Framingham Heart Study

Original Cohort Exam 25

06/06/1997-12/13/1999
N=703

Exam Form Version

#7 Numerical Data, Sentence and Design Handout, Cognitive Function (I-II), Functional Performance, Activities of Daily living (I-III), Falls and Fractures, *CES-D Scale, Berkman Social Network Questionnaire,* First Examiner*, Physician Blood Pressure Readings (first), Medical History, Respiratory Questions, Physician Blood Pressure Readings (second), Electrocardiograph (I-II) & Non-Cardiovascular Diagnosis*

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.

fr006 fr005
fr008 fr002

EXAM 25 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Numerical Data--Part I

250201 FORM NUMBER

Basic Information

fr001

|_| **Site of Exam** (0=Heart Study,1=Nursing home,2=Residence, 3=Other)
If 0 skip down
If 1 or 2 fill ☞ fr002 |_| **Level of Care** 0=None; 1=Skilled care 24hrs, 2=Skilled care 8-16 hrs; 3=Self care; 9=unknown

|_|fr003 **Marital Status** (1=Single, 2=Married, 3=Widowed, 4=Divorced, 5=Separated) * add 9=um

|_|_|_|fr004 **Examiner's Number** (99= unknown) should be age-wt *

|_|_|_|fr005 **Weight** (to nearest pound) (99= unknown)

|_|_|*|_|_|fr006 **Height** (inches, to next lower 1/4 inch) (99= unknown)

fr007 |_| **Proxy used to complete this exam** (0=No, 1=Yes, 9=Unknown)

If yes, fill ☞ **Proxy Name** _____

|_| fr008 **Relationship** (1= 1st Degree Relative(spouse, child), 2= Other relative, 3= Friend, 4= Health Care Professional, 5= Other, 9= Unknown)

fr009 fr010
|_|_|* |_|_| **How long have you known the participant?** (Years, Months)

|_| fr011 **Are you currently living in the same household with the participant?** (0=No, 1=Yes)

|_| fr012 **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)

Technician Blood Pressure	Systolic	Diastolic	Technician ID
	fr013 |_|_|_| to nearest 2 mm Hg	fr014 |_|_|_| to nearest 2 mm Hg	ID |_|_|_| fr015

check

Exam 25 Procedures Sheet

fr016 |_| Blood Lipids (0=No, 1=Yes, 9=Unknown)

fr017 |_| ECG Done

EXAM 25 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Cognitive Function--Part I

250202 FORM NUMBER

dw – |_|_|_| fr018 | **Examiner's Number**

	SCORE CORRECT No Try=6 Unknown=9	Write all responses on exam form.
fr019	0 1 2 3 6 9	**What Is the Date Today?** (Month, day, year, correct score=3)
fr020	0 1 6 9	**What Is the Season?**
fr021	0 1 6 9	**What Day of the Week Is it?**
fr022	0 1 2 3 6 9	**What Town, County and State Are We In?**
r023	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)
fr024	0 1 6 9	**What Floor of the Building Are We on?**
fr025	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**
fr026	|_|_|_|_|_|_|	**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)**
fr027	0 1 2 3 6 9	**What are the 3 objects I asked you to remember a few moments ago?**

EXAM 25 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Cognitive Function --Part II

250203 FORM NUMBER

ch 8 | |_|_|_| fr028 | **Examiner's Number**

	SCORE CORRECT No Try=6 Unknown=9	Write all responses on exam form.
fr029	0 1 6 9	**What Is this Called?** (Watch)
fr030	0 1 6 9	**What Is this Called?** (Pencil)
fr031	0 1 6 9	**Please Repeat the Following: "No Ifs, Ands, or Buts."** (Perfect=1)
fr032	0 1 6 9	**Please Read the Following & Do What it Says** (performed=1, code 6 if low vision)
fr033	0 1 6 9	**Please Write a Sentence** (code 6 if low vision)
fr034	0 1 6 9	**Please Copy this Drawing** (code 6 if low vision)
fr035	0 1 2 3 6 9	**Take this piece of paper in your right hand, fold it in half with both hands, and put it in your lap**.(score 1 for each correctly performed act, code 6 if low vision)
	No Yes Maybe Unk (coding below)	**Factors Potentially affecting Mental Status Testing**
fr036	0 1 2 9	**Illiteracy or low education**
fr037	0 1 2 9	**Not fluent in English**
fr038	0 1 2 9	**Poor Eyesight**
fr039	0 1 2 9	**Poor Hearing**
fr040	0 1 2 9	**Depression**
fr041	0 1 2 9	**Aphasia**
fr042	0 1 2 9	**Coma**
fr043	0 1 2 9	**Parkinsonism**
fr044	0 1 2 9	**Other**

EXAM 25 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Sentence and Design Handout for Patient

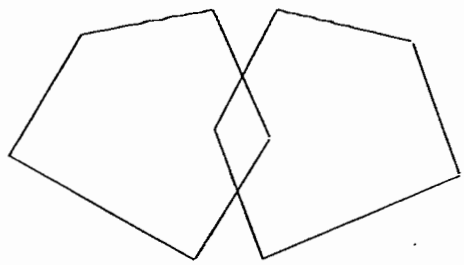
PLEASE WRITE A SENTENCE

_____

_____

_____

PLEASE COPY THIS DESIGN



EXAM 25 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Ch 8

250204 FORM NUMBER

Functional Performance

fr045	___	**Examiner's Number**

Socio-demographics		
__ fr046	**Where do you live:** (0=Private residence, 1=Nursing home, 2=Other institution, such as: home-self care retirement village, 9=Unknown	
__ fr047	**Does anyone live with you** (0=No, 1=Yes, 9=Unknown) Code Nursing Home Residents as NO to these questions	
fr048	__ Spouse	0=No 1=Yes, less than 3 months per year 2=Yes, more than 3 months per year 9=Unknown
If Yes ☞ fr049	__ Significant Other	
If 0 or 9, skip down	__ Children fr 050	
fr051	__ Friends	
fr052	__ Relatives	
fr053	__ Pets	
__ fr054	**Are you employed now?** (0=No, 1=Yes, full time, 2=Yes, part time, 9=Unknown	
___ fr055	**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)	

** Proxy may NOT be used to help complete this section **
__ fr 056 **In general, how is your health now**: (1=Excellent, 2=Good, 3=Fair, 4=Poor, 9=Unkn)
__ fr057 **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 25 FIELD(ID type/ID) FIELD(Last Name). FIELD(First Name)

ch8

Activities of Daily Living--Part I

250205 FORM NUMBER

ch8

_|_|_|_| fr058	**Examiner's Number**

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

_| fr059	**Dressing** (undressing and redressing)
_| fr060	**Bathing** (including getting in and out of tub or shower)
_| fr061	**Eating**
_| fr062	**Transferring** (getting in and out of a chair)
_| fr063	**Toileting Activities** (using bathroom facilities and handle clothing)
_| fr064	**Bladder Continence** (ask if person has "accidents") (code=5 if use special products)
_| fr065	**Bowel Continence** (ask if person has "accidents") (code=5 if use special products)
_| fr066	**Walking on Level Surface about 50 Yards** (length of Thurber St.)
_| fr067	**Walking up and down One Flight Stairs**
_| fr068	**Using a Telephone**
_| fr069	**Preparing and Taking Own Medications** (code as above, and 8=takes no medications regularly)

-1 to 4 or 9

EXAM 25 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

check 8

250206 FORM NUMBER

Activities--Part II

____ fr070	**Examiner's Number**

__ fr071 **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)

__ fr072 **Do you need a special aid (wheelchair, cane, walker) to get around?**
(0=No; 1=Yes, always; 2=Yes, sometimes; 9=Unknown)

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

-1 to 2 or 9

fr073 __ **Cane or walking stick**
fr074 __ **Wheelchair**
fr075 __ **Walker**
fr076 __ **Other (Write in)**_____

Use of Nursing and Community Services

__ fr077 Have you been admitted to a nursing home(or skilled facility) in the past two years?
(0=No, 1=Yes, 9=Unknown)

__ fr078 In past two years, have you been visited by a nursing service, or used home, community, or outpatient programs? (0=No, 1=Yes, 9=Unknown)

if yes, fill below	Past month only	Past two years	
fr079	__	__ fr080	Home health aides
fr081	__	__ fr082	Homemaker visits
fr083	__	__ fr084	Visiting Nurses
fr085	__	__ fr086	Rehabilitation services (such as physical therapy, occupational therapy, speech therapy)
fr087	__	__ fr088	Cardiac Rehabilitation
fr089	__	__ fr090	Meals on Wheels
fr091	__	__ fr092	Community Day Programs
fr093	__	__ fr094	Other (specify_____)

0=None
1=< 1 per month
2=1-5 times per month
3=6-15 times per month
4=15 to 30 times per month
9=unknown

EXAM 25 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Activities II - Continued

250207 FORM NUMBER

____ fr095	**Examiner's Number**

>-2 <3 or 9

Rosow-Breslau Questions

Codes for Next 6 Questions: (0=No, Unable to do; 1=Yes, Independent; 2=Does not do; 9=Unknown)

fr096	__	**Are you able to do heavy work around the house, like shovel snow or wash windows, walls or floors without help?**
fr097	__	**Are you able to walk half a mile without help?** (About 4-6 blocks)
fr098	__	**If you had to, could you do all the housekeeping yourself? (like washing clothes and cleaning)?**
fr099	__	**If you had to, could you do all the cooking yourself?**
fr100	__	**If you had to, could you do all the grocery shopping yourself?**
fr101	__	**Do you drive?** (0=No, 1=Yes, currently, 2=Yes, not now, 9=Unk)
	fr102__	**Reason for not driving now** (1=Health, 2=Other non-health reason, 3=Never licensed, 8=N/A, current driver, 9=Unknown)

EXAM 25 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Activities--Part III

250208 FORM NUMBER

ch 8

ff103	Examiner Number

Nagi Questions

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
(4) Unable to do
(5) Don't do on MD orders
(9) Unknown

> -2 < 6 or 9

ff104	|__|	**Pulling or pushing large objects like a living room chair**
ff105	|__|	**Either stooping, crouching, or kneeling**
ff106	|__|	**Reaching or extending arms below shoulder level**
ff107	|__|	**Reaching or extending arms above shoulder level**
ff108	|__|	**Either writing, handling, or fingering small objects.**
ff109	|__|	**Standing in one place for long periods, say 15 minutes**
ff110	|__|	**Sitting for long periods, say 1 hour**
ff111	|__|	**Lifting or carrying weights under 10 pounds (like a bag of potatoes)**
ff112	|__|	**Lifting or carrying weights over 10 pounds (like a very heavy bag of groceries)**
ff113	|__|	**Getting in and out of car**
ff114	|__|	**Putting on socks or stockings**

EXAM 25 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Falls and Fractures

250209 FORM NUMBER ch8

_|_|_| fr115	**Examiner's Number**

fr116 _\| **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)

_\|_\| fr117 **How many times did you fall in the past year? (88=N/A, 99=Unk)**

Fractures

_\| fr118 **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)
19| fr119 _|	19| fr120 _|	Clavicle (collar bone)
19| fr121 _|	19| fr122 _|	Upper arm (humerus) or elbow
19| fr123 _|	19| fr124 _|	Forearm or wrist
19| fr125 _|	19| fr126 _|	Hand
fr127 19| _|		Back (If disc disease only, code as no)
fr128 19| _|		Pelvis
fr129 19| _|	fr130 19| _|	Hip
fr131 19| _|	fr132 19| _|	Leg
fr133 19| _|	fr134 19| _|	Foot
fr135 19| _|	fr136 19| _|	Toe
fr137 19| _|		Other (specify) fr138

EXAM 25 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

CES-D Scale

250210 FORM NUMBER 5ch8

1 5 5 139 Examiner's Number

The questions below ask about your feelings. For each of the following statements, please say if you felt that way during the past week.

Questions to be answered Circle best answer for each question	Rarely or none of the time (< 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)	Unknown
1. I was bothered by things that usually don't bother me. fr 140	0	1	2	3	9
2. I did not feel like eating; my appetite was poor. fr 141	0	1	2	3	9
3. I felt that I could not shake off the blues, even with help from my family and friends. fr 142	0	1	2	3	9
4. I felt that I was just as good as other people. fr 143	0	1	2	3	9
5. I had trouble keeping my mind on what I was doing. fr 144	0	1	2	3	9
6.I felt depressed. fr 145	0	1	2	3	9
7. I felt that everything I did was an effort. fr 146	0	1	2	3	9
8. I felt hopeful about the future. fr 147	0	1	2	3	9
9. I thought my life had been a failure. fr 148	0	1	2	3	9
10. I felt fearful. fr 149	0	1	2	3	9
11. My sleep was restless. fr 150	0	1	2	3	9
12. I was happy. fr 151	0	1	2	3	9
13. I talked less than usual. fr 152	0	1	2	3	9
14. I felt lonely. fr 153	0	1	2	3	9
15. People were unfriendly. fr 154	0	1	2	3	9
16. I enjoyed life. fr 155	0	1	2	3	9
17. I had crying spells. fr 156	0	1	2	3	9
18. I felt sad. fr 157	0	1	2	3	9
19. I felt that people disliked me. fr 158	0	1	2	3	9
20. I could not "get going". fr 159	0	1	2	3	9

> -2 < 4 or 9

EXAM 25 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Berkman Social Network Questionnaire

250211 FORM NUMBER

The following two page questionnaire asks about your social support. Please read the following questions and circle the response that most closely describes your <u>current</u> situation.

For each question please circle one answer						
Coding scheme	**(Code=0)**	**(Code=1)**	**(Code=2)**	**(Code=3)**	**(Code=4)**	**(Code=9)**
1. How many *close friends* do you have: people that you feel at ease with, can talk to about private matters? fr160	**None**	**1 or 2**	**3 to 5**	**6 to 9**	**10 or more**	**Unknown**
2. How many of these *close friends* do you see at least once a month? fr161	**None**	**1 or 2**	**3 to 5**	**6 to 9**	**10 or more**	**Unknown**
3. How many *relatives* do you have; people that you feel at ease with, can talk to about private matters? fr162	**None**	**1 or 2**	**3 to 5**	**6 to 9**	**10 or more**	**Unknown**
4. How many of these *relatives* do you see at least once a month? fr163	**None**	**1 or 2**	**3 to 5**	**6 to 9**	**10 or more**	**Unknown**

5. Do you participate in any groups such as a senior center, social or work group, church connected group, self-help group, or charity, public service or community group? fr164

Circle one answer		
No (Code=0)	Yes (Code=1)	Unknown (Code=9)

6. About how often do you go to religious meetings or services? fr165

Circle one answer						
Never or almost never (Code=0)	Once or twice a year (Code=1)	Every few months (Code=2)	Once or twice a month (Code=3)	Once a week (Code=4)	More than once a week (Code=5)	Unknown (Code=9)

EXAM 25 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

250212 FORM NUMBER

7. Do you have Medicare or Medicaid? fr166		
Circle one answer		
No (Code=0)	Yes (Code=1)	Unknown (Code=9)

8. Do you have health insurance? fr167		
Circle one answer		
No (Code=0)	Yes (Code=1)	Unknown (Code=9)

For each question please circle one answer						
Coding Scheme	(Code=0)	(Code=1)	(Code=2)	(Code=3)	(Code=4)	(Code=9)
9. Is there someone fr168 available to you whom you can count on to listen to you when you need to talk?	None of the time	A little of the time	Some of the time	Most of the time	All of the time	Unknown
10. Is there someone fr169 available to give you good advice about a problem?	None of the time	A little of the time	Some of the time	Most of the time	All of the time	Unknown
11. Is there someone available to you who shows you love and affection? fr170	None of the time	A little of the time	Some of the time	Most of the time	All of the time	Unknown
12. Can you count on fr171 anyone to prove you with emotional support (talking over problems or helping you make a difficult decision)?	None of the time	A little of the time	Some of the time	Most of the time	All of the time	Unknown
13. Do you have as much fr172 contact as you would like with someone you feel close to, someone in whom you can trust and confide?	None of the time	A little of the time	Some of the time	Most of the time	All of the time	Unknown

Exam 25

25 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

First Examiner --Hospitalizations

250301 FORM NUMBER

SCREEN 1

___ fr173	First Examiner's ID _____ First Examiner Name

DATE _____

Basic Background and Health Care

fr174 _	**Hospitalization (not just E.R.) in Interim** (0=No; 1=yes, hospitalization, 2=yes, more than 1 hospitalization, 9=Unknown)
fr175 _	**E.R. Visit in Interim** (0=No; 1=Yes, 1 visit, 2=Yes, more than 1 visit 9=Unk)
fr176 _	**Day Surgery in Interim** (0=No, 1=Yes, 9=Unknown)
fr177 _	**Illness with visit to doctor in Interim** (0=No, 1=Yes, 1 visit; 2=Yes, more than 1 visit; 9=Unk)
fr178 _	**Check up in interim by doctor** (0=No, 1=Yes, 9=Unknown)
fr179 ____ 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 25 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

First Examiner --Cardiovascular Medications

250302 FORM NUMBER

SCREEN 2

fr180 |__| If yes, fill☞ **Take aspirin regularly (0=No, 1=Yes, 9=Unk)**

- |__|__| fr181 **Number aspirins taken regularly (99=Unknown)**
- |__| fr182 **Aspirin frequency (0=Never, 1=Day, 2=Week ,3=Month, 4=Year, 9=Unk)**
- |__|__|__|__| fr183 **Usual aspirin dose 081=baby, 160=half dose, 325=nl, 500=extra or larger, 999=unk**

fr184 |__| **Currently receiving medication for the treatment of hypertension? (0=No,1=Yes, 9=Unk)**

fr185 |__| **Any of the cardiovascular medications below on this page? (0=No, 1=Yes, 9=Unk)**

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

fr186 |__| **Cardiac Glycosides**

fr187 |__| **Nitroglycerine**

fr188 |__| **Longer acting nitrates (Isordil, Cardilate, etc.)**

fr189 |__| **Calcium Channel Blockers (Specify)**_____

if yes, fill☞

- |__|__| fr190 **Calcium Channel Blocker Group (Verapamil=01 Diltiazem=02 Nifedipine=03 Nicardipine=04 Isradipine=05 Amlodipine =06 Felodipine=07 Nimodipine=08 Mibefradil=09 Nisoldipine=10 Bepridil= 11 Other=12 Unknown=99)**
- |__|__|__| fr191 **Tablet size of Calcium Channel Blocker (number of mg, 999=unknown)**
- |__|__| fr192 **Number of times Calcium Channel Blocker taken per day (99=unknown)**

fr193 |__| **Beta Blockers (Specify)**_____

if yes fill☞ and continue

- fr194 **Beta Blocker Group (Propranolol=01 Timolol =02 Nadolol=03 Atenolol=04 Metoprolol=05 Pindolol =06 Acebutolol=07 Labetalol=08 Other=09 Unknown=99)**
- |__|__|__| fr195 **Dose (mg/day) of Beta Blocker (999=unknown)**

fr196 |__| **Loop Diuretics (Lasix, etc.)**

fr197 |__| **Thiazide/K-sparing diuretics(Dyazide, Maxide, etc.)**

fr198 |__| **Thiazide diuretics**

fr199 |__| **K-sparing diuretics (Aldactone, Triamterene)**

fr200 |__| **Potassium supplements**

fr201 |__| **Alpha-1 agonist (Clonidine, Wytensin, Guanabenz)**

fr202 |__| **Alpha-2 blockers (Prazosin, Terazosin, Doxazosin)**

fr203 |__| **Renin-angiotensin blocking drugs (ACE) (Captopril, Enalapril, Lisinopril)**

fr204 |__| **Peripheral vasodilators (Hydralazine, Minoxidil, etc)**

fr205 |__| **Other anti-hypertensives(Specify)**_____

fr206 |__| **Antiarrhythmics (Quinidine, Procainamide, Norpace,Disopyramide,etc)**

fr207 |__| **Antiplatelet (Anturane, Persantine, etc.)**

fr208 |__| **Anticoagulants (Coumadin, Warfarin, etc.)**

fr209 |__| **Other cardiac medication (Specify)**_____

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

All Medicines-- Scratch Sheet

EXAM 25 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

First Examiner -- Other Medications

250303 FORM NUMBER

SCREEN 3

CODING:
0=No
1=Yes, now
2=Yes, not now
3=Maybe
9=Unknown

fr	210 |__|	Anti cholesterol drugs (Resins--e.g. Questran, Colestid)
fr	211 |__|	Anti cholesterol drugs (Niacin or Nicotinic Acid)
fr	212 |__|	Anti cholesterol drugs (Fibrates--e.g. Genfibrozil)
fr	213 |__|	Anti cholesterol drugs (Statins--e.g.Lovastatin,Pravastatin)
fr	214 |__|	Anti cholesterol drugs (Other--Specify_____)
fr	215 |__|	Antigout--uric acid lowering (Allopurinol, Probenecid etc)
fr	216 |__|	Antigout--(Colchicine)
fr	217 |__|	Thyroid extract (Dessicated Thyroid)
fr	218 |__|	Thyroxine (Synthroid etc.)
fr	219 |__| if yes fill in dose ☞ fr220	Insulin 0=No, 1=Yes, now 2=Yes, not now 3=Maybe 9=Unknown |__|__|__| Total units of insulin a day
fr	221 |__|	Oral hypoglycemics (Specify brand_____)
fr	222 |__|	Oral/patch estrogen (for women users also see estrogen section)
fr	223 |__|	Oral glucocorticoids (Prednisone, Cortisone,etc)
fr	224 |__|	Non-steroidal anti-inflammatory agents (NSAIDS) (Motrin, Ibuprofen, Naprosyn, Indocin, Clinoril)
fr	225 |__|	Analgesic-narcotics (Demerol, Codeine, Dilaudid, etc.)
fr	226 |__|	Analgesic-non-narcotics (Acetaminophen etc.)
fr	227 |__|	Antihistamines
fr	228 |__|	Antiulcer (Tagamet, Ranitidine, Probanthine, H ion inhibitors)
fr	229 |__|	Anti-anxiety, Sedative/Hypnotics etc. (Librium, Valium etc.)
fr	230 |__|	Sleeping pills
fr	231 |__|	Anti-depressants
fr	232 |__|	Eye drops
fr	233 |__|	Antibiotics
fr	234 |__|	Anti-parkinson drugs (Sinemet, L-Dopa, Symmetrel, Cogentin, etc)
fr	235 |__|	Anticonvulsants (Dilantin, Phenobarbital, Tegretol, Mysoline etc)
fr	236 |__|	Bronchodilators and aerosols
fr	237 |__|	Osteoporosis Medications (Alendronate (Fosamax), calcitonin, efidronate, evista (Raloxifere))
fr	238 |__|	Others Specify (include vitamins:_____)

EXAM 25 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Physician Blood Pressure Readings

250304 FORM NUMBER **SCREEN 4**

Physician Blood Pressure (first reading)	Systolic	Diastolic
	fr 239 |_|_|_|	fr 240 |_|_|_|
	to nearest 2 mm Hg	to nearest 2 mm Hg

fr 239 fr 240

EXAM 25 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Medical History --Genitourinary and Thyroid Disease

250305 FORM NUMBER SCREEN 5

Female Genitourinary

fr241 |__| **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 fr242 |__| **Dose/day of premarin conjugated Estrogens, or other oral estrogen**
(0=No, 1=0.3 mg, 2=0.625 mg, 3=0.9 mg, 4=1.25 mg, 5=2.5mg,
6=other_____ (write in) 9=Unk)

☞fr243 |__| **Patch dose of estrogen** (0=No, 1=0.5 mg/wk, 2=other _____ (write in), 9=Unk)

fr244 |__|__| **Number of days a month taking estrogens** (99=Unknown)

fr245 |__| **Estrogen Cream Use in Interim** (0=No, 1=Yes, now; 2=Yes, not now, 8=Man, 9=Unk)

fr246 |__| **Progestin replacement in interim** (e.g. Provera)
(0=No, 1=Yes, now; 2=Yes, not now, 8=Man, 9=Unk)

If yes, fill all to fr247 |__| **Dose/day of progestin:** (0=No, 1=1.25 mg, 2=2.5 mg, 3=5.0 mg, 4=10.0mg,
5=other_____ (write in) 9=Unk)

☞fr248 |__|__| **Number of days a month taking progestins** (99=Unknown)

Male Genitourinary Disease

fr249 |__| **Prostate trouble in interim** (0=No, 1=Yes, now; 2=Yes, not now, 8=Woman, 9=Unk)

fr250 |__| **Prostate surgery in interim**

Medical History -- Thyroid

fr251 |__| **Interim diagnosis of a thyroid condition?** (0=No,1=Yes, 9=Unknown)

Comments_____

fr252 |__| **Smoked cigarettes regularly in the last year?** (0=No, 1=Yes, 9=Unknown)

if yes fill fr253 |__|__| How many cigarettes do/did you smoke a day?
(01=one or less, 99=unknown)

EXAM 25 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Respiratory Questions

250306 FORM NUMBER

SCREEN 6

	Respiratory Symptoms	
fr254 |__|	Do you usually cough on most days for 3 consecutive months or more during the year? (0=No; 1=Yes, new in interim; 2=Yes, old; 9=Unknown)	
fr255 |__|	Do you usually bring up phlegm from your chest on most days for 3 consecutive months or more during the year? (0=No, 1=Yes, 9=Unk)	
fr256 |_|	Have you had asthma in the interim? (0=No, 1=yes, new, 2=yes, old, 9=Unknown)	
fr257 |__|	Have you had wheezing or whistling in your chest at any time in the last 12 months? (0=No, 1=Yes, 9=Unknown)	
fr2158	Night cough (0=No, 1=Yes, 9=Unknown)	
fr2591	Dyspnea on exertion (0=No, 1=Climbing stairs or vigorous exertion, 2=Rapid walking or moderate exertion, 3=Any slight exertion, 9=Unknown)	
fr2601	Dyspnea has increased over the past two years (0=No, 1=Yes, 9=Unknown)	
fr261 |__|	Sleep on 2 or more pillows to help you breathe (0=No, 1=Yes, 9=Unknown)	
|__| fr262	Have you awakened suddenly very short of breath, gasping, or choking (PND) Code most severe symptoms in interim (0=Never 1=1 or 2x/year, 2=few nights/month under special circumstances, 3=at least once weekly, but irregular pattern, 4=3 to 5 nights/week, 5=5 to 7 nights/week, 9=don't know)	
fr2163	Ankle edema bilaterally	(0=No; 1=Yes, ; 2=Maybe; 9=Unknown)
fr2164	Been told you have had heart failure or congestive heart failure in the interim	
fr2165	Been hospitalized for heart failure in interim	

	Respiratory Examiner Opinions	
fr2166	Congestive Heart Failure	0=No; 1=Yes; 2=Maybe; 9=Unknown
|__| fr267	Chronic Bronchitis (Cough that produces sputnum at least 3 months in past 12 months)	

Respiratory Comments:

EXAM 25 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

First Examiner - Coronary Heart Disease Opinions in Interim

250307 FORM NUMBER SCREEN 7

fr268	**Any chest discomfort since last exam**	(0=No, 1=Yes, 2=Maybe, 9=Unknown)	
if yes, fill ☞ and below	fr269 Chest discomfort with exertion or excitement	(0=No, 1=Yes, 2=Maybe, 9=Unknown)	
	fr270 Chest discomfort when quiet or resting		
	Chest Discomfort Characteristics (must have checked box at top of table)		
fr271 __/__/__ fr272	Date of onset	mo/yr, 99/99=Unknown)	
fr273 ___	Usual duration	(minutes, 999=Unknown)	
fr274 ___	Longest duration	(minutes: 1=1 min or less, 900=15 hrs or more, 999=Unknown)	
fr275 __	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)	
fr276 __	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)	
fr277 ___	Frequency (number in past month)	999=Unknown	
fr278 ___	Frequency (number in past year)	999=Unknown	
fr279 __	Type	(1=Pressure, heavy, vise; 2=Sharp; 3=Dull; 4=Other; 9=Unk)	
fr280 __	Relief by Nitroglycerine in <15 minutes	0=No	
fr281 __	Relief by Rest in <15 minutes	1=Yes,	
fr282 __	Relief Spontaneously in <15 minutes	8=Not tried	
fr283 __	Relief by Other cause in <15 minutes	9=Unknown	

	CHD First Opinions	
fr2814	**Angina pectoris in interim**	(0=No, 1=Yes, 2=Maybe, 9=Unknown)
fr2815	**Angina pectoris since revascularization procedure**	
fr2816	**Coronary insufficiency in interim**	
fr2817	**Myocardial infarct in interim**	

Comments about Heart Disease

EXAM 25 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

First Examiner -- Syncope History in Interim

250308 FORM NUMBER SCREEN 8

|__| fr288 **Have you fainted or lost consciousness in the interim?** (0=No, 1=Yes, 2=Maybe, 9=Unknown)
(if due to stroke, skip to screen 11)
If event immediately preceded by head injury or accident code 0=No)

fr289 |__|__| Number of episodes in the past two years

fr290 |__|*|fr291 Date of first episode

fr292 |__|__|__| Usual duration of loss of consciousness

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

fr293 |__| Did you have any injury caused by the event? (0=No, 1=Yes, 2=Maybe, 9=Unknown)

fr294 |__| ER/Hospitalized or saw M.D. (0=No, 1=Hosp/ER, 2=Saw M.D., 9=Unknown)
Hospitalized at: _____

M.D. seen: _____

fr295 Syncope Opinions

|__| **Syncope** (0=No, 1=Yes, 2=Maybe, 3=Presyncope, 9=Unknown)

fr296 |__| Cardiac syncope

fr297 |__| Vasovagal syncope

fr298 |__| Other Specify: _____

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

|__|fr299 **Seizure Disorder** (0=No,1=Yes, 2=Maybe, 9=Unk)

Comments about Syncope _____

EXAM 25 FIELD(ID type/ID) FIELD(Last Name). FIELD(First Name)

First Examiner -- Cerebrovascular and Neurological History and Opinions

250309 FORM NUMBER SCREEN 9

Cerebrovascular Episodes in Interim

fr 300 |_| **Sudden muscular weakness**

fr 301 |_| **Sudden speech difficulty**

fr 302 |_| **Sudden visual defect**

fr 303 |_| **Double vision**

fr 304 |_| **Sudden loss of vision in one eye**

fr 305 |_| **Unconsciousness**

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

: -2 <3 or 9

fr 306 |_| **Numbness, tingling**

if yes, fill ☞ fr307 Numbness and tingling is positional

fr 308 |_| **CT or MRI scan (head) since last exam** (date/place_____)

fr 309 |_| **Seen by neurologist since last exam** (write in who and when below)

_____

Details for "Serious" Cerebrovascular Event in Interim

fr 310 |_|

if yes or maybe

fill all to ☞

Examiner's opinion that "serious" or "significant" cerebrovascular event took place in interim (0=No, 1=Yes, 2=Maybe, 9=Unknown) 99/9999

fr311 |_|_|*|_|_| fr312 Date (mo/yr, 99/99=Unkn

Observed by_____

fr313 |_| Onset time acute

(1=Active, 2=During sleep, 3=While arising, 9=Unkn)

fr314 |_|_|*|_|_| fr315 Exact/approximate time (use 24-hour military time, 99.99=unkn)

fr316 |_|_|*|_|_| fr317 fr318 Duration (use format days/hours/mins, 99/99/99=Unknown)

fr319 |_| Hospitalized or saw M.D.

0=No, 1=Hosp. 2=Saw M.D, 9=Unk

fr320 |_|_| Number of days stayed at

_____

Cerebrovascular Disease Opinion

fr 1321 | **Stroke in Interim**

fr 1322 **Transient Ischemic Attack in Interim (TIA)** (0=No, 1=Yes, 2=Maybe, 9=Unknown)

fr 1323 **Parkinsonism in Interim**

fr 324 **Other-- Specify:**_____

Comments about possible Cerebrovascular Disease

_____

_____

EXAM 25 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

First Examiner --Peripheral Vascular History and Opinion

250310 FORM NUMBER SCREEN 10

fr 325 |__| **Can you walk 50 feet without help? (0=Able to walk 50 feet without help, 1=Needs help, 2=Can't Walk, 9=Unknown)**

fr 326 |__| **Do you have lower limb discomfort while walking? (0=No, 1=Yes, 2=Can't Walk, 9=Unk)**

If Yes, fill in below:

Left	Right	Vascular symptoms (0=No, 1=Yes, 9=Unkn)
fr 327 |__|	fr 328 |__|	Discomfort in calf while walking
fr 329 |__|	fr 330 |__|	Discomfort in lower extremity (not calf) while walking
fr 331 |__|		Occurs with first steps
fr 332 |__|		After walking a while
fr 333 |__|		Related to rapidity of walking or steepness
fr 334 |__|		Forced to stop walking
fr 335 |__|__|		Time for discomfort to be relieved by stopping (minutes) (00=No relief with stopping, 88=Not Applicable) * 99=unk
fr 336 |__|__|		Number of days/month of lower limb discomfort (00=No, 88=N/A, 99=Unknown)

Intermittent Claudication Opinions

fr 337

|__| Intermittent Claudication 0=No, 1=Yes, 2=Maybe, 9=Unknown

Comments about peripheral vascular disease

EXAM 25 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

First Examiner -- CHD and Complications

250311 FORM NUMBER SCREEN 11

Coding: 0=No, 1=Yes 2=Maybe, 9=Unkn	Cardiovascular Procedure (in the interim only, not lifetime)
fr338 |__| if yes fill ☞ fr339	**Exercise Tolerance Test (most recent only)** 19|__|__| Year done Location_____
fr340 |__| if yes fill ☞ fr341	**Coronary arteriogram (most recent only)** 19|__|__|Year done (99=unknown)
fr342 |__| if yes fill ☞ fr343	**Coronary artery angioplasty** 19|__|__| Year first done (99=unknown) fr344 |__| Type of procedure (0=none, 1=balloon, 2=other_____ 9=unkn),
fr345 |__| if yes fill ☞ fr346	**Coronary bypass surgery** 19|__|__| Year first done (99=unknown)
fr347 |__| if yes fill ☞ fr348	**Permanent pacemaker insertion** 19|__|__| Year first done (99=unknown)
fr349 |__| if yes fill ☞ fr350	**Carotid artery surgery** 19|__|__| Year first done (99=unknown)
fr351 |__| if yes fill ☞ fr352	**Thoracic aorta surgery** 19|__|__| Year first done (99=unknown)
fr353 |__| if yes fill ☞ fr354	**Abdominal aorta surgery** 19|__|__| Year first done (99=unknown)
fr355 |__| if yes fill ☞ fr356	**Femoral or lower extremity surgery** 19|__|__| Year first done (99=unknown)
fr357 |__| if yes fill ☞ fr358	**Lower extremity amputation** 19|__|__| Year first done (99=unknown)
fr359 |__| if yes fill ☞ fr360	**Valve surgery** 19|__|__| Year first done (99=unknown) Type_____

Cardiovascular Procedures Interim Summary
Please list all subsequent cardiovascular procedures

Date	Hospital	Type of Procedure
___/___/____		
/ /		

EXAM 25 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

First Examiner - Cancer Site or Type

250312 FORM NUMBER SCREEN 12

fr361 |__| **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.
fr362 |__|	Esophagus			
fr363 |__|	Stomach			
fr364 |__|	Colon			
fr365 |__|	Rectum			
fr366 |__|	Pancreas		7-2	< 4 or = 9
fr367 |__|	Larynx			
fr368 |__|	Trachea/Bronchus/Lung			
fr369 |__|	Leukemia			
fr370 |__|	Skin			
fr371 |__|	Breast			
fr372 |__|	Cervix/Uterus			
fr373 |__|	Ovary			
fr374 |__|	Prostate			
fr375 |__|	Bladder			
fr376 |__|	Kidney			
fr377 |__|	Brain			
fr378 |__|	Lymphoma			
fr379 |__|	Other/Unknown			

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

EXAM 25 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

250313 FORM NUMBER SCREEN 13

Physician Blood Pressure Readings

Physician Blood Pressure (second reading)	Systolic fr380	Diastolic fr381
	___ to nearest 2 mm Hg	___ to nearest 2 mm Hg

EXAM 25 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Electrocardiograph Part I

250314 FORM NUMBER SCREEN 14

fr382 |__|__|__| Examiner ID Number _____Examiner Last Name

fr383 |__| if Yes, fill out rest of form — **ECG done (0=No, 1=Yes)**

Rates and Intervals

fr 384 |__|__|__|__| Ventricular rate per minute (999=Unknown) — write it

fr 385 |__|__|__| P-R interval (hundredths of a second) (99=Fully paced, Atrial Fib, or Unknown)

fr 386 |__|__| QRS interval (hundredths of second) (99=Fully Paced, Unknown)

fr 387 |__|__| Q-T interval (hundredths of second) (99=Fully Paced, Unknown)

fr 388 |__|__|__|__| QRS angle (put plus or minus as needed) (e.g. -045 for minus 45 degrees, +090 for plus 90, 9999=Fully paced or Unknown)

-999 to 999 or 9999

Rhythm

fr389 |__|

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

fr390 |__| IV Block (0=No, 1=Yes, 9=Fully paced or Unknown)

if yes, fill to right:

fr391 |__| Pattern (1=Left, 2=Right, 3=Indeterminate) — 9=unknown

fr392 |__| Complete (QRS interval=.12 sec or greater)(0=No, 1=Yes, 9=Unknown)

fr393 |__| Incomplete (QRS interval = .10 or .11 sec) (0=No, 1=Yes, 9=Unknown)

fr394 |__| Hemiblock (0=No, 1=Left Ant, 2=Left Post, 9=Fully paced or Unknown)

fr395 |__| WPW Syndrome (0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unknown)

Arrhythmias

fr396 |__| Atrial premature beats (0=No, 1=Atr, 2=Atr Aber, 9=Unknown)

fr397 |__| Ventricular premature beats (0=No, 1=Simple, 2=Multifoc, 3=Pairs, 4=Run, 5=R on T, 9=Unk)

fr398 |__|__| Number of ventricular premature beats in 10 seconds (see 10 second rhythm strip)

EXAM 25 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Electrocardiograph Part II

250315 FORM NUMBER SCREEN 15

		Myocardial Infarction Location	
fr399	|__|	Anterior	(0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unknown)
fr400	|__|	Inferior	
fr401	|__|	True Posterior	
		Left Ventricular Hypertrophy Criteria	
fr402	|__|	R > 20mm in any limb lead	(0=No, 1=Yes, 9=Fully paced, Complete LBBB or Unk)
fr403	|__|	R > 11mm in AVL	
fr404	|__|	R in lead I plus S ≥ 25mm in lead III	
		Measured Voltage	
fr405	*|__|__|	R AVL in mm (at 1 mv = 10 mm standard) Be sure to code these voltages	
fr406	*|__|__|	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	
fr407	|__|	R≥ 25mm	(0=No, 1=Yes, 9=Fully paced, Complete LBBB or Unk)
fr408	|__|	S≥ 25mm	
fr409	|__|	R or S ≥ 30mm	
fr410	|__|	R + S ≥ 35mm	
fr411	|__|	Intrinsicoid deflection ≥ .05 sec	
		Hypertrophy, enlargement, and other ECG Diagnoses	
fr412	|__|	Nonspecific S-T segment abnormality (0=No, 1=ST depression, 2=ST flattening, 3=other, 9=Fully paced or Unkn)	
fr413	|__|	Nonspecific T-wave abnormality (0=No, 1=T inversion, 2=T flattening, 3= other, 9=Fully paced or Unkn)	
fr414	|__|	U-wave present (0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unkn)	
fr415	|__|	Atrial enlargement (0=None, 1=Left, 2=Right, 3=Both, 9=Atrial fib. or Unknown)	
fr416	|__|	RVH (0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unknown; If complete RBBB present, RVH=9)	
fr417	|__|	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 25 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

250316 FORM NUMBER

SCREEN 16

	Non-Cardiovascular Diagnoses First Examiner Opinions	
fr418	__ Diabetes Mellitus	
fr419	__ Urinary Tract Disease	0=No, 1=Yes, 2=Maybe, 9=Unknown
fr420	__ Prostate Disease	
fr421	__ Renal Disease	
fr422	__ Emphysema	
fr423	__ Chronic Bronchitis	
fr424	__ Pneumonia	
fr425	__ Asthma	
fr426	__ Other Pulmonary Disease	
fr427	__ Gout	
fr428	__ Degenerative joint disease	
fr429	__ Rheumatoid arthritis	
fr430	__ Gallbladder disease	
fr431	__ Other non C-V diagnosis (for cancer, see special screen)	

Comments on Other Diagnoses

Framingham Heart Study
Lab Data

- -

Id: Exam Date

- -

Fr437 Total Cholesterol (mg/dL)

Fr438 HDL Cholesterol (mg/dL)

Cholesterol to HDL Ratio

Fr439 Triglyceride (mg/dL)

Fr440 Creatinine (mg/dL)

** These results are from a non-fasting specimen.

- -

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