

OMB NO=0925-0216 12/31/2007

Basic Information			
h389	Examiner's Number for Basic Information		
h390	Sex of Participant (1=Male, 2=Female)		
h391	Age of Participant (years) 99=Unknown		
h392	Site of Exam (0=Heart Study, 1=Nursing home, 2=Residence, 3=Other)		
h393	Weight (to nearest pound)	h394 Protocol modification	0=No 1=Yes
If offsite, fill	h395	Method used to obtain weight (0=FHS protocol/field visit with portable scale, 1=Recorded in NH chart, 2= Other, write in _____)	
	h396 h397 h398	Date weight obtained (mm/dd/yyyy)	
h399	Height (inches, to next lower 1/4 inch) Note: Bottom coded at 58 inches	h400 Protocol modification	0=No 1=Yes
h401	In the past year, have you lost more than 10 pounds? 0=No 1= Yes, unintentionally, NOT due to dieting or exercise 2= Yes, intentionally, due to dieting or exercise		

Regional Anthropometry			
(Code boxes below with 9's if not done or unknown)			
h402	Examiner's Number for anthropometry		
h403	Waist Girth at umbilicus (inches, to next lower 1/4 inch)	h404 Protocol modification	0=No
h405	Waist Girth at iliac crest (inches, to next lower 1/4 inch)	h406 Protocol modification	1=Yes 8=Offsite
h407	Sagittal abdominal diameter (to nearest 0.1 cm)	h408 Protocol modification	
h409	Are you fasting \geq 8 hours?		

Comments on all protocol modifications:

TECH01

OMB NO=0925-0216 12/31/2007

Exam 8 Procedures Sheet

h410 Informed Consent Signed0=No, 1=Yes,
2=Consent signed, may qualify for waiver,
3=Waiver used, 4=Other**h411** Anthropometry**h412** Sociodemographic Questions**h413** SF-12 Health Survey**h414** CES-D Scale**h415** Exercise Questionnaire**h416** Mini-Mental Status Exam**h417** Urine Specimen**h418** Blood Draw**h419** ECG0=No,
1=Yes,
8=Offsite visit**h420** Observed performance (Timed walk hand grip)**h421** Tonometry /ECHO/Carotid**h422** Ankle-brachial blood pressure by Doppler**h423** Spirometry**h424** Post bronchodilator Spirometry**h425** Diffusion Capacity**h426** Reason Spirometry not done**h427** Reason post bronchodilator test not done**h428** Reason Diffusion not done1=Major Surgery , 2=Heart Attack, 3=Stroke,
4=Aneurysm, 5=BP>210/110, 6=Refused, 7=Test
Aborted, 8=Other, 10=equipment problems

Exit Interview

h429 Examiner ID**h430** Procedure sheet reviewed**h431** Referral sheet reviewed**h432** Willett dietary questionnaire provided (if not completed in clinic)0=No
1=Yes
8=Offsite**h433** Left clinic w/ belongings**h434** Feedback 0=No feedback, 1=Positive feedback, 2=Negative feedback, 3=Other**h435** Comments _____

TECH02

**For Participants Wish to Complete
Their Exam on a Second Visit**

OMB NO=0925-0216 12/31/2007

_____-_____-_____ h436 h437 h438	Second Exam Date (If participant returns to finish their clinic exam on a date other than the original exam date, then fill in the date they return here. Otherwise leave entire page completely blank)
--	---

Keys: if Second Exam Date is not filled and page is blank' then leave the page all blank.

Fill in with 1=yes if procedure was done on the Second Exam Date and 0=no if procedure was not done on the Second Exam Date. Note that informed consent from first visit will cover the second visit.

Exam 8 Procedures Sheet		
h439	MD Questionnaire	
h440	Anthropometry	
h441	Sociodemographic Questions	
h442	SF-12 Health Survey	
h443	CES-D Scale	
h444	Exercise Questionnaire	
h445	Mini-Mental Status Exam	
h446	Urine Specimen	
h447	Blood Draw	
h448	ECG	
h449	Observed performance (Timed walk hand grip)	
h450	Tonometry /ECHO/Carotid	
h451	Ankle-brachial blood pressure by Doppler	
h452	Spirometry	
h453	Post bronchodilator Spirometry	
h454	Diffusion Capacity	
h455	Reason Spirometry not done	0=No 1=Yes 8=Offsite visit 1=Major Surgery, 2=Heart attack, 3=Stroke, 4=Aneurysm, 5=BP>210/110, 6=Refused, 7=Test Aborted, 8=Other, 10=equipment problems
h456	Reason post bronchodilator test not done	
h457	Reason Diffusion not done	

Rosow-Breslau Scale

OMB NO=0925-0216 12/31/2007

h458	Examiner's Number for Socio-demographics		
Socio-demographics			
h459	Where do you live? (0=Private residence, 1=Nursing home, 2=Other institution, such as: assisted living, retirement community, 9=Unknown)		
h460	Does anyone live with you? (0=No, 1=Yes, 9=Unknown) Code Nursing Home Residents as NO to these questions		
If Yes ☞ If 0 or 9, skip down	h461	Spouse	
	h462	Significant Other	0=No
	h463	Children	1=Yes, less than 3 months per year
	h464	Friends	2=Yes, more than 3 months per year
	h465	Relatives	9=Unknown

Use of Nursing and Community Services		
h466	Have you been admitted to a nursing home (or skilled facility) in the past year)	0=No
h467	In the past year, have you been visited by a nursing service, or used home, community, or outpatient programs?	1=Yes 9=Unknown

Rosow-Breslau Questions		
h468	Are you able to do heavy work around the house, like shoveling snow or washing windows, walls, or floors without help?	0=No
h469	Are you able to walk half a mile without help? (About 4-6 blocks)	1=Yes
h470	Are you able to walk up and down one flight of stairs without help?	9=Unknown

CES-D Scale

The questions below ask about your feelings.

Circle best answer for each question DURING THE PAST WEEK	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
h471 1. I felt that everything I did was an effort	0	1	2	3
h472 2. I could not "get going"	0	1	2	3

TECH03

OMB NO=0925-0216 12/31/2007

h473	Examiner's Number for Activities of Daily Living
During the Course of a Normal Day, Can you do the following activities independently or do you need human assistance or the use of a device? Coding: 0=No help needed, independent, 1=Uses device, independent, 2=Human assistance needed, minimally dependent, 3=Dependent, 4=Do not do during a normal day, 9=Unknown	
h474	Dressing (undressing and redressing) Devices such as: velcro, elastic laces;
h475	Bathing (including getting in and out of tub or shower) Devices such as: bath chair, long handled sponge, hand held shower, safety bars
h476	Eating Devices such as: rocking knife, spork, long straw, plate guard.
h477	Transferring (getting in and out of a chair) Devices such as: sliding board, grab bars, special seat;
h478	Toileting Activities (using bathroom facilities and handle clothing) Devices such as: special toilet seat, commode;

TECH04

Physical Activity Questionnaire--Framingham Heart Study
Tech-administered

OMB NO=0925-0216 12/31/2007

h479	Examiner ID
Rest and Activity for a Typical Day (Activities must equal 24 hours)	
	Number of hours
Sleep --Number of hours that you typically sleep?	h480
Sedentary Number of hours typically sitting?	h481
Slight Activity - Number of hours with activities such as standing, walking?	h482
Moderate Activity - Number of hours with activities such as housework (vacuum, dust, yard chores, climbing stairs; light sports such as bowling, golf)?	h483
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?	h484
Total number of hours (should be the total of above items)	24

h485	What is your normal walking pace outdoors?
	<ul style="list-style-type: none"> 0 = Unable to walk 1 = Easy, casual, slow (less than 2 miles per hour) 2 = Normal, average (2 to 2.9 miles per hour) 3 = Brisk pace (3 to 3.9 miles per hour) 4 = Very brisk pace (4 to 4.9 miles per hour) 9 = Unknown
h486	How many flights of stairs (not steps) do you climb daily?(10 stairs per flight)
	<ul style="list-style-type: none"> 0 = No flights 1 = 1-2 flights 2 = 3-4 flights 3 = 5-9 flights 4 = 10-14 flights 5 = >15 flights 9 = Unknown

TECH05

Physical Activity Questionnaire--Framingham Heart Study

Tech-administered

OMB NO=0925-0216 12/31/2007

I am going to read a list of activities. Please tell me which activities you have done in the past year

h487		Examiner ID			
During the past year	0=No, 1=Yes 8=Refused 9=Unknown	In a typical 2week period of time, how often do you (name of activity)	Average time/session		Number months/year 0-12
			hours	minutes	
h488	Walking for exercise	h489	h490	h491	h492
h493	Calisthenics/general exercise	h494	h495	h496	h497
h498	Moderate strenuous household chores	h499	h500	h501	h502
h503	Mowing the lawn	h504	h505	h506	h507
h508	Gardening	h509	h510	h511	h512
h513	Hiking	h514	h515	h516	h517
h518	Jogging	h519	h520	h521	h522
h523	Biking	h524	h525	h526	h527
h528	Exercise cycle, ski or stair machine	h529	h530	h531	h532
h533	Dancing	h534	h535	h536	h537
h538	Aerobics	h539	h540	h541	h542
h543	Golf	h544	h545	h546	h547
h548	Swimming	h549	h550	h551	h552
h553	Weight training (free weights, machines)	h554	h555	h556	h557
h558	Other, write in_____	h559	h560	h561	h562
h563	Other, write in_____	h564	h565	h566	h567

TECH06

OMB NO=0925-0216 12/31/2007

h568	Examiner's Number for Activities - Part B
Nagi Questions	
<p>For each thing tell me whether you have</p> <p>(0) No Difficulty (1) A Little Difficulty (2) Some Difficulty (3) A Lot Of Difficulty (4) Unable To Do (5) Don't Do On MD Orders (6) Unable to Assess Difficulty Because not Done as Part of Daily Activities (9) Unknown</p>	
h569	Pulling or pushing large objects like a living room chair
h570	Either stooping, crouching, or kneeling
h571	Reaching or extending arms below shoulder level
h572	Reaching or extending arms above shoulder level
h573	Either writing, or handling, or fingering small objects
h574	Standing in one place for long periods, say 15 minutes
h575	Sitting for long periods, say 1 hour
h576	Lifting or carrying weights under 10 pounds (like a bag of potatoes)
h577	Lifting or carrying weights over 10 pounds (like a very heavy bag of groceries)

TECH07

OMB NO=0925-0216 12/31/2007

h578	Examiner's Number for Activities - Part C
-------------	--

Fractures							
h579	Since Your Last Clinic Visit Have You Broken Any Bones? (Code: 0=No, 1=Yes, 2=Unsure, 9=Unknown)						
If Yes, fill 	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">h580</td> <td>Location of fracture</td> </tr> <tr> <td>h580a</td> <td>Location of fracture (if more than one)</td> </tr> <tr> <td>h580b</td> <td>Location of fracture (if more than two)</td> </tr> </table>	h580	Location of fracture	h580a	Location of fracture (if more than one)	h580b	Location of fracture (if more than two)
h580	Location of fracture						
h580a	Location of fracture (if more than one)						
h580b	Location of fracture (if more than two)						
	Location (code unknown as 99)						
	1. Clavicle (collar bone)						
	2. Upper arm (humerus) or elbow						
	3. Forearm or wrist						
	4. Hand						
	5. Back (If disc disease only, code as no)						
	6. Pelvis						
	7. Hip						
	8. Leg						
	9. Foot						
	10. Other (specify) _____						

OMB NO=0925-0216 12/31/2007

I'm going to start by asking questions that require concentration and memory. Some questions are more difficult than others and some will be asked more than one time.

h581	Examiner's Number for Cognitive Function -- Part I+II
-------------	--

SCORE CORRECT No Try=6 Unknown=9				Write all responses on exam form (score 1 point for each correct response)					
h582	0 1 2 3 6 9			What Is the Date Today? (Month, day, year, correct score=3)					
h583	0 1 6 9			What Is the Season?					
h584	0 1 6 9			What Day of the Week Is it?					
h585	0 1 2 3 6 9			What Town, County and State Are We in?					
h586	0 1 6 9			What Is the Name of this Place? (any appropriate answer all right, for instance my home, street address, heart study..max score=1)					
h587	0 1 6 9			What Floor of the Building Are We on?					
h588	0 1 2 3 6 9			I am going to name 3 objects. After I have said them I want you to repeat them back to me. Remember what they are because I will ask you to name them again in a few minutes: Apple, Table, Penny					
h589	<table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>								Now I am going to spell a word forward and I want you to spell it backwards. The word is world. W-O-R-L-D. Please Spell it in Reverse Order. Write in Letters, _____ (Letters Are Entered and Scored Later)
				Score as 66666=Not administered for reason unrelated to cognitive status 00000=Administered, but couldn't do 99999=Unknown					
h590	0 1 2 3 6 9			What are the 3 objects I asked you to remember a few moments ago?					

Cognitive Function --Part II

OMB NO=0925-0216 12/31/2007

SCORE CORRECT No Try=6 Unknown=9				Write all responses on exam form			
h591	0	1	6	9	What Is this Called? (Watch)		
h592	0	1	6	9	What Is this Called? (Pencil)		
h593	0	1	6	9	Please Repeat the Following: "No Ifs, Ands, or Buts." (Perfect=1)		
h594	0	1	6	9	Please Read the Following & Do What it Says (performed=1, code 6 if low vision)		
h595	0	1	6	9	Please Write a Sentence (code 6 if low vision)		
h596	0	1	6	9	Please Copy this Drawing (code 6 if low vision)		
h597	0	1	2	3	6	9	Take this piece of paper in your right hand, fold it in half with both hands, and put in your lap (score 1 for each correctly performed act, code 6 if low vision)

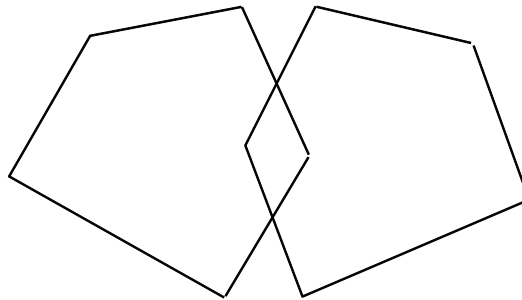
	No	Yes	Maybe	Unk		Factor Potentially Affecting Mental Status Testing
	(coding below)					
h598	0	1	2	9		Illiterate or low education
h599	0	1	2	9		Not fluent in English
h600	0	1	2	9		Poor eyesight
h601	0	1	2	9		Poor hearing
h602	0	1	2	9		Depression / possible depression
h603	0	1	2	9		Other, write in _____

TECH10

Sentence and Design Handout for Participant

PLEASE WRITE A SENTENCE

PLEASE COPY THIS DESIGN



OMB NO=0925-0216 12/31/2007

h604	Examiner's Number
-------------	--------------------------

HAND GRIP TEST Measured to the nearest kilogram		
Right hand		
Trial 1	99=Unknown	h605
Trial 2	99=Unknown	h606
Trial 3	99=Unknown	h607
Left hand		
Trial 1	99=Unknown	h608
Trial 2	99=Unknown	h609
Trial 3	99=Unknown	h610
Was this test completed? (0=No, 1=Yes, 8=Not attempted, 9=Unknown)		h611
If not attempted or completed, why not?		
1=Physical limitation	3=Other _____ write in	h612
2=Refused	9=Unknown	

TECH11

Observed Performance - Part 2

OMB NO=0925-0216 12/31/2007

h613	Examiner's Number
-------------	--------------------------

MEASURED WALKS

Walking aid used: 0=No aid, 1=Cane, 2=Walker, 3=Wheelchair, 4=Other, 9=Unknown

h614

First Walk

Was this test completed? (0=No, 1=Yes, 8=Not attempted, 9=Unknown)

h615

If not attempted or completed, why not?

1=Physical limitation 3=Other _____ write in
 2=Refused 9=Unknown

h616

Walk time (in seconds, 99.99=Unknown)

h617

Second Walk

Was this test completed? (0=No, 1=Yes, 8=Not attempted, 9=Unknown)

h618

If not attempted or completed, why not?

1=Physical limitation 3=Other _____ write in
 2=Refused 9=Unknown

h619

Walk time (in seconds, 99.99=Unknown)

h620

Quick Walk

Was this test completed? (0=No, 1=Yes, 8=Not attempted, 9=Unknown)

h621

If not attempted or completed, why not?

1=Physical limitation 3=Other _____ write in
 2=Refused 9=Unknown

h622

Walk time (in seconds, 99.99=Unknown)

h623

TECH12

OMB NO=0925-0216 12/31/2007

SYSTOLIC BLOOD PRESSURES BY DOPPLER (to be taken in the following order with participant supine after 5 minutes of rest)

h624	Examiner's Number for Doppler Ankle Brachial Blood Pressure	
h625	Cuff size, arm	0= pediatric, 1= regular adult
h626	Cuff size, ankle	2= large adult, 3= thigh

h627	Right arm	
h628	Right ankle	300 = ≥ 300
h629	Left ankle	999 = Unknown or not done
h630	Left arm	

REPEAT SYSTOLIC BLOOD PRESSURE MEASUREMENTS (reverse order)

h631	Left arm	
h632	Left ankle	300= ≥ 300
h633	Right ankle	999= Unknown or not done
h634	Right arm	

THIRD SYSTOLIC BLOOD PRESSURE MEASUREMENT (order as in repeat SBP). To be obtained if initial and repeat SBP at any site differ by more than 10 mmHg

h635	Left arm	
h636	Left ankle	300= ≥ 300
h637	Right ankle	999= Unknown or not done
h638	Right arm	

h639	Right Ankle blood pressure site	0= posterior tibial (ankle)
h640	Left Ankle blood pressure site	1= dorsalis pedis (foot)

EXCLUSIONS:

Right	Left	
h641	h642	Lower Extremity Exclusions 0= None, 1= venous stasis ulceration, 2= amputation, 3= other_____
h643	h644	Upper Extremity Exclusions 0= None, 1=Mastectomy, 3=Other_____

h645	Protocol modification, write in. _____ _____ _____	0= No, 1= Yes 2=Incomplete/ refused
-------------	---	---

TECH13

Respiratory Diagnoses

h646 Examiner ID

h647 1. Since your last exam have you had asthma?

h648 Do you still have it?

h649 Was it diagnosed by a doctor or other health professional? 0=No

If yes, fill **h650** At what age did it start? (Age in years) 1=Yes
88=N/A

h651 If you no longer have it, at what age did it stop? (Age in years)

h652 Have you received medical treatment for this in the past 12 months?

h653 2. Since your last exam have you had hay fever (allergy involving the nose and/or eyes)? 0=No

h654 3. Since your last exam have you had pneumonia (including bronchopneumonia)? 1=Yes

4. Since your last exam have you had

Condition?	Health professional DX?	Age condition began
(0=No, 1=Yes)		99=Unk

Chronic Bronchitis	h655	h656	h657
Emphysema	h658	h659	h660
COPD Chronic obstructive pulmonary disease	h661	h662	h663
Sleep Apnea	h664	h665	h666
Pulmonary Fibrosis	h667	h668	h669

Inhaler Use

h670 5. Do you take inhalers or bronchodilators? 0=No
1=Yes

h671 Do you use any of these medications- Albuterol, Proventil, Ventolin, Combivent, Maxair, Volmax, Xopenex, Bronkometer, pirbuterol, levalbuterol, or metaproterenol 0=No
1=Yes

If yes, fill **h672** How many hours ago did you last use the medication, either by inhaler or nebulizer? (Time in hours)

h673 Do you take any of the following inhalers? 0=No
Serevent, Advair, Foradil, salmeterol, or formoterol 1=Yes

If yes, fill **h674** How many hours ago did you last use the medication? (Time in hours)

Respiratory Disease Questionnaire - Technician Administered

OMB NO=0925-0216 12/31/2007

Triggered airway symptoms

1. When you are near animals, such as cats, dogs, or horses, near feathers, including pillows, quilts, or in a dusty or moldy part of the house, do you ever

h675 Start to cough?

h676 Start to wheeze?

h677 Get a feeling of tightness in your chest?

0=No
1=Yes

h678 Start to feel short of breath?

h679 Get a runny or stuffy nose or start to sneeze?

h680 Get itching or watering eyes?

2. When you are near trees, grass, or flowers, or when there is a lot of pollen in the air, do you ever

h681 Start to cough?

h682 Start to wheeze?

h683 Get a feeling of tightness in your chest?

0=No
1=Yes

h684 Start to feel short of breath?

h685 Get a runny or stuffy nose or start to sneeze?

h686 Get itching or watering eyes?


h687 **3. Do you currently have a cat, dog, or other furry pets living in your home?**

0=No
1=Yes

TECH15

Proxy form

OMB NO=0925-0216 12/31/2007

h688	Proxy used to complete this exam (0=No, 1=Yes, 1 proxy, 2=Yes, more than 1 proxy, 9=Unk)
if yes, fill 	Proxy Name _____
	h689 Relationship (1=1 st Degree Relative(spouse, child), 2=Other Relative, 3=Friend, 4=Health Care Professional, 5=Other, 9=Unknown)
	<input type="text"/> <input type="text"/> * <input type="text"/> <input type="text"/> How long have you known the participant? h690 h691 (Years, months; 99.99 = Unk) example: 3m = 00*03
	h692 Are you currently living in the same household with the participant? (0=No, 1=Yes, 9=Unk)
	h693 How often did you talk with the participant during the prior 11 months (1=Almost every day, 2=Several times a week, 3=Once a week, 4=1 to 3 times per month, 5=Less than once a month, 9=Unknown)
	Proxy Name _____
	h694 Relationship (1=1 st Degree Relative(spouse, child), 2=Other Relative, 3=Friend, 4=Health Care Professional, 5=Other, 9=Unknown)
	<input type="text"/> <input type="text"/> * <input type="text"/> <input type="text"/> How long have you known the participant? h695 h696 (Years, months; 99.99 = Unk) example: 3m = 00*03
	h697 Are you currently living in the same household with the participant? (0=No, 1=Yes, 9=Unk)
	h698 How often did you talk with the participant during the prior 11 months (1=Almost every day, 2=Several times a week, 3=Once a week, 4=1 to 3 times per month, 5=Less than once a month, 9=Unknown)

TECH016

Sociodemographic questions - Part I Self-administered

OMB NO=0925-0216 12/31/2007

h699a	Examiner ID (for offsite visits only)
h699	What is your current marital status?
	1=single/never married, 2=married/living as married/living with partner 3=separated 4=divorced 5=widowed 9=prefer not to answer
Which of the following best describes you?	
Ethnicity (check which applies)	
h700	Hispanic or Latino
h701	Not Hispanic or Latino
Race: (check ALL that apply)	
h702	Caucasian or white
h703	African American or black
h704	Asian
h705	Native Hawaiian or other Pacific Islander
h706	American Indian or Alaska native
h707	prefer not to answer
H7025	Non-white
h708	What is the highest degree or level of school you have completed? (if currently enrolled, mark the highest grade completed, degree received)
	0= no schooling 1=no schooling or grades 1-8 2=grades 9-11 3=completed high school (12 th grade) or GED 4=some college but no degree 5=technical school certificate 6=associate degree (Junior college AA, AS) 7=Bachelor's degree (BA, AB, BS) 8=graduate or professional degree (master's, doctorate, MD, etc.) 9=prefer not to answer
h709	Please choose which of the following best describes your current employment status?
	0=homemaker, not working outside the home 1=employed (or self-employed) full time 2=employed (or self-employed) part time 3=employed, but on leave for health reasons 4=employed, but temporarily away from my job 5=unemployed or laid off or full-time student 6=retired from my usual occupation and not working 7= retired from my usual occupation but working for pay 8= retired from my usual occupation but volunteering 9=prefer not to answer 10=unemployed due to disability

TECH17

Sociodemographic questions. Part II. Self-administered

OMB NO=0925-0216 12/31/2007

h710	What is your current occupation? Write in_____
h711	Using the occupation coding sheet choose the code that best describes your occupation

YES	NO	h712	Do you have some form of health insurance?
YES	NO	h713	Do you have prescription drug coverage?

TECH18

**SF-12® Health Survey (Standard)
Self-administered**

OMB NO=0925-0216 12/31/2007

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.

h714 1. In general, would you say your health is:

Excellent	Very good	Good	Fair	Poor
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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?

h715 2. **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf

h716 3. Climbing **several** flights of stairs

Yes, limited a lot	Yes, limited a little	No, not limited at all
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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?

h717 4. **Accomplished less** than you would like

h718 5. Were limited in the **kind** of work or other activities

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

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)?

h719 6. **Accomplished less** than you would like

h720 7. Didn't do work or other activities as **carefully** as usual

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

TECH19

SF-12® Health Survey (Standard)
Self-administered

OMB NO=0925-0216 12/31/2007

h721 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	A little bit	Moderately	Quite a bit	Extremely
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
h722 9. Have you felt calm and peaceful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

h723 10. Did you have a lot of energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
---	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

h724 11. Have you felt downhearted and blue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
---	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

h725 12. During the <u>past 4 weeks</u> , how much of the time has your <u>physical health or emotional problems</u> interfered with your social activities (like visiting friends, relatives, etc.)?	All of the time	Most of the time	Some of the time	A little of the time	None of the time
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TECH20

Sleep Questionnaire. Part 1
Self-administered

OMB NO=0925-0216 12/31/2007

- h726** How much sleep do you usually get at night (or your main sleep period) on weekdays or work days? (Number of hours)
- h727** How long does it usually take you to fall asleep at bedtime? (Number of hours, 1=1 hour or less)

Sleep Related Symptoms (days/nights)

- h728** In the past 12 months, how often do you snore while you are sleeping? 0=Never
1=Rarely(1-2 nights/week)
2=Occasionally(3-4 nights/week)
3=Frequently(5/more nights/week)
9=Don't know
- h729** In the past 12 months, how often do you snort, gasp, or stop breathing while you are asleep?

Please indicate how often in the past month you experienced each of the following.
(Circle one response for each item)

	Never	Rarely (1/month or less)	Sometimes (2-4/month)	Often (5-15/month)	Almost always (16-30/month)
h730 Have trouble falling asleep	0	1	2	3	4
h731 Wake up during the night and have trouble getting back to sleep.	0	1	2	3	4
h732 Wake up too early in the morning and be unable to get back to sleep.	0	1	2	3	4
h733 Feel excessively (or overly) sleepy during the day.	0	1	2	3	4

TECH21

Sleep Questionnaire. Part 2
Self-administered

OMB NO=0925-0216 12/31/2007

What is the chance that you would doze off or fall asleep (not just “feel tired”) in each of the following situations? (Circle one response for each situation. If you are never or rarely in the situation, please give your best guess for that situation)

	No	Slight	Moderate	High
h734 Sitting and reading	0	1	2	3
h735 Watching TV.	0	1	2	3
h736 Sitting inactive in a public place (such as theater or a meeting)	0	1	2	3
h737 Riding as a passenger in a car for an hour without a break.	0	1	2	3
h738 Lying down to rest in the afternoon when circumstances permit.	0	1	2	3
h739 Sitting and talking to someone.	0	1	2	3
h740 Sitting quietly after a lunch without alcohol.	0	1	2	3
h741 In a car, while stopped in traffic for a few minutes.	0	1	2	3
h742 At the dinner table.	0	1	2	3
h743 While driving	0	1	2	3

Have you ever been told by a doctor or other health professional that you have any of the following? (Circle one response for each item)

	No	Yes	Don't know
h744 Sleep apnea or obstructive sleep apnea.	0	1	9
h745 Insomnia.	0	1	9
h746 Restless legs.	0	1	9

TECH22

Referral Tracking

OMB NO=0925-0216 12/31/2007

<p>h747 if yes fill below</p>	<p>Was further medical evaluation recommended for this participant? 0=No, 1=Yes, 9=Unknown</p>
<p>RESULT</p>	<p>Reason for further evaluation: 0=No, 1=Yes, 9=Unknown</p>
<p>h748</p>	<p>Blood Pressure result ____/____ mmHg Phone call > 200/110 Expedite ≥ 180/100 Elevated > 140/90</p>
<p>h749</p>	<p>Abnormal Urine result _____</p>
<p style="text-align: center;"><i>Write in abnormality</i></p>	
<p>h750</p>	<p>ECG abnormality _____</p>
<p>h751</p>	<p>Clinic Physician _____ identified medical problem</p>
<p>h752</p>	<p>Other _____ _____</p>

<p>h753</p>	<p>Technician ID#</p>	
<p>h754</p>	<p>Was there an adverse event in clinic/offsite that does not require further medical evaluation? (0=No, 1=Yes, 9=Unknown)</p>	
<p>h771</p>	<p>Comments: _____ _____</p>	
<p>offsite only</p>	<p>h755</p>	<p>Technician ID# (OFFSITE visits only)</p>
<p>if yes fill</p>	<p>h756</p>	<p>Was a FHS physician contacted during the examination due to adverse exam finding?(0=No, 1=Yes, 9=Unknown)</p>
	<p>h772</p>	<p>Comments: _____ _____</p>

TECH23

Method used to inform participant of need for further medical evaluation (circle ALL that apply)		
h757	1	Face-to-face in clinic
h758	2	Phone call
h759	3	Result letter
h760	4	Other

Method used to inform participant's personal physician of need for further medical evaluation (circle ALL that apply)		
h761	1	Phone call
h762	2	Result letter mailed
h763	3	Result letter FAX'd
h764	4	Other

Date referral made: / / Use 4 digits for year
 h765 h766 h767

ID number of person completing the referral:
 h768

Notes documenting conversation with participant or participant's personal physician: _____

NOTE: Information below is entered from Footer together with this page. GM
 Version #9 **h769** GM 12-05-05 **h770**

TECH24

**Medical History—Hospitalizations, ER Visits, MD Visits
Offspring EXAM8**

DATE _____

OMB NO=0925-0216 12/31/2007

Last exam on:

Last Health History Update on:

Health Care	
h001	1st Examiner Prefix (0=MD, 1=Tech. for OFFSITE visit)
h002	1st Examiner ID _____ 1st Examiner Name
h003	Hospitalization (not just E.R.) since your last exam (0=No; 1=yes, hospitalization, 2=yes, more than 1 hospitalization, 9=Unknown)
h004	E.R. Visit since your last exam (0=No; 1=Yes, 1 or more E. Room visit, 9=Unk)
h005	Day Surgery (0=No, 1=Yes, 9=Unknown)
h006	Major illness with visit to doctor (0=No, 1=Yes, 1 visit; 2=Yes, more than 1 visit; 9=Unk)
h007	Have you had a fever or infection in past two weeks? (0=No, 1=Yes, 9=Unknown)
h008	Check up by doctor in past 5 years (0=No, 1=Yes, 9=Unknown)
h009	Date of this FHS exam (Today's date - See above)

Note: if FHS needs outside hospital record, please obtain details: mo/yr, hospital site.

Medical Encounter	Month/Year (of last visit)	Site of Hospital or Office	Doctor

MD01

Medical History—Medications

OMB NO=0925-0216 12/31/2007

If yes, fill	h010	Take aspirin regularly? (0=No, 1=Yes, 9=Unk)
	h011	Number aspirins taken regularly (99=Unknown)
	h012	Frequency per (1=Day, 2=Week 3=Month, 4=Year, 9=Unk)
	h013	Usual dose (081=baby,160=half dose, 325=nl, 500=extra or larger, 999=unk)

h014	Since your last exam have you taken medication for hypertension/high blood pressure? (0=no, 1=yes, now, 2=yes, not now, 9=unk)
h015	Since your last exam have you taken medication for high blood cholesterol or high triglycerides? (0=no, 1=yes, now, 2=yes, not now, 9=unk)
h016	Since your last exam have you been told by a doctor you have high blood sugar or diabetes? (0=no, 1=yes, now, 2=yes, not now, 9=unk)
h017	Since your last exam have you taken medication for cardiovascular disease (for example angina/chest pain, heart failure, atrial fibrillation/heart rhythm abnormality, stroke, leg pain when walking?) (0=no, 1=yes, now, 2=yes, not now, 9=unk)

MD02

Medical History – Prescription and Non-Prescription Medications

OMB NO=0925-0216 12/31/2007

Copy the name of medicine, the strength including units, and the total number of doses per day/week/month. Include pills, skin patches, eye drops, creams, salves, injections. . Include herbal, alternative, and soy-based preparations.

h018	Medication bottles/packs used by examiner to record medications?	0 = No, 1 = Yes
-------------	--	-----------------

List medications taken regularly in past month/ongoing medications

Medication Name (Print first 20 letters)														Strength (include mg, IU, etc)	Number per (day/week/month) (circle one)		Prn (0 = no, 1 = yes, 9 = unkn)	
Example	S	A	M	P	L	E	D	R	U	G	N	A	M	E	100 / mg	1	(D)WM	0
															h020	h021	h022	h023
															/		DWM	
															/		DWM	
															/		DWM	
															/		DWM	
															/		DWM	
															/		DWM	
															/		DWM	
															/		DWM	

Continue on the next page →

Medical History—Prescription and Non-Prescription Medications
Continue from screen 3.

OMB NO=0925-0216 12/31/2007

Copy the name of medicine, the strength including units, and the total number of doses per day/week/month. Include pills, skin patches, eye drops, creams, salves, injections. Include herbal, alternative, and soy-based preparations.




*****List medications taken regularly in past month/ongoing medications*****

Medication Name (Print first 20 letters)														Strength (include mg, IU, etc)	Number per (day/week/month) (circle one)		Prn (0 = no, 1 = yes, 9 = unkn)	
Example	S	A	M	P	L	E	D	R	U	G	N	A	M	E	100 / mg	1	(D)WM	0
																	DWM	
															/		DWM	
															/		DWM	
															/		DWM	
															/		DWM	
															/		DWM	
															/		DWM	
															/		DWM	
															/		DWM	

Medical History–Female Reproductive History. Part 1.

OMB NO=0925-0216 12/31/2007

If participant is male, leave questions blank

h024	1. Since your last exam have you taken or used oral contraceptive pills, shots, or hormone implants for birth control or medical indications (not post menopausal hormone replacement)? (0=no, 1=yes, now, 2=yes, not now, 9=unknown)
	What is the name of the current or most recent oral contraceptive, shot or implant used?
	_____ h025 Name
If yes, fill 	_____ h026 Strength
	h027 Form (1=pill, 2=shot, 3=patch, 4=implant)
	h028/h029 h030/h031 ____/____, ____/____ Duration of use mo/yr began, mo/yr ended, year – 4 digits) 99/9999=Unknown, 88/8888=current user
h032	2. Have you had a hysterectomy (uterus/womb removed) since your last exam? (0=no, 1=yes, 9=unknown)
If yes, fill 	h033 Age at hysterectomy
	h034/h035 Date of surgery (mo/yr) Use 4 digits for year 99/9999=Unknown __/____
h036	3. Since your last exam have you had an operation to remove one or both of your ovaries? (0=no, 1=yes, one ovary removed, 2=yes, two ovaries removed, 3=yes, unknown number of ovaries removed, 4=yes, part of an ovary removed, 9=unknown)
If yes, fill 	h037 Age when ovaries removed? If more than one surgery, use age at last surgery

MD05

Medical History–Female Reproductive History. Part 2.

OMB NO=0925-0216 12/31/2007

h038 4. Have your periods stopped (for one year or more)? (Have you reached menopause?)
 (0=not stopped, pregnant, breast feeding, 1 = stopped but now have periods induced by hormones, 2 = yes stopped > 1year, 3 = yes, stopped < 1 year, 9 = unknown)

Please fill in only one of the boxes below, not both!

IF PERIODS NOT STOPPED (pre-menopausal, pregnant, breast feeding!)
h039/ h040/ h041 When was the first day of your last menstrual period?
 _____ / _____ / _____
 (Use 4 digits for year, 99/9999=Unknown)
h042 How many periods have you had in past 12 months?

IF PERIODS STOPPED (post-menopausal, post-menopausal on hormone replacement, or peri-menopausal on hormone replacement)

h043 a) Age when periods stopped (00=not stopped, 99 = unknown) If periods now induced by hormones, code age when periods naturally stopped

h044 b) Was your menopause natural or the result of surgery, chemotherapy, or radiation?
 (1 = natural, 2 = surgical, 3 = chemo/radiation, 4 = other, 9 =unknown)

h045 c) Since your last exam have you taken hormone replacement therapy? (estrogen/progesterone)
 (0 = no, 1 = yes, now, 2 = yes, not now, 9 = unknown)

h046 What age did you begin hormone replacement therapy?
 99 =unknown

If yes, fill **h047** years **h048** For how long did you take hormones?
 99 = unknown
 months

h049 Estrogen use? (0 = no, 1 = yes, now, 2 = yes, not now, 9 = unknown)

If yes, fill **h050** _____ Name of most recent estrogen preparation
h051 _____ Strength
h052 _____ Number of days per month taken

h053 Progesterone use? (0 = no, 1 = yes, now, 2 = yes, not now, 9 = unknown)

If yes, fill **h054** _____ Name of most recent progesterone preparation
h055 _____ Strength
h056 _____ Number of days per month taken

h057 d) Have you used Evista (raloxifene) or Nolvadex (tamoxifen) or other selective estrogen receptor modulator (SERM)?
 (0 = no, 1 = yes, now, 2 = yes, not now, 9 = unknown)

If yes, fill **h058** Number of months used
h059 Current use? (0 = no, 1 = yes, raloxifene, 2 = yes, tamoxifen, 3 = yes, other, 9 = unknown)

MD06

Medical History--Smoking

OMB NO=0925-0216 12/31/2007

Cigarettes

- h060** Since your last exam have you smoked regularly?
(No means less than 1 cigarette a day for 1 year.) (0=no, 1=yes, 9=unknown)
 - h061** Have you smoked cigarettes regularly in the last year?
 - h062** Do you now smoke cigarettes (as of 1 month ago)?
 - h063** How many cigarettes do you smoke per day now?
 - h064** On average, since your last exam, how many cigarettes did you smoke per day?
 - h065** How old were you when you first started regular cigarette smoking?
(99=Unknown)
 - h066** If you have stopped smoking cigarettes completely, how old were you when you stopped?
(Age stopped, 00=not stopped, 99=Unknown)
 - h067** During the time you were smoking since your last exam, did you ever stop smoking for >6 months?
 - h068** During the time since your last exam, for how many years in total did you stop smoking cigarettes (00=never stopped)
- if yes, fill ☞

Other

- h069** Since your last exam, have you regularly smoked a pipe or cigar? 0=No
1=Yes
9=Unknown
 - h070** Do you smoke a pipe or cigar now?
- if yes, fill ☞

MD07

Medical History –Alcohol Consumption

OMB NO=0925-0216 12/31/2007

In the interim did you drink any of the following beverages at least once a month?

Drink? 0=No, 1=Yes, 9=Unk	Beverage	If yes, complete for number of drinks in a typical week/month over past year. <i>Code EITHER per week OR per month as appropriate.</i>		
		Number of drinks		
		Per week	OR	Per month
h071	Beer	12oz bottle, glass, can	h072	h073
h074	Wine	4oz glass	h075	h076
h077	Liquor/spirits	1 ¼ oz jigger	h078	h079

h080	At what age did you stop drinking alcohol? (00= not stopped, 888=never drink99=Unknown)
h081	Over the past year, on average on how many days per week did you drink an alcoholic beverage of any type? (1=1or less, 9=Unknown)
h082	Over the past year, on a typical day when you drink, how many drinks do you have? (99=Unknown)
h083	What was the maximum number of drinks you had in 24 hr. period during the past month? (99=Unknown)
h084	Has there ever been a time in your life when you drank 5 or more alcoholic drinks of any kind almost daily? (0=no, 1=yes, 9=unknown)

MD08

Medical History—Respiratory Symptoms. Part I

OMB NO=0925-0216 12/31/2007

Cough		
h085	Do you usually have a cough? (Exclude clearing of the throat)	0=No 1=Yes
h086	Do you usually have a cough at all on getting up or first thing in the morning?	9=Don't know
If YES to either question above answer the following:		
h087	Do you cough like this on most days for three consecutive months or more during the past year?	0=No 1=Yes 9=Don't know
h088	How many years have you had this cough? (99=Unk.)	# of years
Phlegm		
h089	Do you usually bring up phlegm from your chest ?	0=No 1=Yes
h090	Do you usually bring up phlegm at all on getting up or first thing in the morning?	9=Don't know
If YES to either question above answer the following:		
h091	Do you bring up phlegm from your chest on most days (4 or more days/week) for three consecutive months or more during the year?	0=No 1=Yes 9=Don't know
h092	How many years have you had trouble with phlegm? (99=Unk.)	# of years
Wheeze		
h093	In the last 12 months, have you had wheezing or whistling in your chest at any time?	0=No 1=Yes 9=Don't know
if yes, fill all	h094 In the last 12 months, how often have you had this wheezing or whistling?	0=Not at all 1=Most days or nights 2=A few days or nights a week 3=A few days or nights a month 4=A few days or nights a year 9=Unknown
h095	In the past 12 months, have you had this wheezing or whistling in the chest when you had a cold?	0=No 1=Yes
h096	In the past 12 months, have you had this wheezing or whistling in the chest apart from colds?	9=Don't know
h097	In the last 12 months, have you had an attack of wheezing or whistling in the chest that had made you feel short of breath?	

MD09

OMB NO=0925-0216 12/31/2007

Nocturnal chest symptoms		
h098	In the last 12 months, have you been awakened by shortness of breath?	
h099	In the last 12 months, have you been awakened by a wheezing/whistling in your chest?	0=No 1=Yes 9=Don't know
h100	In the last 12 months, have you been awakened by coughing?	
if yes, fill all ☞	h101	In the last 12 months, how often have you been awakened by coughing?
		0=Not at all 9=Unknown 1=Most days or nights 2=A few days or nights a week 3=A few days or nights a month 4=A few days or nights a year
Shortness of breath		
h102	Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill?	
if yes, fill all ☞	h103	Do you have to walk slower than people of your age on level ground because of shortness of breath?
	h104	Do you ever have to stop for breath when walking at your own pace on level ground?
	h105	Do you ever have to stop for breath after walking 100 yards (or after a few minutes) on level ground?
h106	Do you/have you needed to sleep on two or more pillows to help you breath? (Orthopnea)	0=No 1=Yes 9=Don't know
h107	Since your last exam have you had swelling in both your ankles (ankle edema)?	
h108	Since your last exam have you been told you had heart failure or congestive heart failure?	
h109	Since your last exam have you been hospitalized for heart failure?	
Examiner's opinion:		
h110	First examiner believes CHF	0=No, 1=Yes 2=Maybe, 9=Unkn

Comments _____

MD10

Physician Blood Pressure (first reading)			
Systolic	Diastolic	BP cuff size	Protocol modification
h111 to nearest 2 mm Hg	h112 to nearest 2 mm Hg	h113 0=pedi, 1=reg.adult, 2=large adult, 3= thigh, 9=unknown	h114 0=No, 1=Yes, 9=Unknown
Comments on protocol modification <hr/> <hr/>			

MD11

Medical History—Chest pain

OMB NO=0925-0216 12/31/2007

h115	Any chest discomfort (0=No, 1=Yes, 2=Maybe, 9=Unknown) (please provide narrative comments in addition to checking the appropriate boxes)	
if yes, fill and below	h116	Chest discomfort with exertion or excitement (0=No, 1=Yes, 2=Maybe, 9=Unknown)
	h117	Chest discomfort when quiet or resting
Chest Discomfort Characteristics (must have checked box at top of table)		
	____/____	Date of onset (mo/yr, Use 4 digits for year, 99/9999=Unknown)
	h118/h119	
	h120	Usual duration (minutes: 1=1 min or less, 900=15 hrs or more, 999=Unknown)
	h121	Longest duration (minutes: 1=1 min or less, 900=15 hrs or more, 999=Unknown)
	h122	Location (0=No, 1=Central sternum and upper chest, 2=L Up Quadrant, 3=L Lower ribcage, 4=R Chest, 5=Other, 6=Combination, 9=Unknown)
	h123	Radiation (0=No, 1=Left shoulder or L arm, 2=Neck, 3=R shoulder or arm, 4=Back, 5=Abdomen, 6=Other, 7=Combination, 9=Unknown)
	h124	Frequency (number in past month) 999=Unknown
	h125	Frequency (number in past year) 999=Unknown
	h126	Type (1=Pressure, heavy, vise, 2=Sharp, 3=Dull, 4=Other, 9=Unk)
	h127	Relief by Nitroglycerine in <15 minutes 0=No
	h128	Relief by Rest in <15 minutes 1=Yes,
	h129	Relief Spontaneously in <15 minutes 8=Not tried
	h130	Relief by Other cause in <15 minutes 9=Unknown

h131	Since your last exam, have you been told by a doctor you had a heart attack or myocardial infarction?	0=No, 1=Yes, 2=Maybe 9=Unknown
-------------	--	-----------------------------------

CHD First Opinions		
h132	Angina pectoris	(0=No,
h133	Angina pectoris since revascularization procedure	1=Yes,
h134	Coronary insufficiency	2=Maybe,
h135	Myocardial infarct	9=Unknown)

Comments _____

MD12

OMB NO=0925-0216 12/31/2007

h136 if yes, fill ☞	Have you been told you have/had a heart rhythm problem called atrial fibrillation? (0=No, 1=Yes, 2=Maybe,, 9=Unknown)	
	____/____/____ h137/h138/h139	Date of first episode (99/99/9999=unk) code year as 4 digits, example: Year 1999=1999
	h140	ER/hospitalized or saw M.D. (0=No, 1=Hosp/ER, 2=Saw M.D., 9=Unkn) Hospitalized at: _____ M.D. seen: _____

h141 if yes, fill all ☞	Since your last exam have you fainted or lost consciousness? If event immediately preceded by head injury or accident code 0=No)		Code: 0=No,1=Yes, 2=Maybe,9=Unknown
	h142	Number of episodes in the past two years	999=Unknown
	____/____ h143/h144	Date of first episode (use 4 digits for year, i.e. 1998)	mo/yr, 99/9999=Unknown
	h145	Usual duration of loss of consciousness	(minutes, 999=Unkn) 1=1 min or less
	h146 Did you have any injury caused by the event? (0=No,1=Yes, 2=Maybe,9=Unkn) ER/hospitalized or saw M.D. (0=No, 1=Hosp/ER, 2=Saw M.D., 9=Unkn)		
	h147	Hospitalized at: _____ M.D. seen: _____	

h148 if yes, fill ☞	History (since your last exam) of having a head injury with loss of consciousness (0=No, 1=Yes, 2=Maybe, 9=Unknown)	
	____/____/____ h149/h150/h151	Date of serious head injury with loss of consciousness (00/00/0000 =none, 99/99/9999=unk, Use 4 digits for year)

h152 if yes, fill ☞	History of a seizure disorder. Since your last exam have you had a seizure? (0=No, 1=Yes, 2=Maybe, 9=Unknown)	
	____/____/____ h153/h154/h155	Date of most recent seizure (99/99/9999=unk) code four digit year
	h156	Are you being treated for a seizure disorder? (0=No, 1=Yes, 2=Maybe, 9=Unknown)

Syncope First Opinions		
h157	Syncope (0=No, 1=Yes, 2=Maybe, 3=Presyncope, 9=Unknown) needs second opinion	
	h158	Cardiac syncope
	h159	Vasovagal syncope
	h160	Other-Specify: _____

Comments: _____

MD13

Medical History—Cerebrovascular, Neurological and Venous Diseases

OMB NO=0925-0216 12/31/2007

Cerebrovascular Episodes Since Your Last Exam

h161	Sudden muscular weakness	Code: 0=No, 1=Yes, 2=Maybe, 9=Unknown
h162	Sudden speech difficulty	
h163	Sudden visual defect	
h164	Sudden double vision	
h165	Sudden loss of vision in one eye	
h166	Sudden numbness, tingling	
if yes, fill	h167 Numbness and tingling is positional	
h168	Head CT or MRI scan date: <u>h168a</u> - <u>h168b</u> - <u>h168c</u> Place <u>h168d</u>	0=No, 1=Yes, 2=both, 9=Unkn
h169	Seen by neurologist(write in who and when below)	
h170	Have you been told by a doctor you had a stroke or TIA (transient ischemic attack, mini-stroke)?	Code: 0=No, 1=Yes, 2=Maybe, 9=Unknown
h171	Have you been told by a doctor you have Parkinson Disease?	
h172	Have you been told by a doctor you have memory problems, dementia or Alzheimer's disease?	
h173	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?	

Cerebrovascular Disease First Opinions

h174	TIA or stroke took place	0=No, 1=Yes, 2=Maybe, 9=Unkn
if yes or maybe fill	_____/_____/_____ h175/h176	Date (mo/yr, Use 4 digits for year, 99/9999=Unkn)
	_____/_____/_____ h177/h178/h179	Duration (use format days/hours/mins, 99/99/99=Unknown)
	h180	Hospitalized or saw M.D. (0=No, 1=Hosp.2=Saw M.D, 9=Unk) Name: _____ Address: _____

Neurology Comments: _____

Venous Disease

h181	Since your last exam have you had a Deep Vein Thrombosis (blood clots in legs or arms)	0=No, 1=Yes,
h182	Since your last exam have you had a Pulmonary Embolus (blood clot in lungs)	2=Maybe, 9=Unknown

MD14

Medical History--Peripheral Arterial Disease

OMB NO=0925-0216 12/31/2007

Peripheral Arterial Disease																				
h183	Do you have discomfort in your legs while walking? (0=No, 1=Yes, 9=Unkn)																			
if yes fill ☞	h184	If walking on level ground, how many city blocks until symptoms develop (00=no, 99=unknown) where 10 blocks =1 mile, code as no if more than 98 blocks required to develop symptoms																		
	h185	Year symptoms started (Use 4 digits for year ,00=no, 9999=unkn)																		
	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%;">Left</th> <th style="width: 50%;">Right</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">h186</td> <td style="text-align: center;">h187</td> </tr> <tr> <td style="text-align: center;">h188</td> <td style="text-align: center;">h189</td> </tr> <tr> <td style="text-align: center;">h190</td> <td></td> </tr> <tr> <td style="text-align: center;">h191</td> <td></td> </tr> <tr> <td style="text-align: center;">h192</td> <td></td> </tr> <tr> <td style="text-align: center;">h193</td> <td></td> </tr> <tr> <td style="text-align: center;">h194</td> <td></td> </tr> <tr> <td style="text-align: center;">h195</td> <td></td> </tr> </tbody> </table>	Left	Right	h186	h187	h188	h189	h190		h191		h192		h193		h194		h195		Claudication symptoms (0=No, 1=Yes, 9=Unkn)
Left	Right																			
h186	h187																			
h188	h189																			
h190																				
h191																				
h192																				
h193																				
h194																				
h195																				
		Discomfort in calf while walking																		
		Discomfort in lower extremity (not calf) while walking																		
		Occurs with first steps (code worse leg)																		
		After walking a while (code worse leg)																		
		Related to rapidity of walking or steepness																		
		Forced to stop walking																		
		Time for discomfort to be relieved by stopping (minutes) (00=No relief with stopping, 88=Not Applicable, 99=Unknown)																		
		Number of days/month of lower limb discomfort (00=No,88=N/A,99=Unk)																		

h196	Have you had back pain in the last 12 month?		
if yes, fill ☞	h197	What happens to back and any leg pain that goes with it when you walk?	0=No, 1=all days, 2=most of the days, 3=some days, 4=a few days 0=no change, 1=gets worse, 2=gets better, 9=Unknown
	h198	What happens to back and any pain that goes with it when you sit?	
h199	Have you ever been told by a doctor that you have intermittent claudication or peripheral arterial disease?		0=No, 1=Yes, 9=Unknown
h200	Has a doctor ever told you you had spinal stenosis?		
if yes, fill ☞	h201	Have you had a CT or MRI of your spine? Date h202 - h203 - h204 Location h204a	

PAD First Opinion		
h205	Intermittent Claudication	
		0=No, 1=Yes, 2=Maybe, 9=Unkn.

Comments Peripheral Vascular Disease / Venous Disease _____

MD15

Medical History-- CVD Procedures

OMB NO=0925-0216 12/31/2007

Coding: 0=No, 1=Yes 2=Maybe, 9 =Unkn	Cardiovascular Procedures (if procedure was repeated code only first and provide narrative) (write 4 digits for year, i.e. 1998, 1999, 2000)
h206 if yes fill <input type="checkbox"/>	Heart Valvular Surgery
	h207 Year done (9999-Unk) Location and description _____
h208 if yes fill <input type="checkbox"/>	Exercise Tolerance Test
	h209 Year done (9999-Unk) Location _____
h210 if yes fill <input type="checkbox"/>	Coronary arteriogram
	h211 Year done (9999-Unk)
h212 if yes fill <input type="checkbox"/>	Coronary artery angioplasty/stent/PCI
	h213 Year done (9999-Unk) h214 Type of procedure (0=none, 1=balloon, 2=stent, 3=other, 9=unkn)
h215 if yes fill <input type="checkbox"/>	Coronary bypass surgery
	h216 Year done (9999-Unk)
h217 if yes fill <input type="checkbox"/>	Permanent pacemaker insertion
	h218 Year done (9999-Unk)
h219 if yes fill <input type="checkbox"/>	AICD
	h220 Year done (9999-Unk)
h221 if yes fill <input type="checkbox"/>	Carotid artery surgery/stent
	h222 Year done (9999-Unk)
h223 if yes fill <input type="checkbox"/>	Thoracic aorta surgery
	h224 Year done (9999-Unk)
h225 if yes fill <input type="checkbox"/>	Abdominal aorta surgery/stent
	h226 Year done (9999-Unk)
h227 if yes fill <input type="checkbox"/>	Femoral or lower extremity surgery/stent/angioplasty
	h228 Year done (9999-Unk)
h229 if yes fill <input type="checkbox"/>	Lower extremity amputation
	h230 Year done (9999-Unk)
h231 if yes fill <input type="checkbox"/>	Other Cardiovascular Procedure (write in below)
	h232 Year done (9999-Unk) Description _____

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

Comments _____

Physician Blood Pressure (second reading)			
Systolic h233	Diastolic h234	BP cuff size h235	Protocol modification h236
to nearest 2 mm Hg 999=Unknown	to nearest 2 mm Hg 999=Unknown	0=pedi,1=reg.adult, 2=large adult, 3= thigh, 9=Unknown	0=No, 1=Yes, 9=Unknown

Write in protocol modification:

Cancer Site or Type

h237	Since your last exam have you had cancer or a tumor? (0=No and skip to next screen; If 1=Yes, 2=Maybe, 9=Unknown please continue)				
	Code for table: 0=No, 1=Yes, Cancerous, 2=Maybe, Possible Cancer, 3=Benign, 9=Unknown				
	Code	Site of Cancer or Tumor	Year First Diagnosed	Name Diagnosing M.D.	City of M.D.
	h238	Esophagus			
	h239	Stomach			
	h240	Colon			
	h241	Rectum			
	h242	Pancreas			
	h243	Larynx			
	h244	Trachea/Bronchus/Lung			
	h245	Leukemia			
	h246	Skin			
	h247	Breast			
	h248	Cervix/Uterus			
	h249	Ovary			
	h250	Prostate			
	h251	Bladder			
h252	Kidney				
h253	Brain				
h254	Lymphoma				
h255	Other/Unknown				

Comment (If participant has more details concerning tissue diagnosis, other hospitalization, procedures, treatments)

Physical Exam—Respiratory, Heart, Abdomen

OFFSITE VISIT – leave page BLANK

OMB NO=0925-0216 12/31/2007

Respiratory

h256	Wheezing on auscultation	0=No, 1=Yes, 2=Maybe, 9=Unknown
h257	Rales	
h258	Abnormal breath sounds	

Heart

h259	S3 Gallop	0=No 1=Yes 9=Unknown
h260	S4 Gallop	9=Unknown
h261	Systolic Click	0=No, 1=Yes 2=Maybe 9=Unknown
h262	Neck vein distention at 90 degrees (sitting upright)	9=Unknown

h263 if yes, fill out below	Systolic murmur(s) (0=No, 1=Yes, 2=Maybe, 9=Unknown)			
Murmur Location	Grade 0=No sound 1 to 6 for grade of sound heard 9=Unknown	Type 0=None 1=Ejection 2=Regurgitant 3=Other 9=Unknown	Radiation 0=None 1=Axilla 2=Neck 3=Back 4=Rt. chest 9=Unknown	Origin 0=None, indet. 1=Mitral 2=Aortic 3=Tricuspid 4=Pulm 9=Unknown
Apex	h264	h265	h266	h267
Left Sternum	h268	h269	h270	h271
Base	h272	h273	h274	h275

h276 if yes, fill	Diastolic murmur(s) (0=No, 1=Yes, 2=Maybe, 9=Unknown)
h277	Valve of origin for diastolic murmur(s) (0=No, 1=Mitral, 2=Aortic, 3=Both, 4=Other, 8=N/A, 9=Unk)

Abdominal Abnormalities

h278	Liver enlarged	0=No 1=Yes 2=Maybe 9=Unknown
h279	Surgical scar	
h280	Abdominal aneurysm	
h281	Abdominal bruit	

Comments about respiratory, heart, and abdominal abnormalities

Physical Exam--Peripheral Vessels—Veins and Arterial pulses
OFFSITE VISIT – leave page BLANK

OMB NO=0925-0216 12/31/2007

Left	Right	Varicosities	
h282	h283	Stem varicose veins (Do not code reticular or spider varicosities)	0=No abnormality 1=Yes 9=Unknown
Left	Right	Lower Extremity Abnormalities	
h284	h285	Ankle edema	(0=No, 1=Yes, 2=Maybe, 8=absent due to amputation 9=Unknown)
h286	h287	Amputation level	(0=No, 1=Toes only, 2=Ankle, 3=Knee, 4=Hip, 8=Not applicable, 9=Unknown)

Comments _____

Artery	Pulse		Bruit	
	(0=Normal, 1=Abnormal, 9=Unknown)		(0=Normal, 1=Abnormal, 9=Unknown)	
	Left	Right	Left	Right
Femoral	h288	h289	h290	h291
Popliteal			h292	h293
Post Tibial	h294	h295		
Dorsalis Pedis	h296	h297		

Comments _____

MD19

Physical Exam—Neurological Exam
 OFFSITE VISIT – leave page BLANK

OMB NO=0925-0216 12/31/2007

Neurological Exam		
Left	Right	
h298	h299	Carotid Bruit
h300		Speech disturbance
h301		Disturbance in gait
h302		Other neurological abnormalities on exam Specify _____

Coding
 (0=No,
 1=Yes,
 2=Maybe,
 9=Unknown)

MD20

h303	OFFSITE ONLY
MD Id# _____	MD Name _____

	Rates and Intervals
--	----------------------------

- h304** Ventricular rate per minute (999=Unknown)
- h305** P-R Interval (hundredths of a second) (99=Fully Paced, Atrial Fib, or Unknown)
- h306** QRS interval (hundredths of second) (99=Fully Paced, Unknown)
- h307** Q-T interval (hundredths of second) (99=Fully Paced, Unknown)
- h308** QRS angle (put plus or minus as needed) (e.g. -045 for minus 45 degrees, +090 for plus 90, 99999 =Fully paced or Unknown)

	Rhythm--predominant
--	----------------------------

- h309** 0 or 1 = Normal sinus, (including s.tach, s.brady, s arrhy, 1 degree AV block)
- 3 = 2nd degree AV block, Mobitz I (Wenckebach)
- 4 = 2nd degree AV block, Mobitz II
- 5 = 3rd degree AV block / AV dissociation
- 6 = Atrial fibrillation / atrial flutter
- 7 = Nodal
- 8 = Paced
- 9 = Other or combination of above (list) _____

	Ventricular conduction abnormalities
--	---

- h310** IV Block (0=No, 1=Yes, 9=Fully paced or Unknown)
 - h311** Pattern (1=Left, 2=Right, 3=Indeterminate, 9=Unknown)
- h312** Complete (QRS interval=.12 sec or greater)(0=No, 1=Yes, 9=Unknown)
- h313** Incomplete (QRS interval = .10 or .11 sec) (0=No, 1=Yes, 9=Unknown)
- h314** Hemiblock (0=No, 1=Left Ant, 2=Left Post, 9=Fully paced or Unknown)
- h315** WPW Syndrome (0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unknown)

	Arrhythmias
--	--------------------

- h316** Atrial premature beats (0=No, 1=Atr, 2=Atr Aber, 9=Unknown)
- h317** Ventricular premature beats (0=No, 1=Simple, 2=Multifoc, 3=Pairs, 4=Run, 5=R on T, 9 =Unk)
- h318** Number of ventricular premature beats in 10 seconds (see 10 second rhythm strip)

Electrocardiograph-Part II

OMB NO=0925-0216 12/31/2007

Myocardial Infarction Location	
h319	Anterior
h320	Inferior
h321	True Posterior
(0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unknown)	
Left Ventricular Hypertrophy Criteria	
h322	R > 20mm in any limb lead
h323	R > 11mm in AVL
h324	R in lead I plus S in lead III \geq 25mm
(0=No, 1=Yes, 9=Fully paced, Complete LBBB or Unk)	
Measured Voltage	
h325	R AVL in mm (at 1 mv = 10 mm standard) Be sure to code these voltages
h326	S V3 in mm (at 1 mv = 10 mm standard) Be sure to code these voltages
R in V5 or V6-----S in V1 or V2	
h327	R \geq 25mm
h328	S \geq 25mm
h329	R or S \geq 30mm
h330	R + S \geq 35mm
(0=No, 1=Yes, 9=Fully paced, Complete LBBB or Unk)	
h331	Intrinsicoid deflection \geq .05 sec
h332	S-T depression (strain pattern)
Hypertrophy, enlargement, and other ECG Diagnoses	
h333	Nonspecific S-T segment abnormality (0=No, 1=S-T depression, 2=S-T flattening, 3=Other, 9=Fully paced or unknown)
h334	Nonspecific T-wave abnormality (0=No, 1=T inversion, 2=T flattening, 3=Other, 9=Fully paced or unknown)
h335	U-wave present (0=No, 1=Yes, 2=Maybe, 9=Paced or Unknown)
h336	Atrial enlargement (0=None, 1=Left, 2=Right, 3=Both, 9=Atrial fib. or Unknown)
h337	RVH (0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unknown; If complete RBBB present, RVH=9)
h338	LVH (0=No, 1=LVH with strain, 2=LVH with mild S-T Segment Abn, 3=LVH by voltage only, 9=Fully paced or Unkn, If complete LBBB present, LVH=9)

Comments and Diagnosis _____

OMB NO=0925-0216 12/31/2007

Heart Diagnoses First Examiner Opinions	
h339	Rheumatic Heart Disease
h340	Aortic Valve Disease
h341	Mitral Valve Disease
h342	Other Heart Disease (includes congenital)
h343	Arrhythmia

0=No,
1=Yes,
2=Maybe,
9=Unknown

Peripheral Vascular Disease First Examiner Opinions	
h344	Other Peripheral Vascular Disease
h345	Other Vascular Diagnosis (Specify) _____

0=No,
1=Yes,
2=Maybe,
9=Unknown

Neurologic Disease First Examiner Opinions	
h346	Stroke/ TIA
h347	Dementia
h348	Parkinson's Disease
h349	Adult Seizure Disorder
h350	Other Neurological Disease (Specify) _____

0=No,
1=Yes,
2=Maybe,
9=Unknown

Comments CDI

MD23

Clinical Diagnostic Impression--Part II
Non Cardiovascular Diagnoses First Examiner Opinions

OMB NO=0925-0216 12/31/2007

Endocrine		
h351	Thyroid Disease	
h352	Diabetes Mellitus	0=No, 1=Yes, 2=Maybe, 9=Unknown
h353	Other endocrine disorders, specify _____	
GU/GYN		
h354	Renal disease, specify _____	0=No, 1=Yes,
h355	Prostate disease	2=Maybe,
h356	Gynecologic problems, specify _____	9=Unknown
Pulmonary		
h357	Emphysema	0=No,
h358	Pneumonia	1=Yes,
h359	Asthma	2=Maybe,
h360	Other pulmonary disease, specify _____	9=Unknown
Rheumatologic Disorders		
h361	Gout	0=No,
h362	Degenerative joint disease	1=Yes,
h363	Rheumatoid arthritis	2=Maybe,
h364	Other musculoskeletal or connective tissue disease, specify _____	9=Unknown
GI		
h365	Gallbladder disease	0=No,
h366	GERD/ulcer disease	1=Yes,
h367	Liver disease	2=Maybe,
h368	Other GI disease, specify _____	9=Unknown
Blood		
h369	Hematologic disorder	0=No, 1=Yes,
h370	Bleeding disorder	2=Maybe, 9=Unk
Other		
h371	Eye	
h372	ENT	0=No, 1=Yes,
h373	Skin	2=Maybe, 9=Unknown
h374	Other, specify _____	
Infectious Disease		
h375	If Yes, specify _____ _____	0=No, 1=Yes, 2=Maybe, 9=Unknown
Mental Health		
h376	Depression	0=No,
h377	Anxiety	1=Yes,
h378	Psychosis	2=Maybe,
h379	Other, specify _____	9=Unknown

Comments CDI Diagnoses

MD24

Second Examiner Opinions
OFFSITE VISIT – leave page BLANK

OMB NO=0925-0216 12/31/2007

h380	2nd Examiner ID Number	2nd Examiner Last Name
-------------	-------------------------------	-------------------------------

Coronary Heart Disease Second Examiner Opinions (Provide initiators, qualities, radiation, severity, timing, presence after procedures done)	
h381	Congestive Heart Failure
h382	Cardiac Syncope
h383	Angina Pectoris
h384	Coronary Insufficiency
h385	Myocardial Infarct

0=No,
1=Yes,
2=Maybe,
9=Unknown

Comments about chest and heart disease

Intermittent Claudication Second Examiner Opinions (Provide initiators, qualities, radiation, severity, timing, presence after procedures done)	
h386	Intermittent Claudication

0=No, 1=Yes, 2=Maybe, 9=Unknown

Comments about peripheral vascular disease

Cerebrovascular Disease Second Examiner Opinions (Provide initiators, qualities, severity, timing, presence after procedures done)	
h387	Stroke
h388	TIA

0=No, 1=Yes,
2=Maybe, 9=Unknown

Comments about possible Cerebrovascular Disease

MD25