ No
- ◯ Yes
- ◯ Maybe
- ◯ Fully paced or unknown

Arrhythmias

Atrial premature beats

- ◯ No
- ◯ Atr.
- ◯ Atr. aber.
- ◯ Unknown

Ventricular premature beats

- ◯ No
- ◯ Simple
- ◯ Multifo
- ◯ c. 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

Atrial	◯ Non ◯ Left ◯ Right ◯ Both ◯ Atrial fib. or unknown
RVH (If complete RBBB or LBBB present, code RVH = Unknown)	◯ None ◯ 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 _____

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

	No	Yes	Maybe	Unknown
Aortic valve disease	○	○	○	○
Mitral valve disease	○	○	○	○

Neurological Disease

	No	Yes	Maybe	Unknown
Dementia/ TIA	○	○	○	○
Parkinson's's Disease	○	○	○	○
Adult seizure disorder	○	○	○	○
Migraine	○	○	○	○
Other neurological disease	○	○	○	○

Specify other neurological disease _____

Comments

Endocrine

	No	Yes	Maybe	Unknown
Thyroid disease	○	○	○	○
Diabetes Mellitus	○	○	○	○
Other endocrine disorders	○	○	○	○

Specify other endocrine disorders _____

GU/ GYN

	No	Yes	Maybe	Unknown
Renal disease	○	○	○	○

Specify renal disease _____

	No	Yes	Maybe	Male/Female	Unknown
Prostate disease	○	○	○	○	○
Gynecological problems	○	○	○	○	○

Specify gynecological problems _____

Pulmonary

	No	Yes	Maybe	Unknown
Emphysema	○	○	○	○
Pneumonia	○	○	○	○
Asthma	○	○	○	○
Other pulmonary disease	○	○	○	○

Specify other pulmonary disease _____

Rheumatologic Disorders

	No	Yes	Maybe	Unknown
Gout	○	○	○	○
Degenerative joint disease	○	○	○	○
Rheumatoid arthritis	○	○	○	○
Other muscular or connective tissue disease	○	○	○	○

Specify other muscular or connective tissue disease _____

GI

	No	Yes	Maybe	Unknown
Gallbladder disease				
GERD/ ulcer disease				
Liver disease				
Other GI disease				

Specify other GI disease _____

Blood

	No	Yes	Maybe	Unknown
Hematologic disorder	○	○	○	○
Bleeding disorder	○	○	○	○

Infectious Disease

	No	Yes	Maybe	Unknown
Infectious disease	○	○	○	○

Specify infectious disease _____

Mental Health

	No	Yes	Maybe	Unknown
Depression	○	○	○	○
Anxiety	○	○	○	○
Other mental health	○	○	○	○

Specify other mental health _____

Other

	No	Yes	Maybe	Unknown
Eye	○	○	○	○
ENT	○	○	○	○
Skin	○	○	○	○
Other	○	○	○	○

Specify other _____

Additional Comments

Clinical Diagnostic Impression

M20 Second Examiner Opinions

FHS_IDTYPE_ID _____

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

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 _____

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 participant?
- ◯ No
- ◯ 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

Face-to-face in	◯	◯
clinic Phone call	◯	◯
Result letter	◯	◯
Other	◯	◯

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

	No	Yes
Phone call	◯	◯
Result letter mailed	◯	◯
Result letter FAX'd (inform staff if FAX needed)	◯	◯
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 primarily used in conversing with the participant?

- ◯ English
- ◯ Spanish
- ◯ Mixed
- ◯ Unknown

Additional Comments

Referral Tracking

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

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 _____

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, Aetna, Harvard-Pilgrim, etc.
- ◯ No
- ◯ Yes
- ◯ Prefer not to answer
- ◯ Unknown

If "Yes"

	No	Yes	Unknown
Blue Cross Blue Shield	◯	◯	◯
Harvard-Pilgrim	◯	◯	◯
Tufts	◯	◯	◯
Aetna	◯	◯	◯
United Health Care	◯	◯	◯
Other	◯	◯	◯

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

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.

	No	Yes	Unknown
Did you ever forget to take your medicine?	◯	◯	◯
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

S_3 Health Survey SF12

FHS_IDTYPE_ID _____

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?

2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf
- ◯ No, not limited at all
- ◯ Yes, limited a little
- ◯ Yes, limited a lot

3. 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?

4. Accomplished less than you would like
- ◯ Yes
- ◯ No

5. Were limited in the kind of work or other activities
- ◯ Yes
- ◯ 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)?

6. Accomplished less than you would like
- ◯ Yes
- ◯ No

7. Didn't do work or other activities as carefully as usual
- ◯ Yes
- ◯ No

S_4 Health Survey SF12

FHS_IDTYPE_I _____

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 ...

	Not at all (=0)	A little Bit (=1)	Moderately (=2)	Quite a Bit (=3)	Extremely (=4)
how much did pain interfere with your normal work (including both work outside the home and housework)?	○	○	○	○	○

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

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

	All of the time (=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)
9. Have you felt calm and peaceful?	○	○	○	○	○	○
10. Did you have a lot of energy?	○	○	○	○	○	○
11. Have you felt downhearted and blue?	○	○	○	○	○	○

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

- ○ All of the time
- ○ Most of the
- ○ Some of the
- ○
- ○ A little of the time
- None of the time

S05 Bleeding History

FHS_IDTYPE_I _____

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 or complications? (EXAMPLES: frequent nosebleeds,

◯ No
◯

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) nosebleeds in your lifetime?

◯ No
◯ Yes

Had nosebleeds lasting longer than 5 minutes or which required medical attention?

◯ No
◯

Yes

Do YOU experience frequent or heavy bruising disproportionate to the size of trauma?

◯ No
◯ Yes

Do YOU ever experience prolonged bleeding (>5minutes) with minor cuts, or with bites to lip, cheek or

◯ No
◯

Yes tongue?

Have YOU experienced prolonged bleeding at the dentist that delayed a procedure, or after leaving a

◯ No
◯

Yes dentist's office?

Have YOU experienced bleeding that a surgeon/physician termed abnormal, caused a delay in

◯ No
◯

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?

	No	Yes
Skin bleeding/red spots (petechiae)	◯	◯
Spontaneous Gum bleeding	◯	◯

S05 Bleeding History

FHS_IDTYPE_I _____

Vomiting blood (hematemesis) Black, tarry stools (melena)

Blood stools (hematochezia)	○	○
Excess bleeding w/your period (menorrhagia)	○	○
Excess bleeding w/delivery requiring medical intervention (post-partum hemorrhage)	○	○

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 Alabama USA, code ZZZ, if plans to wear accelerometer while

Alaska visiting USA code state of visit)
Arizona

- ◯ AL =
- ◯
- ◯ AK =
- ◯ AZ =
- ◯
- ◯ 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 _____

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 day) me.
- ◯ Rarely or none of the time (less than 1
- ◯ 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 day) the help of my family or friends.
- ◯ Rarely or none of the time (less than 1
- ◯ 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)

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 had crying spells.

- ◯ 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 shoveling snow or washing windows, walls, or floors without help?

- ◯ No
- ◯ Yes
- ◯ Unknown

Are you able to walk half a mile without help? (About 4-6 blocks)

- ◯ No
- ◯ Yes
- ◯ Unknown

Are you able to walk up and down one flight of stairs without help?

- ◯ No
- ◯ Yes
- ◯ Unknown

Additional Comments

Additional comments for CESD and Rosow-Breslau Questions

T03 Physical Activity

FHS_IDTYPE_I _____

Physical Activity Index (PAI)
[firstname]DOB: [dob]Age: [age]
Sex: [sex] Date of last exam:
[lastexamdate]
Date of last medical health update:

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

T04 Physical Activity Questionnaire

FHS_IDTYPE_I _____

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)

T04 Physical Activity Questionnaire

FHS_IDTYPE_I _____

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 an exercise bicycle? or other machine such as...
- ◯ 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)

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

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
◯ Ye
◯ s
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, carrying, or digging?
◯ 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 home activities such as snow shoveling, moving heavy objects, or weight lifting (including weight training)?
◯ 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 other strenuous sports such as basketball, football, skating, skiing, etc.?
- ◯ 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)

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 baskets, volleyball, ping pong, or leisurely jogging, swimming or biking, which we haven't included above?
- ◯ 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 2

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
◯ Ye
◯ s
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
◯ Ye
◯ s
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 maintenance or gardening, including carpentry, painting, raking, mowing, etc.?

◯ 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 non-strenuous weight training including free weights or machines such as Nautilus?

◯ 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 3

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.

	Never(0 hrs) notrecall	Seldom	Sometimes	Often	Always	Do
At work do you SIT	◯	◯	◯	◯	◯	◯
At work do you STAND At work do you WALK	◯	◯	◯	◯	◯	◯
	◯	◯	◯	◯	◯	◯

My next question is about your leisure time.

In the past week, about how many hours per day did you sit and watch TV or videos?
- ◯ None or < 1 hour
- ◯ 1 hour
- ◯ 2 hours
- ◯ 3 hours
- ◯ 4 hours
- ◯ 5 hours or more
- ◯ Unknown

In the past week, about how many hours per day did you use a computer or play computer games or play video games?
- ◯ None or < 1 hour
- ◯ 1 hour
- ◯ 2 hours
- ◯ 3 hours
- ◯ 4 hours
- ◯ 5 hours or more
- ◯ Unknown

Additional Comments

Physical Activity Questionnaire - Part 4

T08 Respiratory Disease Questionnaire

FHS_IDTYPE_ID _____

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 professional?
◯ No
◯ Yes
◯ Unknown

If it started since your last exam, at what age did it start? (Age in years) If it started before last exam enter 88 = N/A _____ (88 = N/A, 99 = Unknown)

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 past 12 months?
◯ No
◯ 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
- ◯ Ye
- ◯ s
  Unknown

Sleep Apnea	◯ No ◯ Yes ◯ Unknown
Pulmonary Fibrosis	◯ No ◯ Yes ◯ Unknown

Additional Comments

Respiratory Disease Questionnaire

T09
Fractures

FHS_IDTYPE_ID _____

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 ([lastmedinfodate]) have you broken any bones?
- ◯ No
- ◯ 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? - #1 ([fracture1])
- ◯ No
- ◯ Yes

If "No"

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

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

Have you broken any more bones?

- ◯ No
- ◯ Ye
- ◯ s
- 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
- ◯ Righ
- ◯ t
- ◯ 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? - #2 ([fracture2])

- ◯ No
- ◯ Yes

If "No"

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

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

Have you broken any more bones?

- ◯ No
- ◯ Ye
- ◯ s

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
- ◯ Righ
- ◯ t
- ◯ 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? - #3 ([fracture3])
- ◯ No
- ◯ Yes

If "No"

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

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

Have you broken any more bones?
- ◯ No
- ◯ Ye
- ◯ s
- 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
- ◯ Righ
- ◯ t
- ◯ 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? - #4 ([fracture4])
- ◯ No
- ◯ Yes

If "No"

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

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

Have you broken any more bones?
- ◯ No
- ◯ Ye
- ◯ s
- Unknown

If "Yes"

Location of fracture -

- ◯ Hi
- ◯ 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
- ◯ Righ
- ◯ t
- ◯ 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? - #5 ([fracture5])

- ◯ No
- ◯ Yes

If "No"

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

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

Additional Comments

Fractures

T10 Hand Grip

FHS_IDTYPE_I _____

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

T11 Tonometry Worksheet

FHS_IDTYPE_I _____

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 hours?
- ◯ No
- ◯ Yes
- ◯ Unknown

If "Yes"

How many cups? _____ (99 = Unknown)

Have you eaten anything else including a fat freee cereal bar this morning?
- ◯ No
- ◯ Yes
- ◯ Unknown

Have you smoked cigarettes in the last 6 hours?
- ◯ No
- ◯ Ye
- ◯ s
  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

T11 Tonometry Worksheet

FHS_IDTYPE_I _____

Subject discomfort

- ◯ No
- ◯ Yes

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 _____

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 clinic)
◯ No
◯ 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

Adverse Events
(not requiring further medical evaluation)

Technician Number _____

Was there an adverse event in clinic that does not require further medical evaluation?

- ◯ No
- ◯ Yes
- ◯ Unknown

Comments _____

Technician who reviewed that all REDCap form questions were completed _____

Additional Comments

Additional comments for Exit Interview and Adverse Events