Framingham Heart Study

Original Cohort Exam 24

03/10/1995-01/27/1998
N=831

Exam Form Version	
07-19-96	Numerical Data
12-07-95	Sentence and Design Handout, Cognitive Function (I-II), Activities of Daily living (I-III), Functional Performance, Falls and Fractures, First Examiner *& Second Examiner*
No Version Number:	Lab Data

Notes on Framingham Heart Study Main Exam Data Collection Forms

Multiple versions of each exam form were used at the time of data collection. However, only one version of each exam form has been provided in the samples below. The other versions, which can be found in the participants' charts, have the same variables as the sample exam forms, but may be placed in a different format.

On some of the sample exam forms, the same variable may be found on two different data sheets. An example of this would be variable "FA159" on original cohort exam 8, which is "Signs of CVA: Aphasia." This variable appears both in the physical examination and Exam VIII Code Sheet Card No. 4. The reason for the reappearance of variables is that one data sheet was used for collection of the data, while the other was used to enter the data into the computer. Variables appearing more than once on an exam form should hold the same value in both places for that particular participant.

EXAM 24 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Numerical Data--Part I

240201 FORM NUMBER VERSION 7-19-96

Basic Information

fq001 |__| **Site of Exam** (0=Heart Study,1=Nursing home,2=Residence, 3=Other)

If 0 skip down

If 1 or 2 fill → fq002 |__| **Nursing Home Level of Care 0**=None; **1**=Skilled care 24hrs, **2**=Skilled care 8-16 hrs; **3**=Self care; **9**=unknown

fq003 |__| **Marital Status** (1=Single, 2=Married, 3=Widowed, 4=Divorced, 5=Separated)

fq004 |__|__| **Examiner's Number** (99= unknown)

fq005 |__|__|__| **Weight** (to nearest pound) (99= unknown)

fq006 |__|__|*|__|__| **Height** (inches, to next lower 1/4 inch) (99= unknown)

fq007 |__| **Proxy used to complete this exam (0=No, 1=Yes, 9=Unk)**

If yes, fill→ **Proxy Name** _____

fq008 |__| **Relationship** (1= 1st Degree Relative(spouse, child), 2= Other relative, 3= Friend 4= Health Care Professional, 5= Other, 9= Unknown)

fq009 |__|__|__|__| fq010 **How long have you known the participant?** (Years, Months)

fq011 |__| **Are you currently living in the same household with the participant?** (0=No,1=Yes)

fq012 |__| **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/N/A)

	Systolic	Diastolic	Examiner ID
Examiner Blood Pressure (first reading)	fq013 |__|__|__| to nearest 2 mm Hg	fq014 |__|__|__| to nearest 2 mm Hg	Prefix fq015 |__| ID fq016 |__|__|__| 0=MD, 1=Other
Examiner Blood Pressure (second reading)	fq017 |__|__|__| to nearest 2 mm Hg	fq018 |__|__|__| to nearest 2 mm Hg	Prefix fq019 |__| ID fq020 |__|__|__| 0=MD, 1=Other

Exam 24 Procedures Sheet

fq021 |__| **Blood Lipids**

fq022 |__| **ECG Done**

EXAM 24 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Sentence and Design Handout for Patient

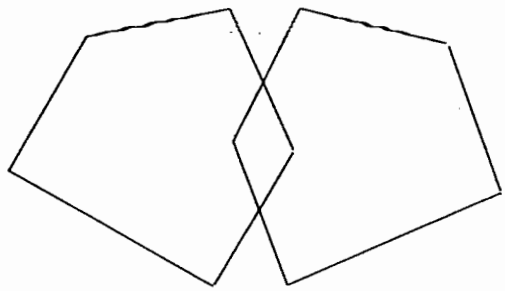
PLEASE WRITE A SENTENCE

_____

_____

_____

PLEASE COPY THIS DESIGN



EXAM 24 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Cognitive Function--Part I

240203 FORM NUMBER VERSION 12/7/95

fq023 / fq024	
|__|-----|__|__|__| (0=MD,1=Other)	**Examiner's Number**

	SCORE CORRECT No Try=6 Unknown=9	Write all responses on exam form.
fq025	0 1 2 3 6 9	**What Is the Date Today?** (Month, day, year, correct score=3)
fq026	0 1 6 9	**What Is the Season?**
fq027	0 1 6 9	**What Day of the Week Is it?**
fq028	0 1 2 3 6 9	**What Town, County and State Are We in?**
fq029	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)
fq030	0 1 6 9	**What Floor of the Building Are We on?**
fq031	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**
fq032	|__|__|__|__|__|	**Now I am going to spell a word forward and I want you to spell if backwards. The word is world. WO-R-L-D. Please Spell it in Reverse Order. Write in Letters,_____** (Letters Are Entered and Scored Later)
fq033	0 1 2 3 6 9	**What are the 3 objects I asked you to remember a few moments ago?**

EXAM 24 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Cognitive Function --Part II

240204 FORM NUMBER

fq034 |__|-----|__|__|__| **Examiner's Number**

fq035

SCORE CORRECT No Try=6 Unknown=9	Write all responses on exam form.
fq036 0 1 6 9	**What Is this Called?** (Watch)
fq037 0 1 6 9	**What Is this Called?** (Pencil)
fq038 0 1 6 9	**Please Repeat the Following: "No Ifs, Ands, or Buts."** (Perfect=1)
fq039 0 1 6 9	**Please Read the Following & Do What it Says** (performed=1, code 6 if low vision)
fq040 0 1 6 9	**Please Write a Sentence** (code 6 if low vision)
fq041 0 1 6 9	**Please Copy this Drawing** (code 6 if low vision)
fq042 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 in your lap** (score 1 for each correctly performed act, code 6if low vision)
No Yes Maybe Unk (coding below)	**Factors Potentially affecting Mental Status Testing**
fq043 0 1 2 9	**Illiteracy or low education**
fq044 0 1 2 9	**Not fluent in English,**
fq045 0 1 2 9	**Poor Eyesight**
fq046 0 1 2 9	**Poor Hearing**
fq047 0 1 2 9	**Depression**
fq048 0 1 2 9	**Aphasia**
fq049 0 1 2 9	**Coma**
fq050 0 1 2 9	**Parkinsonism**
fq051 0 1 2 9	**Other**

EXAM 24 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Activities of Daily Living

240205 FORM NUMBER

fq052	fq053
|__|-----|__|__|__|	**Examiner's Number**

During the Course of a Normal Day, How Do You Carry out the Following Activities? 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	
fq054 |__|	**Dressing** (undressing and redressing)
fq055 |__|	**Bathing** (including getting in and out of tub or shower)
fq056 |__|	**Eating**
fq057 |__|	**Transferring** (getting in and out of a chair)
fq058 |__|	**Toileting Activities** (using bathroom facilities and handle clothing)
fq059 |__|	**Bladder Continence** (ask if person has "accidents") (code=5 if use special products)
fq060 |__|	**Bowel Continence** (ask if person has "accidents") (code=5 if use special products)
fq061 |__|	**Walking on Level Surface about 50 Yards** (length of Thurber St.)
fq062 |__|	**Walking up and down One Flight Stairs**
fq063 |__|	**Using a Telephone**
fq064 |__|	**Taking Own Medications** (code as above, and 8=takes no medications regularly)

EXAM 24 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Activities--Part II

2402052 FORM NUMBER

fq065 |__| **Are you in bed or in a chair for most or all of the day (on the average)?**
(Note: this is a lifestyle question, not due to health) (0=No, 1=Yes, 9=Unk or Not sure)

fq066 |__| **Do you need a special aid (wheelchair, cane, walker) to get around?**
(0=No; 1=Yes,always; 2=Yes,sometimes; 9=Unknown)

fq067 |__| **If use a special aid,which of the following equipment do you use?**
(0=No, 1=Yes,always; 2=Yes,sometimes; 9=Unknown) if yes, note below

fq068 |__| **Cane or walking stick**

fq069 |__| **Wheelchair**

fq070 |__| **Walker**

fq071 |__| **Other (Write in)**_____

fq072 |__| **Are you working now:** (0=No, 1=Yes,Full time, 2=Yes, Part time, 9=Unknown)

fq073 |__|__|_| **During the past 6 months (180 days) how many days were you so sick that you were unable to carry out your usual activities?** (999=Unknown)

(Codes for Next 6 Questions: (0=No,Unable to do; 1=Yes,Independent; 2=Yes, with Human Assistance; 9=Unknown)

fq074 |__| **Are you able to do heavy work around the house, like shovel snow or wash windows, walls or floors without help?**

fq075 |__| **Are you able to walk up and down stairs to the second floor without any help?**

fq076 |__| **Are you able to walk a mile without help?** (About 8 blocks)

fq077 |__| **If you had to, could you do all the housekeeping yourself? (like washing clothes and cleaning)?**

fq078 |__| **If you had to, could you do all the cooking yourself?**

fq079 |__| **If you had to, could you do all the grocery shopping yourself?**

fq080 |__| **Do you drive?** (0=No, 1=Yes,currently, 2=Yes, not now, 9=Unk)

fq081 |__| **Reason for not driving now**
(1=Health, 2=Other non-health reason, 3=Never licensed, 8=N/A, current driver, 9=Unknown)

EXAM 24 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Activities--Part III

2402053 FORM NUMBER

For each activity that subject had a lot of difficulty doing or was unable to do (codes 3 or 4), ask for reason(s)

For each thing tell me whether you have
(0) No difficulty
(1) A little difficulty
(2) Some difficulty
(3) **A lot of difficulty--give reasons**
(4) **Unable to do--give reasons**
(5) Don't do on MD orders
(9) Unknown

fq082 |__| Pulling or pushing large objects like a living room chair.
If code 3 or 4, give reason_____

fq083 |__| Either stooping, crouching, or kneeling
If code 3 or 4, give reason_____

fq084 |__| Reaching or extending arms below shoulder level
If code 3 or 4, give reason_____

fq085 |__| Reaching or extending arms above shoulder level
If code 3 or 4, give reason_____

fq086 |__| Either writing, handling, or fingering small objects.
If code 3 or 4, give reason_____

fq087 |__| Standing in one place for long periods, say 15 minutes
If code 3 or 4, give reason _____

fq088 |__| Sitting for long periods, say 1 hour
If code 3 or 4, give reason_____

fq089 |__| Lifting a 10 pound object off the floor (sack of potatoes)
If code 3 or 4, give reason_____

fq090 |__| Walking one half a mile (4-6 blocks)
If code 3 or 4, give reason_____

EXAM 24 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Functional Performance

240206 FORM NUMBER

fq092

fq091 |__|---|__|__| __|	**Examiner's Number**

	Basic Functions
fq093 |__|	**Where do you live:** (0 = Private Residence, 1 = Nursing home, 2 = Other institution, such as: home-self care retirement village, 9=Unknown)
fq094 |__|	**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

0=No	1=Yes < 3 mo/yr	2=Yes ≥3 mo/yr	9=Unk	Spouse fq095
0=No	1=Yes < 3 mo/yr	2=Yes ≥3 mo/yr	9=Unk	Significant Other fq096
0=No	1=Yes < 3 mo/yr	2=Yes ≥3 mo/yr	9=Unk	Children fq097
0=No	1=Yes < 3 mo/yr	2=Yes ≥3 mo/yr	9=Unk	Friends fq098
0=No	1=Yes < 3 mo/yr	2=Yes ≥3 mo/yr	9=Unk	Relatives fq099

	** **Proxy may not be used to help complete this section** **
fq100 |__|	**In general, how is your health now**: (1=Excellent, 2=Good, 3=Fair, 4=Poor,9=Unkn)
fq101 |__|	**Compare your health to most people your own age:** (1=Better, 2=About the same, 3=Worse, than most people your own age, 9=Unknown)

EXAM 24 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Falls and Fractures

240207 FORM NUMBER

fq102 |__| **In the past year have you accidentally fallen and hit the floor or ground?**
(code as no if during sports activity) (0=no, 1=Yes, 2=Maybe, 9=Unknown)

If yes or maybe fill ☞ and below

fq103 |__|__| **How many times did you fall in the past year?** (88=N/A, 99=Unk

Did any of your falls in the past year result in a:
(Code: 0=No, 1=Yes, 2=Maybe, 8=N/A, 9=Unknown

fq104 |__| **Fracture**
fq105 |__| **Head injury requiring medical attention**
fq106 |__| **Dislocation**
fq107 |__| **Bruise, sprain, or cut**
fq108 |__| **Other** (write in)_____

Fractures

fq109 |__| **Since Your Last Clinic Visit Have You Broken Any Bones?**
(Code: 0=No, 1=Yes, 2=Maybe, 9=Unknown)

If 0 or 9 then skip rest of table

If 1,2, fill ☞

Left	Right	Location(code unknown as 00)
fq110 19|__|__|	fq111 19|__|__|	**Upper arm (humerus) or elbow**
fq112 19|__|__|	fq113 19|__|__|	**Forearm or wrist**
fq114 19|__|__|		**Back** (If disc disease only, code as no)
fq115 19|__|__|		**Pelvis**
fq116 19|__|__|	fq117 19|__|__|	**Hip**
fq118 19|__|__|		**Other** (specify) fq119_____

END OF EXAM 24 #1

EXAM 24 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

First Examiner --Hospitalizations

VERSION 12/7/95
240301 FORM NUMBER

COHORT EXAM 24
(SCREEN 1)

q120 q121 |__|-----|__|__| (0=MD, 1=Other)	**First Examiner's Number** _____ First Examiner Name

DATE _____

Basic Background and Health Care	
q122 |__|	**Hospitalization (not just E.R.) in Interim** (0=No; 1=yes, hospitalization, 2=yes, more than 1 hospitalization, 9=Unknown)
q123 |__|	**E.R. Visit in Interim** (0=No; 1=Yes, 1 or more ER visit, 2=Yes,more than 1 visit 9=Unk)
q124 |__|	**Day Surgery** (0=No, 1=Yes, 9=Unknown)
q125 |__|	**Illness with visit to doctor** (0=No, 1=Yes,1 visit; 2=Yes,more than 1 visit; 9=Unk)
q126 |__|	**Check up** in interim by doctor (0=No, 1=Yes, 9=Unknown)
____q127____ MM DD YY	**Date** of this FHS exam (Today's date - See above)

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

EXAM 24 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

First Examiner --Cardiovascular Medications

240302 FORM NUMBER (SCREEN 2)

fq128 |__| **Take aspirin regularly** (0=No, 1=Yes, 9=Unk)

If yes, fill

|__|__| fq129 **Number aspirins taken regularly** (99=Unknown)

|__| fq130 **Aspirin frequency**- number taken regularly (0=Never, 1=Day, 2=Week ,3=Month, 4=Year, 9=Unk)

|__|__|__| fq131 **Usual aspirin dose for above** 081=baby,160=half dose, 325=nl, 500=extra or larger,999=unk

fq132 |__| **Currently receiving medication for the treatment of hypertension?** (0=No,1=Yes,9=Unk)

fq133 |__| **Any of the cardiovascular medications below on this page?** (0=No, 1=Yes, 9=Unk)

If yes,continue

CODE
0=No;
1=Yes,now;
2=Yes,not now
3=Maybe,
9=Unknown)

fq134 |__| **Cardiac Glycosides**

fq135 |__| **Nitroglycerine**

fq136 |__| **Longer acting nitrates** (Isordil, Cardilate, etc.)

fq137 |__| **Calcium Channel Blockers** (Nifedipine, Verapamil, Diltiazem)

if yes, fill fq138 |__| **Short or long acting** (0=none, 1=short, 2=long, 9=unk)

fq139 |__| **Beta Blockers** (0=No, 1=Yes, 2=Yes, not now, 3=maybe, 9=Unk) (Specify_____)

if yes fill and continue

fq140 |__| **Beta Blocker Group** (Propranolol=01 Timolol =02 Nadolol=03 Atenolol=04 Metoprolol=05 Pindolol =06 Acebutolol=07 Labetalol=08 Other=09)

fq141 |__|__|__| **Dose** (mg/day) of Beta Blocker (999=unknown)

CODING FOR REST OF PAGE
0=No;
1=Yes,now;2=Yes,not now
3=Maybe,9=Unknown)

fq142 |__| **Loop Diuretics** (Lasix, etc.)

fq143 |__| **Thiazide/K-sparing diuretics**(Dyazide, Maxide, etc.)

fq144 |__| **Thiazide diuretics**

fq145 |__| **K-sparing diuretics** (Aldactone, Triamterene)

fq146 |__| **Potassium supplements**

fq147 |__| **Reserpine** derivatives

All Medicines-- Scratch Sheet

fq148 |__| **Methyldopa** (Aldomet)

fq149 |__| **Alpha-1 agonist** (Clonidine, Wytensin, Guanabenz)

fq150 |__| **Alpha-2 blockers** (Prazosin, Terazosin, Doxazosin)

fq151 |__| **Renin-angiotensin blocking drugs (ACE)** (Captopril, Enalapril, Lisinopril)

fq152 |__| **Peripheral vasodilators** (Hydralazine, Minoxidil, etc)

fq153 |__| **Other anti-hypertensives**(Specify)_____

fq154 |__| **Antiarrhythmics** (Quinidine, Procainamide, Norpace,Disopyramide,etc)

fq155 |__| **Antiplatelet** (Anturane, Persantine, etc.)

fq156 |__| **Anticoagulants** (Coumadin, Warfarin, etc.)

fq157 Other cardiac medication (SPECIFY _____)

EXAM 24 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

First Examiner -- Other Medications

2403C3 FORM NUMBER (SCREEN 3)

fq158 __	**Anti cholesterol drugs** (Resins--e.g. Questran, Colestid)	CODING FOR REST OF PAGE
fq159 __	**Anti cholesterol drugs** (Niacin or Nicotinic Acid)	0=No
fq160 __	**Anti cholesterol drugs** (Fibrates--e.g. Gemfibrozil)	1=Yes,now
fq161 __	**Anti cholesterol drugs** (Statins--e.g.Lovastatin,Pravastatin)	2=Yes,not now
fq162 __	**Anti cholesterol drugs** (Other--Specify_____)	3=Maybe
fq163 __	**Antigout--uric acid lowering** (Allopurinol, Probenecid etc)	9=Unknown
fq164 __	**Antigout**--(Colchicine)	
fq165 __	**Thyroid extract** (Dessicated Thyroid)	
fq166 __	**Thyroxine** (Synthroid etc.)	
fq167 __	**Insulin** 0=No, 1=Yes,now 2=Yes,not now 3=Maybe 9=Unknown	
if yes fill in dose ☞ fq168 ___	Total units of insulin a day	
fq169 __	**Oral hypoglycemics** (Specify brand_____)	
fq170 __	**Oral/patch estrogen** (for women users also see estrogen section)	
fq171 __	**Oral glucocorticoids** (Prednisone, Cortisone,etc)	
fq172 __	**Non-steroidal anti-inflammatory agents (NSAIDS)** (Motrin,Ibuprofen, Naprosyn, Indocin, Clinoril)	
fq173 __	**Analgesic-narcotics** (Demerol, Codeine, Dilaudid, etc.)	
fq174 __	**Analgesic-non-narcotics** (Acetaminophen etc.)	
fq175 __	**Antihistamines**	
fq176 __	**Antiulcer** (Tagamet, Ranitidine, Probanthine, H ion inhibitors)	
fq177 __	**Anti-anxiety, Sedative/Hypnotics** etc. (Librium, Valium etc.)	
fq178 __	**Sleeping pills**	
fq179 __	**Anti-depressants**	
fq180 __	**Eyedrops**	
fq181 __	**Antibiotics**	
fq182 __	**Anti-parkinson drugs** (Sinemet, L-Dopa, Symmetrel, Cogentin, etc)	
fq183 __	**Anticonvulsants** (Dilantin, Phenobarbital, Tegretol, Mysoline etc)	
fq184 __	**Bronchodilators and aerosols**	
fq185 __	**Others** Specify:_____	

EXAM 24 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

First Examiner --Genitourinary and Thyroid Disease

240304 FORM NUMBER (SCREEN 4)

Female Genitourinary

Q186 |__| **Estrogen replacement in interim** (e.g. Premarin)
(0=No, 1=Yes,now; 2=Yes,not now, 8=Man, 9=Unk)

If yes, fill all to

Q187 |__| **Dose/day of premarin conjugated Estrogens, or other oral estrogen**
(0=No, 1=0.3 mg, 2=0.625 mg, 3=1.25 mg, 4=2.5mg,, (pick nearest dose)
5=other_____ 9=Unk)
(write in)

☞Q188 |__| **Patch dose of estrogen** (0=No, 1=0.5 mg/wk, 2=other _____, 9=Unk)
(write in)

Q189 |__|__| **Number of days a month taking estrogens** (99=Unknown)

Q190 |__| **Progesterone use interim** (0=No, 1=Yes,now; 2=Yes,not now, 8=Man, 9=Unk)

Male Genitourinary Disease

Q191 |__| **Prostate trouble in interim** (0=No, 1=Yes,now; 2=Yes,not now, 8=Woman, 9=Unk)

Q192 |__| **Prostate surgery in interim**

Medical History-- Thyroid

Q193 |__| **Interim diagnosis of a thyroid condition?**(0=No,1=Yes,9=Unknown)

Comments_____

EXAM 24 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

First Examiner --Smoking and Respiratory

240305 FORM NUMBER (SCREEN 5)

fq194	|__|	**Smoked cigarettes regularly in the last year?** (0=No, 1=Yes, 9=Unkown)
if yes fill rest of this table	fq195 |__|__|	How many cigarettes do/did you smoke a day? (01=one or less, 99=unknown)

Respiratory Symptoms

fq196	|__|	**Chronic cough in interim** (at least 3 months/year) (0=No; 1=Yes, productive; 2=Yes, non-productive; 9=Unknown)
if yes, ☞	fq197 |__|	Type of Cough (1=New in interim, 2=Old, 9=Unknown)
fq198	|__|	**Wheezing or asthma** (0=No, 1=Yes, 9=Unknown)
fq199	|__|	**Dyspnea on exertion** (0=No) (1=Climbing stairs or vigorous exertion) (2=Rapid walking or moderate exertion) (3=Any slight exertion) (9=Unknown)
if yes, ☞	fq200 |__|	**Dyspnea has increased over the past two years** (0=No, 1=Yes, 9=Unk)
fq201	|__|	**Orthopnea**
fq202	|__|	**Paroxysmal nocturnal dyspnea**
fq203	|__|	**Ankle edema bilaterally**

(0=No, 1=Yes-new in interim, 2=Yes-old complaint, 9=Unknown)

Respiratory Comments _____

EXAM 24 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

First Examiner -- Heart and Cerebrovascular

240306 FORM NUMBER (SCREEN 6)

q204	|__|	**Any chest discomfort since last exam**	**(0=No, 1=Yes,2=Maybe,9=Unknown)**
if yes, fill ☞ and below	q205 |__|	Chest discomfort with exertion or excitement	(0=No, 1=Yes,2=Maybe,9=Unknown)
	q206 |__|	Chest discomfort when quiet or resting	
	q207 |__|	Seen MD for above	
	q208 |__|	Been hospitalized for above	

Syncope

q209 |__|	**Have you fainted or lost consciousness in the interim?** (If due to stroke code as no and skip to cerebrovascular section) If event immediately preceded by head injury or accident code 0=No)	Code: 0=No, 1=Yes, 2=Maybe, 9=Unknown

Cerebrovascular Episodes in Interim

q210 |__|	**Stroke**	Code: 0=No, 1=Yes, 2=Maybe, 9=Unknown
q211 |__|	**Mini-stroke or transient ischemic attack (TIA)**	
q212 |__|	**CT or MRI scan (head) since last exam** (date/place_____)	
q213 |__|	**Seen by neurologist since last exam** (write in who and when below): 0=No, 1=Yes,2=Maybe, 9=Unknown _____	

Neurology Comments_____

EXAM 24 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

First Examiner --Peripheral Arterial and Venous

240307 FORM NUMBER (SCREEN 7)

f214	0= Able	1=Needs help	2= Can't Walk	9=Unkn	**Can you walk 50 feet without help?** (e.g. no cane, walker, wheelchair) (0=Able to walk 50 feet without help,1=Needs help, 2=Can't Wak 9=Unk)
f215	0= No	1=Yes	2= Can't Walk	9=Unkn	**Do you have cramping in calves or thighs while walking?** (0=No, 1=Yes, 2= Can't Walk 9=Unkn)
f216	0= No	1=Yes		9=Unkn	**Have you been tested for cramping in calves or thighs?** (0=No, 1=Yes, 9=Unkn) if yes, give details_____ _____

Comments Peripheral Vascular Disease_____

EXAM 24 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

First Examiner -- CHD and Complications

240308 FORM NUMBER (SCREEN 8)

Coding: 0=No, 1=Yes 2=Maybe, 9=Unkn	Cardiovascular Procedure (in the interim only, not lifetime)
fq217 |__| if yes fill☞	fq228 **Exercise Tolerance Test (most recent only)** 19|__|__| Year done Location_____
fq218 |__| if yes fill☞	fq229 **Coronary arteriogram (most recent only)** 19|__|__|Year done (99=unknown)
fq219 |__| if yes fill☞	fq230 **Coronary artery angioplasty** 19|__|__| Year first done (99=unknown) fq231 |__| Type of procedure (0=none, 1=balloon, 2=other_____ 9=unkn),
fq220 |__| if yes fill☞	fq232 **Coronary bypass surgery** 19|__|__| Year first done (99=unknown)
fq221 |__| if yes fill☞	fq233 **Permanent pacemaker insertion** 19|__|__| Year first done (99=unknown)
fq222 |__| if yes fill☞	fq234 **Carotid artery surgery** 19|__|__| Year first done (99=unknown)
fq223 |__| if yes fill☞	fq235 **Thoracic aorta surgery** 19|__|__| Year first done (99=unknown)
fq224 |__| if yes fill☞	fq236 **Abdominal aorta surgery** 19|__|__| Year first done (99=unknown)
fq225 |__| if yes fill☞	fq237 **Femoral or lower extremity surgery** 19|__|__| Year first done (99=unknown)
fq226 |__| if yes fill☞	fq238 **Lower extremity amputation** 19|__|__| Year first done (99=unknown)
fq227 |__| if yes fill☞	fq239 **Valve surgery** fq240 19|__|__| Year first done (99=unknown) Type _____

Cardiovascular Procedures Interim Summary
Please list all subsequent cardiovascular procedures

Date	Hospital	Type of Procedure
__/__/____		
__/__/____		
__/__/____		
__/__/____		

EXAM 24 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

First Examiner - Cancer Site or Type

240309 FORM NUMBER (SCREEN 9)

fq241	|__|	**Have you, since your last clinic visit, 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.
fq242	|__|	Esophagus			
fq243	|__|	Stomach			
fq244	|__|	Colon			
fq245	|__|	Rectum			
fq246	|__|	Pancreas			
fq247	|__|	Larynx			
fq248	|__|	Trachea/Bronchus/Lung			
fq249	|__|	Leukemia			
fq250	|__|	Skin			
fq251	|__|	Breast			
fq252	|__|	Cervix/Uterus			
fq253	|__|	Ovary			
fq254	|__|	Prostate			
fq255	|__|	Bladder			
fq256	|__|	Kidney			
fq257	|__|	Brain			
fq258	|__|	Lymphoma			
fq259	|__|	Other/Unknown _____			

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

EXAM 24 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

First Examiner --Items needing Second Opinion

240310 FORM NUMBER (SCREEN 10)

Coronary Heart Disease First Examiner Opinions (Medical Assistant)		
fq260	|__| **Possible Heart Disease in Interim (angina, MI, valvular disease, CHF)**	0=No,
fq261	|__| **Possible Syncope in Interim**	1=Yes,
fq262	|__| **Possible Cerebrovascular Disease in Interim (stroke, TIA, other)**	2=Maybe, 9=Unknown
fq263	|__| **Possible Peripheral Vascular Disease in Interim**	

EXAM 24 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Second Examiner ---Electrocardiograph Part I

240311 FORM NUMBER (SCREEN 11)

fq264 |__|----|__|__| (0=MD, 1=Other) fq265	2nd Examiner ID Number	_____ 2nd Examiner Last Name

fq266 |__| if Yes, fill out rest of form	ECG done (0=No, 1=Yes)	
	Rates and Intervals	
fq267 |__|__|__|	Ventricular rate per minute (999=Unknown)	
fq268 |__|__|	P-R Interval (hundreths of a second) (99=FullyPaced, Atrial Fib, or Unknown)	
fq269 |__|__|	QRS interval (hundreths of second) (99=Fully Paced, Unknown)	
fq270 |__|__|	Q-T interval (hundreths of second) (99=Fully Paced, Unknown)	
fq271 |__|__|__|__|	QRS angle (put plus or minus as needed) (e.g. -045 for minus 45 degrees, +090 for plus 90, 9999=Fully paced or Unknown)	
	Rhythm	
fq272 |__|	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	
fq273 |__|	IV Block (0=No, 1=Yes, 9=Fully paced or Unknown)	
if yes, fill to right	fq274 |__| Pattern (1=Left, 2=Right, 3=Indeterminate)	
	fq275 |__| Complete (QRS interval=.12 sec or greater)(0=No, 1=Yes, 9=Unknown)	
	fq276 |__| Incomplete (QRS interval = .10 or .11 sec) (0=No, 1=Yes, 9=Unknown)	
fq277 |__|	Hemiblock (0=No, 1=Left Ant, 2=Left Post, 9=Fully paced or Unknown)	
fq278 |__|	WPW Syndrome (0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unknown)	
	Arrhythmias	
fq279 |__|	Atrial premature beats (0=No, 1=Atr, 2=Atr Aber, 9=Unknown)	
fq280 |__|	Ventricular premature beats (0=No, 1=Simple, 2=Multifoc, 3=Pairs, 4=Run, 5=R on T, 9=Unk)	
fq281 |__|__|	Number of ventricular premature beats in 10 seconds (see 10 second rhythm strip)	

EXAM 24 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Second Examiner -Electrocardiograph Part II

240312 FORM NUMBER (SCREEN 12)

Myocardial Infarction Location

fq282 |__|	Anterior	(0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unknown)
fq283 |__|	Inferior	
fq284 |__|	True Posterior	

Left Ventricular Hypertrophy Criteria

fq285 |__|	R > 20mm in any limb lead	(0=No, 1=Yes, 9=Fully paced, Complete LBBB or Unk)
fq286 |__|	R > 11mm in AVL	
fq287 |__|	R in lead I plus S ≥ 25mm in lead III	

Measured Voltage

fq288 *|__|__|	R AVL in mm (at 1 mv = 10 mm standard) Be sure to code these voltages
fq289 *|__|__|	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

fq290 |__|	R≥ 25mm	(0=No, 1=Yes, 9=Fully paced, Complete LBBB or Unk)
fq291 |__|	S≥= 25mm	
fq292 |__|	R or S ≥ 30mm	
fq293 |__|	R + S ≥ 35mm	
fq294 |__|	Intrinsicoid deflection ≥ .05 sec	
fq295 |__|	ST depression	

Hypertrophy, enlargement, and other ECG Diagnoses

fq296 |__|	Nonspecific S-T segment abnormality	(0=No, 1=Yes, 2=Maybe, 9=Paced or Unk)
fq297 |__|	Nonspecific T-wave abnormality	
fq298 |__|	U-wave present	
fq299 |__|	Atrial enlargement (0=None, 1=Left, 2=Right, 3=Both, 9=Atrial fib. or Unknown)	
fq300 |__|	RVH (0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unknown; If complete RBBB present, RVH=9)	
fq301 |__|	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_____

_____

_____

EXAM 24 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Second Examiner -- Blood Pressure and Opinions in Interim

240313 FORM NUMBER (SCREEN 13)

f9302 f9303 |---|	2nd Examiner ID Number	_____ 2nd Examiner Last Name

Second Examiner Blood Pressure (first reading)	Systolic	Diastolic	Examiner ID
	f9304 |_|_|_|	f9305 |_|_|_|	Prefix f9306 |_| ID f9307 |_|_|_|
	to nearest 2 mm Hg	to nearest 2 mm Hg	0=MD, 1=Other

Second Examiner Blood Pressure (second reading)	Systolic	Diastolic	Examiner ID
	f9308 |_|_|_|	f9309 |_|_|_|	Prefix f9310 |_| ID f9311 |_|_|_|
	to nearest 2 mm Hg	to nearest 2 mm Hg	0=MD, 1=Other

EXAM 24 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Second Examiner --Coronary Heart Disease Opinions in Interim

240314 FORM NUMBER (SCREEN 14)

q313 |__| if yes, fill below	**Chest Discomfort Characteristics (0=No, 1=Yes, 9=Unk)**		
q313 |__|__|*|__|__| q314	Date of onset	mo/yr,99/99=Unknown)	
q315 |__|__|__|	Usual duration	(minutes, 999=Unknown)	
q316 |__|__|__|	Longest duration	(minutes: 1=1 min or less, 900=15 hrs or more, 999=Unknown)	
q317 |__|	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)	
q318 |__|	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)	
q319 |__|__|__|	Frequency (number in past month)	999=Unknown	
q320 |__|__|__|	Frequency (number in past year)	999=Unknown	
q321 |__|	Type	(1=Pressure,heavy,vise; 2=Sharp; 3=Dull; 4=Other; 9=Unk)	
q322 |__|	Relief by Nitroglycerine in <15 minutes	0=No	
q323 |__|	Relief by Rest in <15 minutes	1=Yes,	
q324 |__|	Relief Spontaneously in <15 minutes	8=Not tried	
q325 |__|	Relief by Other cause in <15 minutes	9=Unknown	

Coronary Heart Disease Second Examiner Opinions		
q326 |__|	Congestive Heart Failure	0=No, 1=Yes, 2=Maybe, 9=Unknown
q327 |__|	Angina Pectoris	
q328 |__|	Coronary Insufficiency	
q329 |__|	Myocardial Infarct	

Comments about heart disease

EXAM 24 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Second Examiner -- Syncope History in Interim

240315 FORM NUMBER (SCREEN 15)

q330 _	**Have you fainted or lost consciousness in the interim?** (If due to stroke code as no and fill out stroke sheet) If event immediately preceded by head injury or accident code 0=No)		Code: 0=No, 1=Yes, 2=Maybe, 9=Unknown
if yes, fill all ☞ q331	___	Number of episodes in the past two years	(999=Unknown)
q332	__/__	q333 Date of first episode	(mo/yr, 99/99=Unknown)
q334	___	Usual duration of loss of consciousness	(minutes, 999=Unkn)
if yes, fill all ☞ q335	__	Usual Activity Preceding Event (00=None, 01=Exertion, 02=Rest, 03=Defecation/Micturition/Cough, 04=Emotional upset, 05=Alcohol consumption, 06=Turning neck (e.g. shaving), 07=Postural change (e.g. lying to standing), 08=Recent medication change or ingestion, 09=Other, or combination (specify)_____, 10=Pain, 11 illness, specify _____ 99=Unknown)	

	Symptoms noted before event(s) (0=No, 1=Yes, 2=Maybe, 9=Unkn)		Symptoms noted after event(s) (0=No, 1=Yes, 2=Maybe, 9=Unkn)
if yes, fill both columns to ☞ q336	_ Nausea/vomiting	q341	_ Urinary/fecal incontinence
q337	_ Warning signs (e.g. Aura)	q342	_ Confusion
q338	_ Chest discomfort	q343	_ Focal weakness (e.g. arm,leg)
q339	_ Shortness of breath	q344	_ Other (specify)_____
q340	_ Palpitations		

q345 _	Did you have any injury caused by the event? (0=No, 1=Yes, 2=Maybe, 9=Unkn)	
if yes, fill ☞ q346 _	Was event observed? (0=No, 1=Yes, 2=Maybe, 9=Unkn) Who observed event? _____	
q347 _	ER/hospitalized or saw M.D. (0=No, 1=Hosp., 2=Saw M.D., 9=Unkn) Hospitalized at: _____	
	M.D. seen: _____	

Syncope Second Opinions

q348 _ Syncope (0=No, 1=Yes, 2=Maybe, 3=Presyncope, 9=Unknown)

q349 _	Cardiac syncope	(0=No, 1=Yes, 2=Maybe, 9=Unknown)
q350 _	Vasovagal syncope	
q351 _	Other Specify:_____	

_ Seizure Disorder (0=No,1=Yes, 2=Maybe,9=Unk)

q352

EXAM 24 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Second Examiner -- Cerebrovascular and Neurological History and Opinions

240316 FORM NUMBER (SCREEN 16)

Cerebrovascular Episodes in Interim

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

f@353	I__I	Sudden muscular weakness
f@354	I__I	Sudden speech difficulty
f@355	I__I	Sudden visual defect
f@356	I__I	Double vision
f@357	I__I	Loss of vision in one eye
f@358	I__I	Unconsciousness
f@359	I__I	Numbness, tingling
if yes, fill ☞ f@360	I__I	Numbness and tingling is positional

Details for "Serious" Cerebrovascular Event in Interim

f@361 I__I

Examiner's opinion that "serious" or "significant" cerebrovascular event took place in interim (0=No, 1=Yes, 2=Maybe, 9=Unknown)

if yes or maybe fill all to ☞

f@362 I__I__I*I__I__I f@363	Date (mo/yr,99/99=Unkn Observed by_____
f@364 I__I	Onset time (1=Active, 2=During sleep, 3=While arising, 9=Unkn)
f@365 I__I__I*I__I__I f@366	Exact/approximate time (use 24-hour military time, 99.99=unkn)
f@367 I__I__I*I__I__I*I__I__I f@369 (f@368)	Duration (use format days/hours/mins, 99/99/99=Unknown)
f@370 I__I	Hospitalized or saw M.D. 0=No,1=Hosp.2=Saw M.D,9=Unk
f@371 I__I__I	Number of days stayed at _____

Stroke/TIA and Parkinson's Disease Second Opinions

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

f@372	I__I	Stroke in Interim
f@373	I__I	Transient Ischemic Attack in Interim (TIA)
f@374	I__I	Parkinsonism in Interim
f@375	I__I	Other-- Specify:

Comments about possible Cerebrovascular Disease

_____

_____

_____

_____

EXAM 24 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Second Examiner --Peripheral Vascular History and Opinion

240317 FORM NUMBER (SCREEN 17)

Left	Right	Vascular symptoms (0=No, 1=Yes, 9=Unkn)
f0376 |__|	f0377 |__|	Discomfort in calf while walking
f0378 |__|	f0379 |__|	Discomfort in lower extremity (not calf) while walking
f0380 |__|		Occurs with first steps
f0381 |__|		After walking a while
f0382 |__|		Related to rapidity of walking or steepness
f0383 |__|		Forced to stop walking
f0384 |__|__|		Time for discomfort to be relieved by stopping (minutes) (00=No relief with stopping, 88=Not Applicable)
f0385 |__|__|		Number of days/month of lower limb discomfort (00=No, 88=N/A, 99=Unknown)

Intermittent Claudication Second Examiner Opinions		
f0386 |__|	Intermittent Claudication	0=No, 1=Yes, 2=Maybe, 9=Unknown

Comments about peripheral vascular disease

_____

_____

_____

_____

Interim Non Cardiovascular Diagnoses		
f0387 |__|	Diabetes Mellitus	0=No, 1=Yes, 2=Maybe, 9=Unknown
f0388 |__|	Prostate Disease	
f0389 |__|	Emphysema	
f0390 |__|	Chronic Bronchitis (Cough that produces sputum at least 3 months in past 12 months)	
f0391 |__|	Other non C-V diagnosis (for cancer, see special screen)	

Framingham Heart Study
Lab Data

- -

Id: Exam Date

- -

Fq396 Total Cholesterol (mg/dL)

Fq397 HDL Cholesterol (mg/dL)

Cholesterol to HDL Ratio

Fq398 Triglyceride (mg/dL)

Fq399 Creatinine (mg/dL)

- -

Interpretation:

Total Cholesterol Level (mg/dL)	Heart Disease Risk
under 200	Low
200 - 240	Average
over 240	Above average

Cholesterol to HDL Ratio:

Good	under 4.5
Ideal	under 3.5

Cholesterols are frequently higher in older patients

Triglycerides over 200 mg/dL are considered elevated

Normal creatinine levels:

under 1.3 mg/dL for women
under 1.5 mg/dL for men