Framingham Heart Study

Original Cohort Exam 26

05/27/1999-11/27/2001
N=558

Exam Form Version	
#13	Numerical Data, Sentence and Design Handout, Cognitive Function (I-II), 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:	Laboratory Report

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

Numerical Data--Part I

260201 FORM NUMBER

Basic Information

fs001 |__| **Site of Exam** (0=Heart Study,1=Nursing home,2=Residence, 3=Other)

If 0 skip down
If 1 or 2 fill ☞

fs002 |__| **Level of Care 0**=None; **1**=Skilled care 24hrs, **2**=Skilled care 8-16 hrs; **3**=Self care; **9**=unknown

fs 003 |__| **Marital Status** (1=Single, 2=Married, 3=Widowed, 4=Divorced, 5=Separated)

fs 004 |__|__|__| **Examiner's Number** (99= unknown)

fs 005 |__|__|__| **Weight** (to nearest pound) (99= unknown)

fs 008 |__||__|*|__|__| **Height** (inches, to next lower 1/4 inch) (99.99=Unk)

|__| **Method used to obtain weight** (home visit)
0= Framingham Study field visit protocol (portable scale).
1= Recorded from Nursing Home chart
2= Other (write in)_____

|__|__/|__|__/|__|__| **Date weight was obtained** (home visit)

fs 009 |__| **Proxy used to complete this exam** (0=No, 1=Yes, 9=Unknown)

If yes, fill☞ **Proxy Name** _____

fs 010 |__| **Relationship** (1= 1st Degree Relative(spouse, child), 2= Other relative, 3= Friend, 4= Health Care Professional, 5= Other, 9= Unknown)

fs 011 fs 012 |__|__|*|__|__| **How long have you known the participant?** (Years, Months)

fs 013 |__| **Are you currently living in the same household with the participant?** (0=No,1=Yes)

fs 014 |__| **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's Blood Pressure to nearest 2 mm Hg	Systolic	Diastolic	Technician's Blood Pressure ID
	fs 015 |__|__|__|	fs 016 |__|__|__|	fs 017 |__|__|__|

EXAM 26 Procedures Sheet

0=No, 1=Yes, 9=Unknown

fs 018 |__| **ECG Done**

fs 019 |__| **Blood Drawn**

fs 020 |__| **Tonometry done** -1, 0, 1, 9

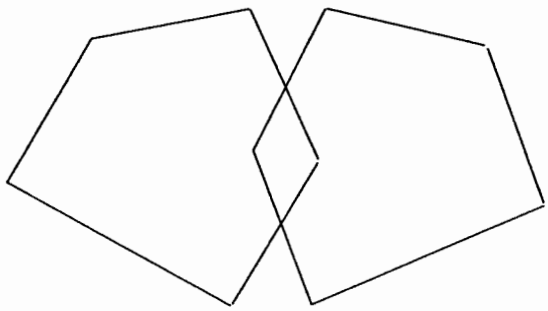
fs 021 |__| **Observed Physical Performance Measure** -1, 0, 1, 9

- clinic only
home visit only

Sentence and Design Handout for Patient

PLEASE WRITE A SENTENCE

PLEASE COPY THIS DESIGN



EXAM 26 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Cognitive Function--Part I

260202 FORM NUMBER

fs022

|__|__|__|	**Examiner's Number**

	SCORE CORRECT No Try=6 Unknown=9	**Write all responses on exam form.**
fs023	0 1 2 3 6 9	**What Is the Date Today?** (Month, day, year, correct score=3)
fs024	0 1 6 9	**What Is the Season?**
fs025	0 1 6 9	**What Day of the Week Is it?**
fs026	0 1 2 3 6 9	**What Town, County and State Are We In?**
fs027	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)
fs028	0 1 6 9	**What Floor of the Building Are We on?**
fs029	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**
fs030	|__|__|__|__|__|	**Now I am going to spell a word forward and I want you to spell if 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)
fs031	0 1 2 3 6 9	**What are the 3 objects I asked you to remember a few moments ago?**

EXAM 26 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Cognitive Function --Part II

260203 FORM NUMBER

fs032	___	**Examiner's Number**

	SCORE CORRECT No Try=6 Unknown=9	Write all responses on exam form.
fs033	0 1 6 9	**What Is this Called?** (Watch)
fs034	0 1 6 9	**What Is this Called?** (Pencil)
fs035	0 1 6 9	**Please Repeat the Following: "No Ifs, Ands, or Buts."** (Perfect=1)
fs036	0 1 6 9	**Please Read the Following & Do What it Says** (performed=1, code 6 if low vision)
fs037	0 1 6 9	**Please Write a Sentence** (code 6 if low vision)
fs038	0 1 6 9	**Please Copy this Drawing** (code 6 if low vision)
fs039	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
fs040	0 1 2 9	**Illiteracy or low education**
fs041	0 1 2 9	**Not fluent in English**
fs042	0 1 2 9	**Poor Eyesight**
fs043	0 1 2 9	**Poor Hearing**
fs044	0 1 2 9	**Depression**
fs045	0 1 2 9	**Aphasia**
fs046	0 1 2 9	**Coma**
fs047	0 1 2 9	**Parkinsonism**
fs048	0 1 2 9	**Other**

EXAM 26 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

260204 FORM NUMBER

fs049

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

		Socio-demographics		
fs050	|___|	**Where do you live:** (0=Private residence, 1=Nursing home, 2=Other facility, such as a continuing care retirement community or assisted living facility, 9=Unknown		
fs051	|___|	**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	fs052 |___|	Spouse	0=No 1=Yes, less than 3 months per year 2=Yes, more than 3 months per year 9=Unknown
		fs053 |___|	Significant Other	
		fs054 |___|	Children	
		fs055 |___|	Friends	
		fs056 |___|	Relatives	
		fs057 |___|	Pets	
fs058	|___|	**Are you currently working at a paying job?** (0=No, 1=Yes, full time (≥ 32 hours), 2=Yes, part time (<32 hours), 9=Unknown)		
fs059	|___|	**Do you currently do unpaid volunteer or community work?** (0=No, 1=Yes, 9=Unknown) -1, 0, 1, 9		
fs060	|___|___|___|	**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 ****	
fs061	|___|	**In general, how is your health now**: (1=Excellent, 2=Good, 3=Fair, 4=Poor, 9=Unkn)
fs062	|___|	**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 26 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Activities of Daily Living--Part I

260205 FORM NUMBER

fs063

|_|_|_|	**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
Note: *Use highest level of dependence.*

fs064 |_|	**Dressing** (undressing and redressing) Devices such as: velcro, elastic laces.
fs065 |_|	**Bathing** (including getting in and out of tub or shower) Devices such as: bath chair, long handled sponge, hand held shower, safety bars.
fs066 |_|	**Eating** Devices such as: rocking knife, spork, long straw, plate guard.
fs067 |_|	**Transferring**(getting in and out of a chair) Devices such as: sliding board, grab bars, special seat.
fs068 |_|	**Toileting Activities** (using bathroom facilities and handle clothing) Devices such as: special toilet seat, commode.
fs069 |_|	**Bladder Continence** (ask if person has "accidents") (code=5 if use special products) Devices such as: external catheter, drainage bags, ileal appliance, protective device.
fs070 |_|	**Bowel Continence** (ask if person has "accidents") (code=5 if use special products) Devices such as: suppositories, bedpan, regular enemas, colostomy.
fs071 |_|	**Walking on Level Surface about 50 Yards** (length of Thurber St.) Devices such as: cane, crutches, or walker.
fs072 |_|	**Walking up and down One Flight Stairs** Devices such as: handrail, cane.
fs073 |_|	**Using a Telephone** Devices such as: large numbers, voice activation, amplication.
fs074 |_|	**Preparing and Taking Own Medications** Specify device (write in)_____

EXAM 26 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Activities--Part II

260206 FORM NUMBER

fs075

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

fs076 |_| **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)

fs077 |_| **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

fs078 |_| **Cane or walking stick**

fs079 |_| **Wheelchair**

fs080 |_| **Walker**

fs081 |_| **Other (Write in)**_____

EXAM 26 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Activities II - Continued

260207 FORM NUMBER

fs082

|__|__|__|	**Examiner's Number**

(.. > -2 and .. < 200) or .. = 601 or ... 999

Use of Nursing and Community Services

fs083 |__| In the past two years, have you been admitted to a nursing home (or skilled facility)? (0=No, 1=Yes, 9=Unknown)

fs084 |__| In the 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

0=No
One or more times per...
1=Day
2=Week
3=Month
4=Other (write in)_____
9=Unknown

0=None
1=One month or less
2-98=Put in actual number of month used
(98=98 or more)
99=Unknown

Currently	Since Last Exam	# Months Used Since Last Exam	
fs085 |__|	fs086 |__|	fs087 |__|__|	Home health aides
fs088 |__|	fs089 |__|	fs090 |__|__|	Homemaker visits
fs091 |__|	fs092 |__|	fs093 |__|__|	Visiting Nurses
fs094 |__|	fs095 |__|	fs096 |__|__|	(PCA) Personal Care Attendant
fs097 |__|	fs098 |__|	fs099 |__|__|	Rehabilitation services (such as physical therapy, occupational therapy, speech therapy)
fs100 |__|	fs101 |__|	fs102 |__|__|	Cardiac Rehabilitation
fs103 |__|	fs104 |__|	fs105 |__|__|	Meals on Wheels
fs106 |__|	fs107 |__|	fs108 |__|__|	Community Day Programs
fs109 |__|	fs110 |__|	fs111 |__|__|	Other (specify _____)

(... > -2 and ... < 5) or .. = 9
valid error mess.:
-1, 0, 1, 2, 3, 4 or 9

(.. > -2 and .. < 100)

EXAM 26 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Activities II - Continued

260208 FORM NUMBER

fs 112

|__|__|__|	Examiner's Number

Rosow-Breslau Questions

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

fs 113 |__| **Are you able to do heavy work around the house, like shovel snow or wash windows, walls or floors without help?**

fs 114 |__| **Are you able to walk half a mile without help? (About 4-6 blocks)**

fs 115 |__| **If you had to, could you do all the housekeeping yourself? (like washing clothes and cleaning)?**

fs 116 |__| **If you had to, could you do all the cooking yourself?**

fs 117 |__| **If you had to, could you do all the grocery shopping yourself?**

fs 118 |__| **Do you drive? (0=No, 1=Yes, currently, 2=Yes, not now, 9=Unk)**

fs 119 |__| **Reason for not driving now**
(1=Health, 2=Other non-health reason, 3=Never licensed, 8=N/A, current driver, 9=Unknown)

EXAM 26 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Activities--Part III

260209 FORM NUMBER

fs 020

|___|___|___| **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 activity 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

fs 121	|__|	**Pulling or pushing large objects like a living room chair**
fs 122	|__|	**Either stooping, crouching, or kneeling**
fs 123	|__|	**Reaching or extending arms below shoulder level**
fs 124	|__|	**Reaching or extending arms above shoulder level**
fs 125	|__|	**Either writing, handling, or fingering small objects.**
fs 126	|__|	**Standing in one place for long periods, say 15 minutes**
fs 127	|__|	**Sitting for long periods, say 1 hour**
fs 128	|__|	**Lifting or carrying weights under 10 pounds (like a bag of potatoes)**
fs 129	|__|	**Lifting or carrying weights over 10 pounds (like a very heavy bag of groceries)**
fs 130	|__|	**Getting in and out of car**
fs 131	|__|	**Putting on socks or stockings**

EXAM 26 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Falls and Fractures

260210 FORM NUMBER

fs 132

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

fs 133 |__| **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)

fs 134 |__|__| **How many times did you fall in the past year? (88=N/A, 99=Unk)**

Fractures

fs 135 |__| **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)
fs 136 |__|__|	fs 137 |__|__|	**Clavicle (collar bone)**
fs 138 |__|__|	fs 139 |__|__|	**Upper arm (humerus) or elbow**
fs 140 |__|__|	fs 141 |__|__|	**Forearm or wrist**
fs 142 |__|__|	fs 143 |__|__|	**Hand**
fs 144 |__|__|		**Back (If disc disease only, code as no)**
fs 145 |__|__|		**Pelvis**
fs 146 |__|__|	fs 147 |__|__|	**Hip**
fs 148 |__|__|	fs 149 |__|__|	**Leg**
fs 150 |__|__|	fs 151 |__|__|	**Foot**
fs 152 |__|__|	fs 153 |__|__|	**Toe**
fs 154 |__|__|		**Other (specify)** fs 155

EXAM 26 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

CES-D Scale

260211 FORM NUMBER

fs 156 |__|__|__| | **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. fs 157	0	1	2	3	9
2. I did not feel like eating; my appetite was poor. fs 158	0	1	2	3	9
3. I felt that I could not shake off the blues, even with help from my family and friends. fs 159	0	1	2	3	9
4. I felt that I was just as good as other people. fs 160	0	1	2	3	9
5. I had trouble keeping my mind on what I was doing. fs 161	0	1	2	3	9
6.I felt depressed. fs 162	0	1	2	3	9
7. I felt that everything I did was an effort. fs 163	0	1	2	3	9
8. I felt hopeful about the future. fs 164	0	1	2	3	9
9. I thought my life had been a failure. fs 165	0	1	2	3	9
10. I felt fearful. fs 166	0	1	2	3	9
11. My sleep was restless. fs 167	0	1	2	3	9
12. I was happy. fs 168	0	1	2	3	9
13. I talked less than usual. fs 169	0	1	2	3	9
14. I felt lonely. fs 170	0	1	2	3	9
15. People were unfriendly. fs 171	0	1	2	3	9
16. I enjoyed life. fs 172	0	1	2	3	9
17. I had crying spells. fs 173	0	1	2	3	9
18. I felt sad. fs 174	0	1	2	3	9
19. I felt that people disliked me. fs 175	0	1	2	3	9
20. I could not "get going" fs 176	0	1	2	3	9

EXAM 26 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Berkman Social Network Questionnaire

260215 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 current 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? fs 177	**None**	**1 or 2**	**3 to 5**	**6 to 9**	**10 or more**	**Unk.**
2. How many of these *close friends* do you see at least once a month? fs 178	**None**	**1 or 2**	**3 to 5**	**6 to 9**	**10 or more**	**Unk.**
3. How many *relatives* do you have; people that you feel at ease with, can talk to about private matters? fs 179 ✓	**None**	**1 or 2**	**3 to 5**	**6 to 9**	**10 or more**	**Unk.**
4. How many of these *relatives* do you see at least once a month? fs 180	**None**	**1 or 2**	**3 to 5**	**6 to 9**	**10 or more**	**Unk.**

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?

Circle one answer					
fs 181	**No** (Code=0)		**Yes** (Code=1)		**Unknown** (Code=9)

6. About how often do you go to religious meetings or services? fs 182

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

260216 FORM NUMBER

7. Do you have Medicare or Medicaid?		
fs 183 ✓	**Circle one answer**	
No (Code=0)	**Yes** (Code=1)	**Unknown** (Code=9)

8. Do you have health insurance?		
Circle one answer		
fs184 **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 fs185 **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**	**Unk.**
10. Is there someone fs186 **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**	**Unk.**
11. Is there someone fs187 **available to you who shows you love and affection?**	**None of the time**	**A little of the time**	**Some of the time**	**Most of the time**	**All of the time**	**Unk.**
12. Can you count on fs188 **anyone to provide 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**	**Unk.**
13. Do you have as much fs189 **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**	**Unk.**

EXAM 26 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

260212 FORM NUMBER

Demonstrate the use of the vasamar dynamometer to the participant. The dynamometer should be held with the elbow bent at 90 degree angle with the arm held slightly away from the body and supported by the arm of a chair. The hand/dynamometer should dangle over the side of the chair.

fs190 same as in clinic

|_|_|_| **Examiner's Number**		
Hand Grip Strength Test measured to the nearest kilogram		
Right Hand	99=Unknown	
Trial 1		fs191 |_|_| (>-2 and < 90) .. OR=99
Trial 2		fs192 |_|_|
Trial 3		fs193 |_|_|
Left Hand	99=Unknown	
Trial 1		fs194 |_|_|
Trial 2		fs195 |_|_|
Trial 3		fs196 |_|_|
Was this test completed?	**0=No**	**1=Yes** fs197 |_| (.. >-2 and .. <2) OR .. =9
If not, why?		fs198 |_|
1=Physical limitation **2=Refused** **3=Test not attempted**	**4=Other**_____ **9=Unknown**	(.. >-2 and .. <5) OR .. =9

EXAM 26 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

260213 FORM NUMBER

fs199 |_|_|_|_| Examiner's Number

Physical Function Test

Side by Side, Semi-Tandem, and Tandem Stands

Side by Side

Held for 10 seconds 0=No 1=Yes 8=Not attempted 9=Unknown fs200 |_| (-2 2) or =8 or =9

Number of seconds held if less than 10 fs201 |_|*|_|_| fs202 (-2 <10) (>-2 <60) =99

If not attempted;
1=Unsafe 4=Other_____
2=Unable to stand unassisted
3=Refused 9=Unknown fs203 |_| (>-2 <5) =9

Semi-Tandem

Held for 10 seconds 0=No 1=Yes 8=Not attempted 9=Unknown fs204 |_| (>-2 <2) =8 =9

Number of seconds held if less than 10 fs205 |_|*|_|_| fs206 (>-2 <10) =9 (>-2 <60) =99

If not attempted;
1=Unsafe 4=Other_____
2=Unable to stand unassisted
3=Refused 9=Unknown fs207 |_| (>-2 <5) =9

Tandem

Held for 10 seconds 0=No 1=Yes 8=Not attempted 9=Unknown fs208 |_| (>-2 <2) =8 =9

Number of seconds held if less than 10 fs209 |_|*|_|_| fs210 see above

If not attempted;
1=Unsafe 4=Other_____
2=Unable to stand unassisted
3=Refused 9=Unknown fs211 |_| (>-2 <5) =9

EXAM 26 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

260214 FORM NUMBER

fs212 |__|__|__| **Examiner number**

Measured Walks-First Walk, Second Walk, and Quick Walk

First Walk

Walk time (in seconds) fs213 |__|__|*|__|__| fs214

If not attempted; (>-2 and <98) or .=99 (-60)
1=Unsafe 4=Other_____
2=Unable to stand unassisted
3=Refused 9=Unknown fs215 |__| (>-2 <5) =9

Second Walk

Walk time (in seconds) fs216 |__|__|*|__|__| fs217

If not attempted;
1=Unsafe 4=Other_____
2=Unable to stand unassisted
3=Refused 9=Unknown fs218 |__|

Quick Walk

Walk time (in seconds) fs219 |__|__|*|__|__| fs220

If not attempted;
1=Unsafe 4=Other_____
2=Unable to stand unassisted
3=Refused 9=Unknown fs221 |__|

Walking Aids Used: 0=No aid, 1=Cane, 2=Walker, 3=Wheelchair |__| (>-2 <5) =9
4=Other, 9=Unknown fs222

Repeated Chair Stands

Time to complete five stands in seconds
If not completed in 1 minute - stop (99.99=Unknown) fs223 |__|__|*|__|__| fs224 (>-2 <61) =9.99 (both)

If less than five stands, enter the number fs225 |__| (>-2 <5) =9

Was this test completed? 0=No 1=Yes fs226 |__| (>-2 <2) =9

If not, why? fs227 |__|__| (>-2 <6) =9
0=Used arms/unable to stand 4=Other_____
1=Physical limitation
2=Test not attempted 5=Test stopped at 60 sec
3=Refused 9=Unknown

Post - Repeated chair stand 30 second heart rate fs228 |__|__|__|
(>-2 <) =999

EXAM 26 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

First Examiner --Hospitalizations

260301 FORM NUMBER **SCREEN 1**

fs229

|_|_|_|	**First Examiner's ID** _____ **First Examiner Name**

DATE _____

Basic Background and Health Care

fs230 |__| **Hospitalization (not just E.R.) in Interim** (0=No; 1=yes, hospitalization, 2=yes, more than 1 hospitalization, 9=Unknown)

fs231 |__| **E.R. Visit in Interim** (0=No, 1=Yes, 1 visit, 2=Yes, more than 1 visit 9=Unk)

fs232 |__| **Day Surgery in Interim** (0=No, 1=Yes, 9=Unknown)

fs233 |__| **Illness with visit to doctor in Interim** (0=No, 1=Yes, 1 visit; 2=Yes, more than 1 visit; 9=Unk)

fs234 |__| **Check up** in interim by doctor (0=No, 1=Yes, 9=Unknown)

fs 235 _____ **Date** of this FHS exam (Today's date - See above)
MM DD YY

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

EXAM 26 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

First Examiner --Cardiovascular Medications

260302 FORM NUMBER SCREEN 2

fs236 |__| **Currently receiving medication for the treatment of hypertension?** (0=No,1=Yes, 9=Unk)

fs257 |__| **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)

fs 238 |__| **Cardiac Glycosides**

fs 239 |__| **Nitroglycerine**

fs 240 |__| **Longer acting nitrates** (Isordil, Cardilate, etc.)

fs 241 |__| **Calcium Channel Blockers** (Specify)_____

if yes, fill ☞ fs242 |__|__| **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)

fs243 |__|__|__| **Tablet size of Calcium Channel Blocker** (number of mg, 999=unknown)

fs244 |__|__| **Number** of times Calcium Channel Blocker taken per day (99=unknown)

fs 245 |__| **Beta Blockers** (Specify)_____

if yes fill ☞ and continue fs246 |__|__| **Beta Blocker Group** (Propranolol=01 Timolol =02 Nadolol=03 Atenolol=04 Metoprolol=05 Pindolol =06 Carvedilol=07 Labetalol=08 Other=09 Unknown=99)

fs247 |__|__|__| **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)

fs 248 |__| **Loop Diuretics** (Lasix, etc.)

fs 249 |__| **Thiazide/K-sparing diuretics**(Dyazide, Maxide, etc.)

fs 250 |__| **Thiazide diuretics**

fs 251 |__| **K-sparing diuretics** (Aldactone, Triamterene)

fs 252 |__| **Potassium supplements**

fs 253 |__| **Reserpine derivatives** (...>=2 and ...<4) or ...=9

fs 254 |__| **Methyldopa (Aldomet)**

fs 255 |__| **Alpha-1 agonist** (Clonidine, Wytensin, Guanabenz)

fs 256 |__| **Alpha-2 blockers (Prazosin, Terazosin, Doxazosin)**

fs 257 |__| **Renin-angiotensin blocking drugs (ACE) (Captopril, Enalapril, Lisinopril)**

fs 258 |__| **Peripheral vasodilators (Hydralazine, Minoxidil, etc)**

fs 259 |__| **Angiotensin II antagonists (Losartan etc)** (...>=2 and ...<4) or ...=9

fs 260 |__| **Other anti-hypertensives**(Specify)_____

All Medicines-- Scratch Sheet

_____

_____

_____

fs 261 |__| **Antiarrhythmics (Quinidine, Procainamide, Norpace,Disopyramide,etc)**

fs 262 |__| **Antiplatelet (Anturane, Persantine, etc.)**

fs 263 |__| **Anticoagulants (Coumadin, Warfarin, etc.)**

fs 264 |__| **Other cardiac medication (Specify)**_____

EXAM 26 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Medical History -- Aspirin

260303 FORM NUMBER 180 SCREEN 3

fs265	|__|	**Take aspirin regularly** (0=No, 1=Yes, 9=Unk)
If yes, fill☞ fs266	|_|_| 181	**Number aspirins taken regularly** (99=Unknown)
fs267	|_| 182	**Aspirin frequency** (0=Never, 1=Day, 2=Week ,3=Month, 4=Year, 9=Unk)
fs268	|_|_|_| 183 12	**Usual aspirin dose** 081=baby, 160=half dose, 325=nl, 500=extra or larger, 999=unk

First Examiner -- Noncardiovascular Medications I

fs 269	|__|	**Anti cholesterol drugs** (Resins--e.g. Questran, Colestid)	CODING:
fs 270	|__|	**Anti cholesterol drugs** (Niacin or Nicotinic Acid)	0=No
fs 271	|__|	**Anti cholesterol drugs** (Fibrates--e.g. Gemfibrozil)	1=Yes, now
fs 272	|__|	**Anti cholesterol drugs** (Statins--e.g.Lovastatin,Pravastatin)	2=Yes, not now
fs 273	|__|	**Anti cholesterol drugs** (Other--Specify______________)	3=Maybe
fs 274	|__|	**Antigout--uric acid lowering** (Allopurinol, Probenecid etc)	9=Unknown
fs 275	|__|	**Antigout**--(Colchicine)	
fs 276	|__|	**Thyroid extract** (Dessicated Thyroid)	
fs 277	|__|	**Thyroxine** (Synthroid etc.)	
fs 278	|__|	**Insulin** 0=No, 1=Yes, now 2=Yes, not now 3=Maybe 9=Unknown	
if yes fill in dose☞ fs279	|__|__|__|	Total units of insulin a day	
fs 280	|__|	**Oral hypoglycemics**	
if yes fill in dose☞ fs281	|__|	**Metformin**	
fs282	|__|	**Rosiglitazone**	
fs283	|__|	**Glipizide**	(...>=2 and ...<4) or ...=9
fs284	|__|	**Glyburide**	
fs285	|__|	**Chlorpropamide**	
fs286	|__|	**Repaglinide**	
fs287	|__|	**Glimepriride**	
fs288	|__|	**Other (specify**__________________________)	
fs289	|__|	**Unknown**	
fs 290	|__|	**Oral/patch estrogen** (for women users also see estrogen section)	
fs 291	|__|	**Oral glucocorticoids** (Prednisone, Cortisone,etc)	

EXAM 26 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

First Examiner -- Noncardiovascular Medications II

260304 FORM NUMBER **SCREEN 4**

fs	292 |__|	**Non-steroidal anti-inflammatory agents** (NSAIDS) (Motrin, Ibuprofen, Naprosyn, Indocin, Clinoril)
fs	293 |__|	**Analgesic-narcotics** (Demerol, Codeine, Dilaudid, etc.)
fs	294 |__|	**Analgesic-non-narcotics** (Acetaminophen etc.)
fs	295 |__|	**Antihistamines**
fs	296 |__|	**Antiulcer** (Tagamet, Ranitidine, Probanthine, H ion inhibitors)
fs	297 |__|	**Anti-anxiety, Sedative/Hypnotics** etc. (Librium, Valium etc.)
fs	298 |__|	**Sleeping pills**
fs	299 |__|	**Anti-depressants**
fs	300 |__|	**Eye drops**
fs	301 |__|	**Antibiotics**
fs	302 |__|	**Anti-parkinson drugs** (Sinemet, L-Dopa, Symmetrel, Cogentin, etc)
fs	303 |__|	**Anticonvulsants** (Dilantin, Phenobarbital, Tegretol, Mysoline etc)
fs	304 |__|	**Medications for memory loss or dementia** (Tacrine, Donepezil)
fs	305 |__|	**Bronchodilators and aerosols**
fs	306 |__|	**Osteoporosis Medications**
fs	307 |__|	Bisphosphorates (Alendronate (Fosamax), Etidronate)
fs	308 |__|	Calcitonin
fs	309 |__|	SERMS, Evista (Raloxifene)
fs	310 |__|	Other_____
fs	311 |__|	**Others** Specify (include vitamins): _____

(...>-2 and ...<4) or ...=9

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

Physician Blood Pressure Readings

Physician Blood Pressure (first reading)	Systolic	Diastolic
	fs 312 |__|__|__| to nearest 2 mm Hg	fs 313 |__|__|__| to nearest 2 mm Hg

EXAM 26 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Medical History --Genitourinary and Thyroid Disease

260305 FORM NUMBER SCREEN 5

Female Hormone Replacement

fs 314 |__| **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 ☞ fs 315 |__| **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_____ 9=Unk)
(write in)

fs 316 |__| **Patch dose of estrogen** (0=No, 1=0.5 mg/wk, 2=other _____, 9=Unk)
(write in)

fs 317 |__|__| **Number of days a month taking estrogens** (99=Unknown)

fs 318 |__| **Estrogen Cream Use in Interim** (0=No, 1=Yes, now; 2=Yes, not now, 8=Man, 9=Unk)

fs 319 |__| **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 ☞ fs 320 |__| **Dose/day of progestin:** (0=No, 1=1.25 mg, 2=2.5 mg, 3=5.0 mg, 4=10.0mg,
5=other_____ 9=Unk)
(write in)

fs 321 |__|__| **Number of days a month taking progestins** (99=Unknown)

Prostate Disease

fs 322 |__| **Prostate trouble in interim** **(0=No, 1=Yes, now; 2=Yes, not now, 8=Woman, 9=Unk)**

fs 323 |__| **Prostate surgery in interim**

Medical History -- Thyroid

fs 324 |__| **Interim diagnosis of a thyroid condition?**(0=No,1=Yes, 9=Unknown)

Comments_____

EXAM 26 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

260306 FORM NUMBER SCREEN 6

fs325 |__| **Do you <u>now consume</u>, or have you <u>ever consumed</u>, at least 12 drinks of any type of alcohol (beer, wine, or liquor/spirits) during the period of a year?** (0=No, 1=Yes, 9=Unknown)
(...>-2 and ...<2) or ...=9

fs326 |__| **During the <u>past year</u>, have you consumed at least 12 drinks of any type of alcohol (beer, wine, or spirits?** (0=No, 1=Yes, 9=Unknown)
(...>-2 and ...<2) or ...=9

Alcohol Consumption (Usual over past year)

If yes, fill ☞	Beverage	In the past year, have you had any:	If you usually drink this beverage: IF At least 1/week (Code 0, if less than 1/week) — Average # days/week you drink it (Code 1-7=# days, 9=Unknown)	IF At least 1/week — Average # drinks per week (Code number 99=unknown)	IF Less than 1/week (Code 0, if more than 1/week) — Average # drinks per month (Code number 99=Unknown)
	Beer (12 oz.)	fs327 No Yes	fs328 |__|	fs329 |__|__|	fs330 |__|__|
	White Wine (4-5 oz.) (or rose,champagne)	fs331 No Yes	fs332 |__|	fs333 |__|__|	fs334 |__|__|
	Red Wine (4-5 oz.) (e.g.,port/sherry)	fs335 No Yes	fs336 |__|	fs337 |__|__|	fs338 |__|__|
	Other Wine (4-5 oz)	fs339 No Yes	fs340 |__|	fs341 |__|__|	fs342 |__|__|
	Liquor/Spirits (1 1/2 oz.)	fs343 No Yes	fs344 |__|	fs345 |__|__|	fs346 |__|__|
			(>-2 & <2) or ...=9	(>-2 and ...<8) or ...=9	(>-2 <100)

Smoking Status

fs347 |__| 252 **Smoked cigarettes regularly in the last year?** (0=No, 1=Yes, 9=Unknown)

if yes fill

fs348 |__|__| 253 **How many cigarettes do/did you smoke a day?** (01=one or less, 99=unknown)

EXAM 26 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Respiratory Questions

260307 FORM NUMBER **SCREEN 7**

		Respiratory Symptoms	
fs 349	|___|	**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)	
fs350	|___|	**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)	
fs351	|___|	**Have you had asthma in the interim?** (0=No, 1=yes, new, 2=yes, old, 9=Unknown)	
fs352	|___|	**Have you had wheezing or whistling in your chest at any time in the last 12 months?** (0=No, 1=Yes, 9=Unknown)	
fs353	|___|	**Night cough** (0=No, 1=Yes, 9=Unknown)	
fs354	|___|	**Dyspnea on exertion** (0=No, 1=Climbing stairs or vigorous exertion, 2=Rapid walking or moderate exertion, 3=Any slight exertion, 9=Unknown)	
fs355	|___|	**Dyspnea has increased over the past two years** (0=No, 1=Yes, 9=Unknown)	
fs356	|___|	**Sleep on 2 or more pillows to help you breathe** (0=No, 1=Yes, 9=Unknown)	
fs357	|___|	**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)	
fs358	|___|	**Ankle edema bilaterally**	(0=No; 1=Yes, ; 2=Maybe; 9=Unknown)
fs359	|___|	**Been told you have had heart failure or congestive heart failure in the interim**	
fs360	|___|	**Been hospitalized for heart failure in interim**	

		Respiratory Examiner Opinions	
fs361	|___|	**Congestive Heart Failure**	0=No; 1=Yes; 2=Maybe; 9=Unknown
fs362	|___|	**Chronic Bronchitis** (Cough that produces sputnum at least 3 months in past 12 months)	

Respiratory Comments:

EXAM 26 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

First Examiner - Coronary Heart Disease Opinions in Interim

260308 FORM NUMBER SCREEN 8

fs363 |__| **Any chest discomfort since last exam (0=No, 1=Yes, 2=Maybe, 9=Unknown)**

if yes, fill ☞ and below

fs364 |__| Chest discomfort with exertion or excitement (0=No, 1=Yes, 2=Maybe, 9=Unknown)

fs365 |__| Chest discomfort when quiet or resting

Chest Discomfort Characteristics (must have checked box at top of table)

fs366 |__|__|	Date of onset	(mo/yr, 99/9999=Unknown)
fs367 |__|__|__|__|		
fs368 |__|__|__|	Usual duration	(minutes: 1=1 min or less, 900=15 hrs or more,999=Unk)
fs369 |__|__|__|	Longest duration	(minutes: 1=1 min or less, 900=15 hrs or more,999=Unk)
fs370 |__|	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)
fs371 |__|	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)
fs372 |__|__|__|	Frequency (number in past month)	999=Unknown
fs373 |__|__|__|	Frequency (number in past year)	999=Unknown
fs374 |__|	Type	(1=Pressure, heavy, vise; 2=Sharp; 3=Dull; 4=Other; 9=Unk)

Chest pain relief

fs375 |__|	Relief by Nitroglycerine in <15 minutes	0=No
fs376 |__|	Relief by Rest in <15 minutes	1=Yes,
fs377 |__|	Relief Spontaneously in <15 minutes	**8=Not tried**
fs378 |__|	Relief by Other cause in <15 minutes	9=Unknown

CHD First Opinions

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

fs379 |__|	**Angina pectoris in interim**
fs380 |__|	**Angina pectoris since revascularization procedure**
fs381 |__|	**Coronary insufficiency in interim**
fs382 |__|	**Myocardial infarct in interim**

Comments about Heart Disease _____

_____

_____

EXAM 26 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

First Examiner -- Syncope History in Interim

260309 FORM NUMBER SCREEN 9

fs 383

|__| **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)

fs 384 |__|__| Number of episodes in the past two years

fs 385 |__|__| Date of first episode (mo/yr, 99/9999=Unknow)

fs 386 |__|__|__|__|

fs 387 |__|__|__| Usual duration of loss of consciousness

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

fs 388 |__| Did you have any injury caused by the event? (0=No, 1=Yes, 2=Maybe, 9=Unknown)

fs 389 |__| ER/Hospitalized or saw M.D. (0=No, 1=Hosp/ER, 2=Saw M.D., 9=Unknown)
Hospitalized at: _____

M.D. seen: _____

Syncope Opinions

fs 390 |__| **Syncope** (0=No, 1=Yes, 2=Maybe, 3=Presyncope, 9=Unknown)

fs 391 |__| Cardiac syncope

fs 392 |__| Vasovagal syncope

fs 393 |__| Other Specify: _____

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

fs 394 |__| **Seizure Disorder** (0=No,1=Yes, 2=Maybe, 9=Unk)

Comments about Syncope _____

fs235 date exam

EXAM 26 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

First Examiner -- Cerebrovascular and Neurological History and Opinions

260310 FORM NUMBER SCREEN 10

Cerebrovascular Episodes in Interim

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

fs 395 |__| **Sudden muscular weakness**

fs 396 |__| **Sudden speech difficulty**

fs 397 |__| **Sudden visual defect**

fs 398 |__| **Double vision**

fs 399 |__| **Sudden loss of vision in one eye**

fs 400 |__| **Unconsciousness**

fs 401 |__| **Numbness, tingling**

if yes, fill ☞ fs 402 |__| Numbness and tingling is positional

fs 403 |__| **CT or MRI scan (head) since last exam** (date/place _____)

fs 404 |__| **Seen by neurologist since last exam** (write in who and when below)

_____

Details for "Serious" Cerebrovascular Event in Interim

fs 405 |__| 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 ☞

fs 406 |__|__|*|__|__|__|__| fs 407 Date (mo/yr, 99/9999=Unkn
Observed by_____

fs 408 |__| Onset time (1=Active, 2=During sleep, 3=While arising, 9=Unkn)

fs 409 |__|__|*|__|__| fs 410 Exact/approximate time (use 24-hour military time, 99.99=unkn)

fs 411 |__|__|*|__|__|*|__|__| fs 412 fs 413 Duration (use format days/hours/mins, 99/99/99=Unknown)

fs 414 |__| Hospitalized or saw M.D. 0=No,1=Hosp.2=Saw M.D, 9=Unk

fs 415 |__|__| Number of days stayed at _____

Cerebrovascular Disease Opinion

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

fs 416 |__| **Stroke in Interim**

fs 417 |__| **Transient Ischemic Attack in Interim (TIA)**

fs 418 |__| **Parkinsonism in Interim**

fs 419 |__| **Other-- Specify:**_____

Comments about possible Cerebrovascular Disease

_____

_____

EXAM 26 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

First Examiner --Peripheral Vascular History and Opinion

260311 FORM NUMBER SCREEN 11

fs 420 |__| **Can you walk 50 feet without help? (0=Able to walk 50 feet without help, 1=Needs help, 2=Can't Walk, 9=Unknown)**

fs 421 |__| **Do you have lower limb discomfort while walking? (0=No, 1=Yes, 2=Can't Walk, 9=Unk)**

if yes fill to right: fs 422 |__|__| 12 (...>-2 and ...<100) — **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

if yes fill to right: fs 423 |__|__|__|__| 62 (...=-1 or (...>1939 and ... <) or ...=9999 — **Year symptoms started** (00=no, 9999=unknown)

if yes fill to right	Left	Right	Vascular symptoms (0=No, 1=Yes, 9=Unkn)
	fs 424 |__|	fs 425 |__|	Discomfort in calf while walking
	fs 426 |__|	fs 427 |__|	Discomfort in lower extremity (not calf) while walking
	fs 428 |__|		Occurs with first steps
	fs 429 |__|		After walking a while
	fs 430 |__|		Related to rapidity of walking or steepness
	fs 431 |__|		Forced to stop walking
	fs 432 |__|__|		Time for discomfort to be relieved by stopping (minutes) (00=No relief with stopping, 88=Not Applicable)
	fs 433 |__|__|		Number of days/month of lower limb discomfort (00=No, 88=N/A, 99=Unknown)

Venous Disease

Left	Right	
fs 434 |__| (...>-2 and ...<2) or ...=9	fs 435 |__|	Deep Vein Thrombosis (blood clots in legs or arms) Code: 0=No, 1=Yes, 9=Unknown

Intermittent Claudication Opinions

fs 436 |__| **Intermittent Claudication** 0=No, 1=Yes, 2=Maybe, 9=Unknown

Comments about peripheral vascular disease

EXAM 26 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

First Examiner -- CHD and Complications

260312 FORM NUMBER SCREEN 12

Coding: 0=No, 1=Yes 2=Maybe, 9=Unkn

Cardiovascular Procedure (in the interim only, not lifetime)

Exercise Tolerance Test (most recent only)

fs 437 |__| if yes fill ☞ fs 438 |__|__|__|__| Year done Location _____

Coronary arteriogram (most recent only)

fs 439 |__| if yes fill ☞ fs 440 |__|__|__|__| Year done (9999=unknown)

Coronary artery angioplasty

fs 441 |__| if yes fill ☞ fs 442 |__|__|__|__| Year done (9999=unknown)

fs 443 |__| Type of procedure (0=none, 1=balloon, 2=other _____ 9=unkn),

Coronary bypass surgery

fs 444 |__| if yes fill ☞ fs 445 |__|__|__|__| Year done (9999=unknown)

Permanent pacemaker insertion

fs 446 |__| if yes fill ☞ fs 447 |__|__|__|__| Year done (9999=unknown)

Valve surgery

fs 448 |__| if yes fill ☞ fs 449 |__|__|__|__| Year done (9999=unknown) Type _____

359 360

Carotid artery surgery

fs 450 |__| if yes fill ☞ fs 451 |__|__|__|__| Year done (9999=unknown)

Thoracic aorta surgery

fs 452 |__| if yes fill ☞ fs 453 |__|__|__|__| Year done (9999=unknown)

Abdominal aorta surgery

fs 454 |__| if yes fill ☞ fs 455 |__|__|__|__| Year done (9999=unknown)

Femoral or lower extremity surgery

fs 456 |__| if yes fill ☞ fs 457 |__|__|__|__| Year done (9999=unknown)

Lower extremity amputation

f 458 |__| if yes fill ☞ fs 459 |__|__|__|__| Year done (9999=unknown)

dif. place moved

EXAM 26 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

First Examiner - Cancer Site or Type

260313 FORM NUMBER SCREEN 13

fs 460 |__|

Have you, since your last clinic visit, had cancer or a tumor?
0=No [Skip to next screen]
1=Yes, fill in table below, using the following code:

Code: 1=Definite cancer
2=Tumor, nature unknown
3=Definitely benign

Code each "site", putting "0" for all sites having no interim tumor of any sort.

	Code	Site of Cancer or Tumor	Year First Diagnosed	Name Diagnosing M.D.	City of M.D.
fs 461	|__|	Esophagus			
fs 462	|__|	Stomach			
fs 463	|__|	Colon			
fs 464	|__|	Rectum			
fs 465	|__|	Pancreas			
fs 466	|__|	Larynx			
fs 467	|__|	Trachea/Bronchus/Lung			
fs 468	|__|	Leukemia			
fs 469	|__|	Skin			
fs 470	|__|	Breast			
fs 471	|__|	Cervix/Uterus			
fs 472	|__|	Ovary			
fs 473	|__|	Prostate			
fs 474	|__|	Bladder			
fs 475	|__|	Kidney			
fs 476	|__|	Brain			
fs 477	|__|	Lymphoma			
fs 478	|__|	Other/Unknown _____			

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

260314 FORM NUMBER **SCREEN 14**

Physician Blood Pressure Readings

Physician Blood Pressure (second reading)	Systolic	Diastolic
	fs 479 |__|__|__| to nearest 2 mm Hg	fs 480 |__|__|__| to nearest 2 mm Hg

EXAM 26 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Electrocardiograph Part I

260315 FORM NUMBER SCREEN 15

fs 481 |__|__|__|	Examiner ID Number	_____ Examiner Last Name

fs 482 |__| if Yes, fill out rest of form	**ECG done** (0=No, 1=Yes)
	Rates and Intervals
fs 483 |__|__|__|	Ventricular rate per minute (999=Unknown)
fs 484 |__|__|	P-R Interval (hundredths of a second) (99=Fully paced, Atrial Fib, or Unknown)
fs 485 |__|__|	QRS interval (hundredths of second) (99=Fully Paced, Unknown)
fs 486 |__|__|	Q-T interval (hundredths of second) (99=Fully Paced, Unknown)
fs 487 |__|__|__|__|	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
fs 488 |__|	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
fs 489 |__|	IV Block (0=No, 1=Yes, 9=Fully paced or Unknown)
if yes, fill to right: fs 490 |__|	Pattern (1=Left, 2=Right, 3=Indeterminate)
fs 491 |__|	Complete (QRS interval= .12 sec or greater)(0=No, 1=Yes, 9=Unknown)
fs 492 |__|	Incomplete (QRS interval = .10 or .11 sec) (0=No, 1=Yes, 9=Unknown)
fs 493 |__|	Hemiblock (0=No, 1=Left Ant, 2=Left Post, 9=Fully paced or Unknown)
fs 494 |__|	WPW Syndrome (0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unknown)
	Arrhythmias
fs 495 |__|	Atrial premature beats (0=No, 1=Atr, 2=Atr Aber, 9=Unknown)
fs 496 |__|	Ventricular premature beats (0=No, 1=Simple, 2=Multifoc, 3=Pairs, 4=Run, 5=R on T, 9=Unk)
fs 497 |__|__|	Number of ventricular premature beats in 10 seconds (see 10 second rhythm strip)

EXAM 26 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

Electrocardiograph Part II

260316 FORM NUMBER SCREEN 16

Myocardial Infarction Location

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

fs 498 |__| Anterior

fs 499 |__| Inferior

fs 500 |__| True Posterior

Left Ventricular Hypertrophy Criteria

(0=No, 1=Yes, 9=Fully paced, Complete LBBB or Unk)

fs 501 |__| R > 20mm in any limb lead

fs 502 |__| R > 11mm in AVL

fs 503 |__| R in lead I plus S ≥ 25mm in lead III

Measured Voltage

fs 504 |__|__| R AVL in mm (at 1 mv = 10 mm standard) Be sure to code these voltages

fs 505 |__|__| 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

(0=No, 1=Yes, 9=Fully paced, Complete LBBB or Unk)

fs 506 |__| R≥ 25mm

fs 507 |__| S≥ = 25mm

fs 508 |__| R or S ≥ 30mm

fs 509 |__| R + S ≥ 35mm

fs 510 |__| Intrinsicoid deflection ≥ .05 sec

fs 511 |__|1 S-T depression (strain pattern) (.>=2 and ..<2) or ...=9

Hypertrophy, enlargement, and other ECG Diagnoses

fs 512 |__| Nonspecific S-T segment abnormality (0=No, 1=ST depression, 2=ST flattening, 3=other, 9=Fully paced or Unkn)

fs 513 |__| Nonspecific T-wave abnormality (0=No, 1=T inversion, 2=T flattening, 3= other, 9=Fully paced or Unkn)

fs 514 |__| U-wave present (0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unkn)

fs 515 |__| Atrial enlargement (0=None, 1=Left, 2=Right, 3=Both, 9=Atrial fib. or Unknown)

fs 516 |__| RVH (0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unknown; If complete RBBB present, RVH=9)

fs 517 |__| 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_____

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EXAM 26 FIELD(ID type/ID) FIELD(Last Name), FIELD(First Name)

260317 FORM NUMBER SCREEN 17

	Non Cardiovascular Diagnoses First Examiner Opinions	
fs 518	|__| **Diabetes Mellitus**	
fs 519	|__| **Urinary Tract Disease**	
fs 520	|__| **Prostate Disease**	0=No, 1=Yes, 2=Maybe, 9=Unknown
fs 521	|__| **Renal Disease**	
fs 522	|__| **Emphysema**	
fs 523	|__| **Chronic Bronchitis**	
fs 524	|__| **Pneumonia**	
fs 525	|__| **Asthma**	
fs 526	|__| **Other Pulmonary Disease**	
fs 527	|__| **Gout**	
fs 528	|__| **Degenerative joint disease**	
fs 529	|__| **Rheumatoid arthritis**	
fs 530	|__| **Gallbladder disease**	
fs 531	|__| **Other non C-V diagnosis (for cancer, see special screen)**	

Comments on Other Diagnoses _____

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Framingham Heart Study
Laboratory Report

ID:
Exam date:

Please note: These results are from a non-fasting sample.

Test	Result	Interpretation	
FS535 Total cholesterol (mg/dl)		less than 200	desirable
		200-239	borderline high
		greater than 239	high
FS534 HDL cholesterol (mg/dl)		less than 35	undesirable
		greater than 60	desirable
Total cholesterol to HDL ratio		less than 3.5	ideal
		less than 4.5	good
FS536 Triglycerides (mg/dl)		greater than 200 is considered elevated	
FS533 Random glucose (mg/dl) [blood sugar]		less than 50	hypoglycemia [low blood sugar]
		greater than 160	hyperglycemia [high blood sugar]

Please be advised that laboratory testing at the Framingham Study is done for research purposes only. Blood test results provide a guide to participants and their physicians. Framingham laboratory results should not be used in place of regular clinic care.