Framingham Heart Study

Offspring Cohort Exam 6

01/26/1995-09/02/1998
N=3532

Exam Form Version	
#1	Numerical Data (I-II), Sentence and Design Handout, *Cognitive Function (I-II),* Functional Performance, Activities Questions (A-C), *CES-D Scale, Medical History, Cancer Site or Type, Physical Exam, Electrocardiograph (I-II), Clinical Diagnosis Impression (I-III), Second Examiner Opinions in interim,* Cancer Screening Information, Prostate Symptoms & Awareness Of Coronary Effects
No Version Number:	Lipid and Glucose 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.

EXAM 6 ,

Numerical Data--Part I

VERSION 01/19/95

|6|0|2|0|1| FORM NUMBER

Basic Information

|__| F001 **Sex of Patient** (1=Male, 2=Female)

|__|__| F002 **Age of Patient** (years)

|__| F003 **Site of Exam** (0=Heart Study,1=Nursing home,2=Residence)

If 0 skip down

If 1 or 2 fill ☞

|__| F004 **Nursing Home Level of Care 0**=None; **1**=Skilled care 24hrs,Medicare **2**=Skilled care 24 hrs, Medicaid or private; **3**=Skilled care 8-16 hrs; **4**=Self care; **9**=unknown

|__| F005 **Marital Status** (1=Single, 2=Married, 3=Widowed, 4=Divorced, 5=Separated)

|__|__| F006 **Nurse Examiner's Number** (99= unknown)

|__|__|__| F007 **Weight** (to nearest pound)

|__|__|*|__|__| F008 **Height** (inches, to next lower 1/4 inch)

Regional Anthropometry

Left	Right	(Code boxes below with 9's if not done or unknown)
F009 |__|__|	F010 |__|__|	**Skinfold Triceps** (millimeters)
F011 |__|__|	F012 |__|__|	**Skinfold Subscapular** (millimeters)
|__|__|__| F013		**Skinfold Abdomen** (millimeters)
|__|__|*|__|__| F014		**Neck Circumference** (inches, to next lower1/4 inch)
|__|__|*|__|__| F015		**Right Arm Girth--Upper Third** (inches, to next lower 1/4 inch)
|__|__|*|__|__| F016		**Waist Girth** (inches, to next lower 1/4 inch)
|__|__|*|__|__| F017		**Hip Girth** (inches, to next lower 1/4inch)
|__|__|*|__|__| F018		**Thigh Girth** (inches, to next lower 1/4 inch)
|__|__| F019		**Carbon Monoxide Level**
|__|__|*|__| F020		**Knee Height** (centimeters)
|__|__| F021		**Number of Hours Fasting** (99=Unknown)
|__|__| F022		**Number of Days since Last Dose of Aspirin** (00=Never, 01=Within 1 day, 98=98 days or more, 99=Unknown) typical value 01 to 07 for use in past week
|__|__| F023		**Hamilton Baldness Scale** (01-12 from table, 88=woman, 99=Unknown)
|__| F024		**Hand preferred for eating** (1=right, 2=left, 9=unknown)
|__| F025		**Hand preferred for writing** (1=right, 2=left, 9=unknown)

Nurse's Blood Pressure to nearest 2 mm Hg	Systolic	Diastolic	Nurse's Blood Pressure ID
	F026 |__|__|__|	F027 |__|__|__|	F028 |__|__|__|

Body Comp	Resistance	Reactance	Nurse ID for Body Composition
Trial #1	F029 |__|__|__|	F030 |__|__|__|	|__|__|__| F035
Trial #2	F031 |__|__|__|	F032 |__|__|__|	
Trial #3	F033 |__|__|__|	F034 |__|__|__|	

EXAM 6 ,

Numerical Data--Part II

|6|0|2|0|2| FORM NUMBER

|_|_| F036	**Nurse Examiner's Number**

Urinalysis

|_| F037	**Urinalysis Specimen Obtained** (0=No, 1=Yes, 9=Unknown) If no, then skip to next section

If Yes, continue below

	Test	Neg	Unk	Trace	Small	Moderate	Large
F038 |_|_|	**Blood**	0	99	10	1	2	3
F039 |_|_|_|	**Ketones**	0	999	5	15	40	080-160
F040 |_|_|	**Glucose**	0	99	10	1	2	03-04
F041 |_|_|_|_|	**Albumin**	0	9999	10	30	100	0300-2000
F042 |_|.|_|	**pH**		99	Values= 5.0, 6.,0, 6.5, 7.0, 7.5, 8.0, 8.5			

Exam 6 Procedures Sheet

F043 |_|	**Echocardiogram**
F044 |_|	**Echo Doppler**
F045 |_|	**Carotid Doppler**
F046 |_|	**Body Composition**
F047 |_|	**Ankle-arm blood pressure**
F048 |_|	**Exercise Questionnaire**
F049 |_|	**Spirometry Done**
F050 |_|	**Blood Lipids**
F051 |_|	**Diet Questionnaire**
F052 |_|	**Glucose Tolerance Test**
F053 |_|	**Methionine Challenge Test**
F054 |_|	**ECG Done**
F055 |_|	**Hearing Test**
F056 |_|	**Osteoporosis Test**
F057 |_|	**Exercise Text**
F058 |_|	**Heart Rate Monitor**
F059 |_|	**Urinalysis Abnormal Results**
F060 |_|	cognitive function

Coding for all items to left
0=No,
1=Yes,
9=Unknown

(0=No, 1=Yes, and list below)

_____

_____

EXAM 6 ,

Sentence and Design Handout for Patient

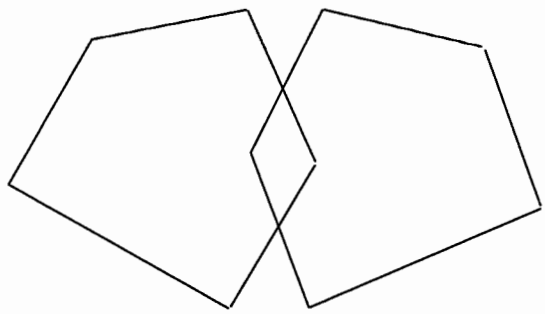
PLEASE WRITE A SENTENCE

_____

_____

_____

PLEASE COPY THIS DESIGN



EXAM 6

VERSION 02/28/91

Cognitive Function--Part I

|6|0|2|0|3| FORM NUMBER

|_|_|_| F061	**Nurse Examiner's Number**

SCORE CORRECT No Try=6 Unknown=9	**Write all responses on exam form.**
0 1 2 3 6 9 F062	**What Is the Date Today?** (Month, day, year, correct score=3)
0 1 6 9 F063	**What Is the Season?**
0 1 6 9 F064	**What Day of the Week Is it?**
0 1 2 3 6 9 F065	**What Town, County and State Are We in?**
0 1 6 9 F066	**What Is the Name of this Place?** (any appropriate answer all right, for instance my home, street address, heart study ..max score=1)
0 1 6 9 F067	**What Floor of the Building Are We on?**
0 1 2 3 6 9 F068	**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**
|_|_|_|_|_| F069	**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)
0 1 2 3 6 9 F070	**What are the 3 objects I asked you to remember a few moments ago?**

EXAM 6

Cognitive Function --Part II

|6|0|2|0|4| FORM NUMBER

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

SCORE CORRECT **No Try=6 Unknown=9**	**Write all responses on exam form.**
0 1 6 9 F071	**What Is this Called?** (Watch)
0 1 6 9 F072	**What Is this Called?** (Pencil)
0 1 6 9 F073	**Please Repeat the Following: "No Ifs, Ands, or Buts."** (Perfect=1)
0 1 6 9 F074	**Please Read the Following & Do What it Says** (performed=1, code 6 if low vision)
0 1 6 9 F075	**Please Write a Sentence** (code 6 if low vision)
0 1 6 9 F076	**Please Copy this Drawing** (code 6 if low vision)
0 1 2 3 6 9 F077	**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)
F078 |__|	**Examiner's Assessment of Subject's Mental Status** 1 = normal, 2 = possible dementia, 3 = factors such as illiteracy, not fluent in English, or depression cause poor testing 4 = dementia present 9 = unknown

EXAM 6
(HOME 1)

VERSION 02/28/91

Functional Performance

|6|0|0|0|4| FORM NUMBER

|__|__| F079	**Nurse Examiner's Number**

Basic Functions

|__| F080	**Where do you live:** (0 = Private Residence, 1 = Nursing home, 2 = Other institution, such as: home-self care retirement village, 9=Unknown)

F081 \|__\| 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

F082 |__|	Spouse	0=No 1=Yes, **less** than 3 months per year 2=Yes, **more** than 3 months per year 9=Unknown
F083 |__|	Significant Other	
F084 |__|	Children	
F085 |__|	Friends	
F086 |__|	Relatives	

F087 |__|	**In general, how is your health now:** (1=Excellent, 2=Good, 3=Fair, 4=Poor,9=Unkn)
F088 |__|	**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)
F089 |__|	**Are you working now:** (0=No, 1=Yes,Full time, 2=Yes, Part time, 9=Unknown)
F090 |__|__|__|	**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)

Activities of Daily Living

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

F091 |__|	**Dressing** (undressing and redressing)
F092 |__|	**Bathing** (including getting in and out of tub or shower)
F093 |__|	**Eating**
F094 |__|	**Transferring** (getting in and out of a chair)
F095 |__|	**Toileting Activities** (using bathroom facilities and handle clothing)
F096 |__|	**Bladder Continence** (ask if person has "accidents") (code=5 if use special products)
F097 |__|	**Bowel Continence** (ask if person has "accidents") (code=5 if use special products)
F098 |__|	**Walking on Level Surface about 50 Yards** (length of Thurber St.)
F099 |__|	**Walking up and down One Flight Stairs**
F100 |__|	**Using a Telephone**
F101 |__|	**Taking Own Medications** (code as above, and 8=takes no medications regularly)

EXAM 6
(HOME 2)

VERSION 02/28/91

Activities Questions- Part A

|6|0|0|0|5| FORM NUMBER

|_|_| F102	**Nurse Examiner's Number**

Use of Nursing and Community Services

|_| F103 **if yes, continue☞ and below**

In the past two years, have you been admitted to a nursing home, been visited by a nursing service, or used community programs (0=No, 1=Yes, 9=Unknown)

|_| F104 Been admitted to nursing home (or skilled facility) in past two years (0=No, 1=Yes, 9=Unknown)

Past month only	Past two years		
F105 |_|	F106 |_|	Home health aides	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
F107 |_|	F108 |_|	Homemaker visits	
F109 |_|	F110 |_|	Visiting Nurses	
F111 |_|	F112 |_|	Rehabilitation services (such as physical therapy, occupational therapy, speech therapy)	
F113 |_|	F114 |_|	Meals on Wheels	
F115 |_|	F116 |_|	Community Day Programs	
F117 |_|	F118 |_|	Other (specify_____)	

Rosow-Breslau Questions

|_| F119 **Are you able to do heavy work around the house, like shovel snow or wash windows, walls or floors without help?** (0=No, 1=Yes, 9=Unknown)

|_| F120 **Are you able to walk up and down stairs to the second floor without any help?** (0=No, 1=Yes, 9=Unknown)

|_| F121 **Are you able to walk half a mile without help?** (About 4 to 6 blocks) (0=No, 1=Yes, 9=Unknown)

F122 |_| **Have you driven a car in the past ?** (0=No, 1=Yes, 9=Don't Know)

F123 |_| **Do you drive now?** (0=No, 1=Yes, 9=Don't Know)

if no then☞

|_| F124 **Reason for <u>not</u> driving now** (1=Health, 2=Other non-health reason, 3=never drove a car 9=Unknown

EXAM 6 ,

(HOME 3 VERSION 02/28/91

Activities Questions - Part B

|6|0|0|0|6| FORM NUMBER

|_|_| F125	**Nurse Examiner's Number**

Nagi Questions

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

|_| F126	Pulling or pushing large objects like a living room chair.
|_| F127	Either stooping, crouching, or kneeling
|_| F128	Reaching or extending arms below shoulder level
|_| F129	Reaching or extending arms above shoulder level
|_| F130	Either writing, or handling, or fingering small objects.
|_| F131	Standing in one place for long periods, say 15 minutes
|_| F132	Sitting for long periods, say 1 hour
|_| F133	Lifting or carrying weights under 10 pounds (like a bag of potatoes)
|_| F134	Lifting or carrying weights over 10 pounds (like a very heavy bag of groceries)
|_| F135	Getting in and out of car
|_| F136	Putting on socks or stockings

EXAM 6
INTERVIEW

Activities Questions Part C

|6|0|0|0|7| FORM NUMBER

|_|_| F137	**Nurse Examiner's Number**

|_| F138 **In the past year have you accidentally fallen and hit the floor or ground?**

if yes, fill ☞

(code as no if during sports activity) (0=No, 1=Yes, 2=Maybe, 9=Unk)

|_|_| F139 How many times did you fall in the past year? (99=Unknown)

Fractures

|_| F140 **Since Your Last Clinic Visit Have You Broken Any Bones?**

(Code: 0=No, 1=Yes, 2=Unsure, 3=Under age 30, 9=Unknown)

If 0,3,9 then skip rest of table

If 1,2, fill ☞

Left	Right	Location
19|_|_| F141	19|_|_| F142	**Upper arm (humerus) or elbow**
19|_|_| F143	19|_|_| F144	**Forearm or wrist**
	19|_|_| F145	**Back** (If disc disease only, code as no)
	19|_|_| F146	**Pelvis**
19|_|_| F147	19|_|_| F148	**Hip**
	19|_|_| F149	**Other** (specify)_____

EXAM 6

CES-D Scale

|6|0|0|0|0|1|8 FORM NUMBER

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

|_|_| F150	Nurse Examiners Number

Questions to be answered Circle best answer for each question	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or moderate amount of time (3-4 days)	Most or all of the time (5-7 days)	Unknown
1. I was bothered by things that usually don't bother me. F151	0	1	2	3	9
2. I did not feel like eating; my appetite was poor. F152	0	1	2	3	9
3. I felt that I could not shake off the blues, even with help from my family and friends. F153	0	1	2	3	9
4. I felt that I was just as good as other people. F154	0	1	2	3	9
5. I had trouble keeping my mind on what I was doing. F155	0	1	2	3	9
6.I felt depressed. F156	0	1	2	3	9
7. I felt that everything I did was an effort. F157	0	1	2	3	9
8. I felt hopeful about the future. F158	0	1	2	3	9
9. I thought my life had been a failure. F159	0	1	2	3	9
10. I felt fearful. F160	0	1	2	3	9
11. My sleep was restless. F161	0	1	2	3	9
12. I was happy. F162	0	1	2	3	9
13. I talked less than usual. F163	0	1	2	3	9
14. I felt lonely. F164	0	1	2	3	9
15. People were unfriendly. F165	0	1	2	3	9
16. I enjoyed life. F166	0	1	2	3	9
17. I had crying spells. F167	0	1	2	3	9
18. I felt sad. F168	0	1	2	3	9
19. I felt that people disliked me. F169	0	1	2	3	9
20. I could not "get going" F170	0	1	2	3	9

|_| F171	Examiner's opinion

EXAM 6 ,

Medical History--Hospitalizations

(SCREEN 1) VERSION 09/30/92

OFFSPRING EXAM 6 DATE _____

|6|0|3|0|1| FORM NUMBER

Basic Background and Health Care	
F172 |__|	**Sex of Patient** (1=Male, 2=Female)
F173 |__|__|__|	**1st Examiner ID** _____ 1st Examiner Name
F174 |__|	**Hospitalization (not just E.R.) in Interim** (0=No; 1=yes, hospitalization, 2=yes, more than 1 hospitalization, 9=Unknown)
F175 |__|	**E.R. Visit in Interim** (0=No; 1=Yes, 1 or more Emergency Room visit, 9=Unknown)
F176 |__|	**Day Surgery** (0=No, 1=Yes, 9=Unknown)
F177 |__|	**Illness with visit to doctor** (0=No, 1=Yes,1 visit; 2=Yes,more than 1 visit; 9=Unk)
F178 |__|	**Check up** in interim by doctor (0=No, 1=Yes, 9=Unknown)
F179 _____ 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

Medical History--Cardiovascular Medications

|6|0|3|0|2| FORM NUMBER (SCREEN 2)

F180|__| **Take aspirin regularly** (0=No, 1=Yes, 9=Unk)

If yes, fill ☞

F181|__|__| **Number aspirins taken regularly** (99=Unknown)

F182|__| **Aspirin frequency**- number taken regularly (0=Never, 1=Day, 2=Week ,3=Month, 4=Year, 9=Unk)

F183 |__|__|__| **Usual aspirin dose for above** 081=baby,160=half dose, 325=nl, 500=extra or larger,999=unk

F184|__| **Currently receiving medication for the treatment of hypertension?** (0=No,1=Yes,9=Unk)

F185|__| **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)

F186|__| **Cardiac Glycosides**

F187|__| **Nitroglycerine**

F188|__| **Longer acting nitrates** (Isordil, Cardilate, etc.)

F189|__| **Calcium Channel Blockers** (Nifedipine, Verapamil, Diltiazem)

F190|__| **Beta Blockers** (Specify_____ (0=No, 1=Yes, 9=Unk)

if yes fill ☞ **and continue**

F191 |__| **Beta Blocker Group** (Propranolol=01 Timolol =02 Nadolol=03 Atenolol=04 Metoprolol=05 Pindolol =06 Acebutolol=07 Labetalol=08 Other=09)

F192 |__| **Dose** (mg/day) of Beta Blocker (999=unknown)

F193|__| **Loop Diuretics** (Lasix, etc.)

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

F194|__| **Thiazide/K-sparing diuretics**(Dyazide, Maxide, etc.)

F195|__| **Thiazide diuretics**

F196|__| **K-sparing diuretics** (Aldactone, Triamterene)

F197|__| **Potassium supplements**

F198|__| **Reserpine** derivatives

F199 |__| **Methyldopa** (Aldomet)

F200|__| **Alpha-1 agonist** (Clonidine, Wytensin, Guanabenz)

F201 |__| **Alpha-2 blockers** (Prazosin, Terazosin, Doxazosin)

F202|__| **Renin-angiotensin blocking drugs (ACE)** (Captopril, Enalapril, Lisinopril)

F203|__| **Peripheral vasodilators** (Hydralazine, Minoxidil, etc)

F204|__| **Other anti-hypertensives**(Specify)_____

All Medicines-- Scratch Sheet

_____

_____

_____

_____

_____

_____

F205|__| **Antiarrhythmics** (Quinidine, Procainamide, Norpace,Disopyramide,etc)

F206|__| **Antiplatelet** (Anturane, Persantine, etc.)

F207|__| **Anticoagulants** (Coumadin, Warfarin, etc.)

F208|__| **Other cardiac medication** (Specify)_____

Medical History-- Other Medications

|6|0|3|0|3| FORM NUMBER (SCREEN 3)

F209 |__|	Anti cholesterol drugs (Resins--e.g. Questran, Colestid)	CODING FOR REST OF PAGE
F210 |__|	Anti cholesterol drugs (Niacin or Nicotinic Acid)	0=No
F211 |__|	Anti cholesterol drugs (Fibrates--e.g. Gemfibrozil)	1=Yes,now
F212 |__|	Anti cholesterol drugs (Statins--e.g.Lovastatin,Pravastatin)	2=Yes,not now
F213 |__|	Anti cholesterol drugs (Other--Specify_____)	3=Maybe
F214 |__|	Antigout--uric acid lowering (Allopurinol, Probenecid etc)	9=Unknown
F215 |__|	Antigout--(Colchicine)	
F216 |__|	Thyroid extract (Dessicated Thyroid)	
F217 |__|	Thyroxine (Synthroid etc.)	
F218 |__| **if yes fill in dose** ☞ F219	Insulin 0=No, 1=Yes,now 2=Yes,not now 3=Maybe 9=Unknown |__|__|__| Total units of insulin a day	
F220 |__|	Oral hypoglycemics (Specify brand_____)	
F221 |__|	Oral/patch estrogen (for women users also see estrogen section)	
F222 |__|	Oral glucocorticoids (Prednisone, Cortisone,etc)	
F223 |__|	Non-steroidal anti-inflammatory agents (NSAIDS) (Motrin,Ibuprofen, Naprosyn, Indocin, Clinoril)	
F224 |__|	Analgesic-narcotics (Demerol, Codeine, Dilaudid, etc.)	
F225 |__|	Analgesic-non-narcotics (Acetaminophen etc.)	
F226 |__|	Antihistamines	
F227 |__|	Antiulcer (Tagamet, Ranitidine, Probanthine, H ion inhibitors)	
F228 |__|	Anti-anxiety, Sedative/Hypnotics etc. (Librium, Valium etc.)	
F229 |__|	Sleeping pills	
F230 |__|	Anti-depressants	
F231 |__|	Eyedrops	
F232 |__|	Antibiotics	
F233 |__|	Anti-parkinson drugs (Sinemet, L-Dopa, Symmetrel, Cogentin, etc)	
F234 |__|	Anticonvulsants (Dilantin, Phenobarbital, Tegretol, Mysoline etc)	
F235 |__|	Bronchodilators **and aerosols**	
F236 |__|	Others Specify:_____	

EXAM 6 ,

Medical History-- Female Genitourinary Disease

|6|0|1|3|0|4| FORM NUMBER (SCREEN 4)

F237 |__| **Menstrual periods have stopped one year or more** (0=No, 1=Yes, 8=Man, 9=Unknown)

If yes F238 |__|__| Age when periods stopped (Years) (00=Not stopped, 88=Man, 99=Unk)

☞ F239 |__| Cause of cessation of menses
(0=Not stopped, 1=Natural, 2=Surgery, 3=Other,8=Man, 9=Unk)

If no or unsure F240 |__| Did you have one or more menstrual periods in last 2 months?
(0=No, 1=Yes, 2=Unsure, 8=Man, 9=Unknown)

fill☞ F241 |__|__| Number of days since last period ended?
(00=currently having menstrual period, acceptable range 01-60;
(88=not applicable, man; 99=unsure or unknown)

F242 |__|__| **Age at hysterectomy** (years) (00=No, 88=Man,99=Unknown)

F243 |__| **Ovary or ovaries removed** (0=No; 1=Yes,one; 2=Yes,two; 8=Man, 9=Unknown)

F244 |__| **Number of live births** (88=Not Applicable-man, 88=Man, 99=Unknown)

F245 |__|__| **Age at tubal ligation** (00=No, 88=Man, 99=Unknown)

F246 |__| **Oral contraceptives in interim** (0=No, 1=Yes,now; 2=Yes,not now, 8=Man, 9=Unk)

_____ Name of oral contraceptive last used
(e.g. Demulen 1/50) (only list if agent used since last exam)

F247 |__| **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 ☞

|__| F248 **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)

F249 |__| **Patch dose of estrogen** (0=No, 1=0.5 mg/wk, 2=other _____, 9=Unk)
(write in)

|__|__| F250 **Number of days a month taking estrogens** (99=Unknown)

F251 |__| **Estrogen cream use interim** (0=No ; 1=Yes,now; 2=Yes,not now; 8=man; 9=Unknown)

F252 **Progesterone use interim**

F253 |__| **Urinary disease in interim** (0=No,1=Yes,2=Maybe 8=man; ,9=Unknown)

F254 |__| **Kidney disease in interim**

F255 |__| **Kidney stones in interim**

EXAM 6

Medical History-- Male Genitourinary Disease

|6|0|3|0|5| FORM NUMBER (SCREEN 5)

F256	**Urinary disease in interim**	Coding: 0=No, 1=Yes, 2=Maybe, 8=Woman 9=Unknown
F257	**Kidney disease in interim**	
F258	**Kidney stones in interim**	
F259	**Prostate trouble in interim**	
F260	**Prostate surgery in interim**	
F261	**Vasectomy history** (0=No, 1=Yes, in interim, 2=Yes, not in interim, 8=Woman 9=Unknown)	
if yes, ☞ F262	Age at vasectomy (years 99=unknown)	

EXAM 6

Medical History-- Thyroid, Gastrointestinal, Beverages

|6|0|3|0|6| FORM NUMBER (SCREEN 6)

Thyroid and Gastrointestinal

F263 |__| Interim diagnosis of a **thyroid** condition?(0=No,1=Yes,9=Unknown)

Comments_____

F264 |__| Interim **ulcer** condition? (e.g., stomach, duodenum, peptic)(0=No,1=Yes, 9=Unknown)

F265 |__| Interim **hiatal hernia**? (0=No,1=Yes,9=Unknown)

F266 |__| Have you ever had **gallbladder disease**? (0=No, 1=Yes, 9=Unknown)

If yes,☞ F267 |__|__| **Gallbladder procedure**
1=Surgical removal, 2=Lithotropsy, 3=Diagnosis only, 9=Unknown)

Comments_____

Daily intake over past year

Caffeinated Beverages	Unit	# per day	Method§	Decaffeinated Beverages	Unit	# per day	Method§
Coffee	cup	F268 |__|__|	F269 |__|	**Coffee**	cup	F270 |__|__|	F271 |__|
Tea	cup	F272 |__|__|		**Tea**	cup	F273 |__|__|	
Cola	12 oz	F274 |__|__|		**Cola**	12 oz	F275 |__|__|	

§ Method used predominantly: 0=Non drinker, 1=Filter, 2=Perc, 3=Boil, 4=Instant, 8=Other, 9=Unknown

Alcohol Consumption

Beverage	Unit	Average Number of drinks per week over course of year Code 00=never, 01=1 or less, 99=unknown	Number days drink per week Code 0-7 9=Unknown	On Average, Limit for number of drinks at one period of time Code number 99=Unknown
Beer	bottle,can,glass (12 oz)	F276 |__|__|	F277 |__|	F278 |__|__|
White Wine (or Rosé)	glass (4 oz)	F279 |__|__|	F280 |__|	F281 |__|__|
Red Wine	glass (4 oz)	F282 |__|__|	F283 |__|	F284 |__|__|
Liquor	cocktail,highball	F285 |__|__|	F286 |__|	F287 |__|__|

EXAM 6

Medical History--Smoking

|6|0|3|0|7| FORM NUMBER (SCREEN 7)

|__| F288 **if yes fill rest of this table**

Smoked cigarettes regularly in the last year? (0=No, 1=Yes, 9=Unkown)

|__|__| F289 How many cigarettes do/did you smoke a day? (01=one or less, 99=unknown)

|__| F290 Do you inhale? (0=No,1=Yes,9=Unknown)

Cigarette Brand	Strength	Type	Filter	Length
Code the first eight letters	Code 1=Normal 2=Lite 3=Ultralite 8=N/A 9=Unknown	Code 1=Regular 2=Menthol 8=N/A 9=Unknown	Code 1=Nonfilter 2=Filter 8=N/A 9=Unknown	Code 1=Regular 2=King 3=100 mm 4=120 mm 8=N/A 9=Unknown
F291 |__|__|__|__|__|__|__|__|	F292 |__|	F293 |__|	F294 |__|	F295 |__|

F296 |__|__| How many hours since last cigarette?
(01=1 hour or less, 24=24 or more hours,)
(88=currently non-smoker, 99=Unknown)

Cigars and Pipes

|__| F297 **Do you now smoke cigars?** (0=no, 1=yes,inhale, 2=yes, no inhale 9=unk)

|__| F298 **Do you now smoke pipes?**

Passive Smoking

|__| F299 **Does your spouse smoke now?** (0=no, 1=yes, 2=not married, 9=unknown)

If yes, ☞

Location	Cigarettes/day	Pipes/day	Cigars/day
Total	|__|__| F300	|__|__| F301	|__|__| F302
At home	|__|__| F303	|__|__| F304	|__|__| F305

F306 |__|__| **Excluding you and your spouse, *how many other smokers* live in your household?**
(Cigarette, cigar or pipe smokers)
(0=none, 98=nursing home resident, 99=unknown)

EXAM 6 ,

Medical History-- Respiratory

|6|0|3|0|8| FORM NUMBER (SCREEN 8)

Respiratory Symptoms

F307 **Chronic cough in interim** (at least 3 months/year)
(0=No; 1=Yes, productive; 2=Yes, non-productive; 9=Unknown)

if yes, ☞ F308 Type of Cough (0=None, 1=New in interim, 2=Old, 8=N/A, 9=Unknown)

1 F309 **Wheezing or asthma** (0=No, 1=Yes, 9=Unknown)

1 F310 **Dyspnea on exertion**
(0=No)
(1=Climbing stairs or vigorous exertion)
(2=Rapid walking or moderate exertion)
(3=Any slight exertion)
(9=Unknown)

F311 **Dyspnea has increased over the past two years** (0=No, 1=Yes, 9=Unknown)

F312 **Orthopnea**

F313 **Paroxysmal nocturnal dyspnea**

F314 **Ankle edema bilaterally**

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

Respiratory First Opinions

F315 **1st Examiner believes CHF**

F316 **1st Examiner believes Chronic Bronchitis**
(Cough that produces sputum at least 3 months in past 12 months)
No second opinion needed for bronchitis

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

Respiratory Comments _____

EXAM 6 ,

Medical History-- Heart Part I

6|0|3|0|9| FORM NUMBER (SCREEN 9)

|_| F317 if yes, fill ☞ and below	**Any chest discomfort since last exam**	**(0=No, 1=Yes,2=Maybe,9=Unknown)**	
	F318 |_| Chest discomfort with exertion or excitement	(0=No, 1=Yes,2=Maybe,9=Unknown)	
	F319 |_| Chest discomfort when quiet or resting		
	Chest Discomfort Characteristics (must have checked box at top of table)		
	F320 |__|*|__| F321 Date of onset	mo/yr,99/99=Unknown)	
	|__|__|__| F322 Usual duration	(minutes, 999=Unknown)	
	|__|__|__| F323 Longest duration	(minutes: 1=1 min or less, 900=15 hrs or more, 999=Unknown)	
	|_| F324 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)	
	|_| F325 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)	
	|__|__|__| F326 Frequency (number in past month)	999=Unknown	
	|__|__|__| F327 Frequency (number in past year)	999=Unknown	
	|_| F328 Type	(1=Pressure,heavy,vise; 2=Sharp; 3=Dull; 4=Other; 9=Unk)	
	|_| F329 Relief by Nitroglycerine in <15 minutes	0=No	
	|_| F330 Relief by Rest in <15 minutes	1=Yes,	
	|_| F331 Relief Spontaneously in <15 minutes	8=Not tried	
	|_| F332 Relief by Other cause in <15 minutes	9=Unknown	

CHD First Opinions	
F333 **Angina pectoris in interim**	(0=No, 1=Yes, 2=Maybe, 9=Unknown)
F334 **Angina pectoris since revascularization procedure**	
F335 **Coronary insufficiency in interim**	
F336 **Myocardial infarct in interim**	

Comments_____

_____

_____

EXAM 6

Medical History-- Syncope

|6|0|3|1|0| FORM NUMBER Version 3/26/95 (SCREEN 10)

F337 |__|	**Have you fainted or lost consciousness in the interim?** (If due to stroke skip to screen 11) 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 ☞	F338 |__|__|__|	Number of episodes in the past two years	(999=Unknown)
	F339 |__|*|F340 |__|__|	Date of first episode	(mo/yr, 99/99=Unknown)
	F341 |__|__|	Usual duration of loss of consciousness	(minutes, 999=Unkn)
if yes, fill all ☞	|__|__|F342	**Usual Activity Preceding Event** (00=None, 01=Exertion,0 2=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), 0 8=Recent medication change or ingestion, 09=Other, or combination (specify)_____, 10=Pain, 11 illness, specify_____ 99=Unknown)	

if yes, fill both columns to ☞	**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)	
	F343 |__|	Nausea/vomiting	F349 |__|	Urinary/fecal incontinence
	F344 |__|	Warning signs (e.g. Aura)	F350 |__|	Confusion
	F345 |__|	Chest discomfort	F351 |__|	Focal weakness (e.g. arm,leg)
	F346 |__|	Shortness of breath	F352 |__|	Other (specify)_____
	F347 |__|	Palpitations		_____
	F348 |__|	Other		

F353 \|__\| Did you have any injury caused by the event? (0=No, 1=Yes, 2=Maybe, 9=Unkn)

if yes, fill ☞ F354 \|__\| Was event observed? (0=No, 1=Yes, 2=Maybe, 9=Unkn) Who observed event?_____

F355 \|__\| ER/hospitalized or saw M.D. (0=No, 1=Hosp., 2=Saw M.D., 9=Unkn)
Hospitalized at: _____

M.D. seen: _____

Syncope First Opinions

\|__\| F356 **Syncope** (0=No, 1=Yes, 2=Maybe, 3=Presyncope, 9=Unknown) needs second opinion

F357 |__|	**Cardiac syncope**	(0=No,1=Yes,2=Maybe,9=Unknown)
F358 |__|	**Vasovagal syncope**	
F359 |__|	**Other-- Specify:**_____	

\|__\| F360 **Seizure Disorder** (0=No, 1=Yes, 2=Maybe, 9=Unknown)

Comments _____

EXAM 6 ,

Medical History--Cerebrovascular

|6|0|3|1|1|1| FORM NUMBER (SCREEN 11)

Cerebrovascular Episodes in Interim

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

F361 |__| **Sudden muscular weakness**

F362 |__| **Sudden speech difficulty**

F363 |__| **Sudden visual defect**

F364 |__| **Double vision**

F365 |__| **Loss of vision in one eye**

F366 |__| **Unconsciousness**

F367 |__| **Numbness, tingling**

if yes, fill ☞ F368 |__| Numbness and tingling is positional

F369 |__| **CT or MRI scan (head) since last exam** (date/place_____)

F370 |__| **Seen by neurologist since last exam** (write in who and when below)

_____

Details for "Serious" Cerebrovascular Event in Interim

F371 |__| **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 ☞

F372 |__|__|*|__|__| F373 **Date** (mo/yr,99/99=Unkn

Observed by_____

F374 |__| **Onset time** (1=Active, 2=During sleep, 3=While arising, 9=Unkn)

F375 |__|__|*|__|__| F376 **Exact/approximate time** (use 24-hour military time, 99.99=unkn)

F377 |__|__|*|__|__|*|__|__| F379 **Duration** (use format days/hours/mins, 99/99/99=Unknown)

|_| F380 **Hospitalized or saw M.D.** 0=No,1=Hosp.2=Saw M.D,9=Unk

|_| F381 **Number of days stayed at** _____

Stroke/TIA First Opinions

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

|_| F382 **Stroke in Interim**

|_| F383 **Transient Ischemic Attack in Interim (TIA)**

|_| F384 **Other-- Specify:**_____

Neurology Comments_____

_____

EXAM 6

Medical History--Peripheral Arterial and Venous

|6|0|3|1|12| FORM NUMBER (SCREEN 12)

0= Able 1=Needs help 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, 9=Unk)
F385	

0= No F386 1=Yes 9=Unkn	**Do you have lower limb discomfort while walking?** (0=No, 1=Yes, 9=Unkn)

if yes fill in below	Left	Right	Vascular symptoms (0=No, 1=Yes, 9=Unkn)
	F387	F388	Discomfort in calf while walking
	F389	F390	Discomfort in lower extremity (not calf) while walking
	F391		Occurs with first steps
	F392		After walking a while
	F393		Related to rapidity of walking or steepness
	F394		Forced to stop walking
	F395		Time for discomfort to be relieved by stopping (minutes) (00=No relief with stopping, 88=Not Applicable)
	F396		Number of days/month of lower limb discomfort (00=No, 88=N/A, 99=Unknown)

F397	**Is one foot colder than the other?** (0=No, 1=Yes, 9=Unknown)

Venous Disease			
Left	**Right**		
F398	F399	**Phlebitis**	Code: 0=No, 1=Yes, 9=Unknown
F400	F401	**Leg ulcers**	
F402	F403	**Treatment for varicose veins**	

PVD and Venous Disease First Opinions	
F404 **Intermittent Claudication**	(0=No, 1=Yes, 2=Maybe, 9=Unknown)
F405 **Venous Insufficiency**	

Comments Peripheral Vascular Disease_____

_____

EXAM 6

Medical History-- Raynaud's and Heart Surgery

|6|0|3|1|1|3| FORM NUMBER (SCREEN 13)

Raynaud's Questions

F406 |__|	Are either your fingertips or toes unusually sensitive to the cold? (0=no, 1=yes, 9=unknown)		
F407 |__|	**Do your fingers ever show unusual color changes?** (0=no, 1=yes, 9=unknown)		
	F408 |__|	At what age did this begin? (99=unkn)	
If yes fill☞	F409 |__|	Do they become white?	(0=no, 1=yes, 9=unknown)
	F410 |__|	Do they become blue?	
	F411 |__|	Do they become red?	
	F412 |__|	Have you consulted a doctor for color changes or sensitivity in fingers?	
F413 |__|	**Have you ever used vibrating power tools?** (0=no, 1=yes, 9=unk)		
If yes fill☞	F414 |__|	Used vibrating power tools at home	(0=no, 1=yes, 9=unk)
	F415 |__|	Used vibrating power tools at work	

History of Heart Surgery (Not Coronary Surgery)

If unsure, please write in comments for later coding

Valve Procedure	Aortic	Mitral	Tricuspid	Pulmonic
0 =No or none 1 =Mechanical (Bjork, Starr Edwards 2 =Bioprosthesis (Pig, homograft) 3 =Commissurotomy, Balloon valvuloplasty 4 =Repair (NOT A commusurotomy 5 =Other-Specify _____ 9 =Unknown	F416 |__|	F417 |__|	F418 |__|	F419 |__|
Year Performed	19|F420	19|F421	19|F422	19|F423

Comments_____

_____

_____

EXAM 6 ,

Medical History-- CHD and Complications

|6|0|3|1|4| FORM NUMBER (SCREEN 14)

Coding: 0=No, 1=Yes 2=Maybe, 9=Unkn	Cardiovascular Procedure
F424 |__| if yes fill☞	**Exercise Tolerance Test (most recent only)**
	19|F425| Year done Location_____
F426 |__| if yes fill☞	**Coronary arteriogram (most recent only)**
	19|F427| Year done (99=unknown)
F428 |__| if yes fill☞	**Coronary artery angioplasty**
	19|F429| Year first done (99=unknown)
	|F430| Type of procedure (0=none, 1=balloon, 2=other_____ 9=unkn),
F431 |__| if yes fill☞	**Coronary bypass surgery**
	19|F432| Year first done (99=unknown)
F433 |__| if yes fill☞	**Permanent pacemaker insertion**
	19|F434| Year first done (99=unknown)
F435 |__| if yes fill☞	**Carotid artery surgery**
	19|F436| Year first done (99=unknown)
F437 |__| if yes fill☞	**Thoracic aorta surgery**
	19|F438| Year first done (99=unknown)
F439 |__| if yes fill☞	**Abdominal aorta surgery**
	19|F440| Year first done (99=unknown)
F441 |__| if yes fill☞	**Femoral or lower extremity surgery**
	19|F442| Year first done (99=unknown)
F443 |__| if yes fill☞	**Lower extremity amputation**
	19|F444| Year first done (99=unknown)

Cardiovascular Procedures Summary
Please list all subsequent cardiovascular procedures

Date	Hospital	Type of Procedure
__/__/F445	F446	F447
__/__/F448	F449	F450
__/__/F451	F452	F453
__/__/F454	F455	F456

EXAM 6 ,

Cancer Site or Type

|6|0|3|1|1|5| FORM NUMBER (SCREEN 15)

F457 |__| **Have you ever 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.
F458	|__|	Esophagus			
F459	|__|	Stomach			
F460	|__|	Colon			
F461	|__|	Rectum			
F462	|__|	Pancreas			
F463	|__|	Larynx			
F464	|__|	Trachea/Bronchus/Lung			
F465	|__|	Leukemia			
F466	|__|	Skin			
F467	|__|	Breast			
F468	|__|	Cervix/Uterus			
F469	|__|	Ovary			
F470	|__|	Prostate			
F471	|__|	Bladder			
F472	|__|	Kidney			
F473	|__|	Brain			
F474	|__|	Lymphoma			
F475	|__|	Other/Unknown _____			

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

_____

_____

_____

_____

_____

EXAM 6 ,

Physical Exam--Head, Neck and Respiratory

|6|0|3|1|1|6| FORM NUMBER (SCREEN 16)

Physician Blood Pressure (first reading)	Systolic	Diastolic
	F476 |__|__|__| to nearest 2 mm Hg	F477 |__|__|__| to nearest 2 mm Hg

Eyes and Xanthomata

|__| F478 **Corneal arcus** (0=No, 1=Slight, 2=Moderate, 3=Marked, 9=Unknown)

|__| F479 **Xanthelasma** (0=No, 1=Yes, 2=Maybe, 9=Unknown)

|__| F480 **Xanthomata** (0=No, 1=Yes, 2=Maybe, 9=Unknown)

If yes, fill ☞

- F481 |__| Achilles tendon xanthomata (0=No, 1=Yes, 2=Maybe, 9=Unknown)
- F482 |__| Palmar xanthomata
- F483 |__| Tuberous xanthomata

Thyroid

F484 |__| **Thyroid abnormality** (0=No, 1=Yes, 2=Maybe, 9=Unknown)

If yes, fill ☞

- F485 |__| Scar
- F486 |__| Other
- F487 |__| Diffuse enlargement
- F488 |__| Single Nodule
- F489 |__| Multiple Nodules

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

Comments about Thyroid_____

_____

Respiratory

|__| F490 **Increased anterior-posterior diameter**

|__| F491 **Fixed thorax**

|__| F492 **Other**

|__| F493 **Wheezing on auscultation**

|__| F494 **Rales**

|__| F495 **Other abnormal breath sounds**

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

Comments about Respiratory_____

_____

EXAM 6 ,

Physical Exam--Heart

|6|0|3|1|1|7| FORM NUMBER (SCREEN 17)

	Heart	
F496 |_|	**Left Heart Enlargement**	This section (0=No, 1=Yes, 9=Unknown)
F497 |_|	**Right Heart Enlargement**	
F498 |_|	**S3Gallop**	
F499 |_|	**S4 Gallop**	
F500 |_|	**Systolic Click**	This section (0=No, 1=Yes, 3=Maybe, 9=Unknown)
F501 |_|	**Diastolic Click**	
F502 |_|	**Abnormally split S2**	
F503 |_|	**Diminished A2**	
F504 |_|	**Neck vein distention at 45 degrees**	
F505 |_|	**Other--Specify** _____	

F506 \|_\| **if yes, fill out below** — **Systolic murmur(s)** (0=No, 1=Yes, 2=Maybe, 9=Unknown)

Murmur Location	Grade (0=No sound 1 to 6 for grade of sound heard)	Type (0=None, 1=Ejection, 2=Regurgitant 3=Other 9=Unknown)	Radiation (0=None, 1=Axilla, 2=Neck, 3=Back, 4=Rt chest, 9=Unknown	Valsalva (0=Nochange, 1=Increase 2=Decrease 9=Unknown)	Origin (0=None,indet. 1=Mitral 2=Aortic 3=Tricuspid 4=Pulm 9=Unknown)
Apex	F507 |_|	F508 |_|	F509 |_|	F510 |_|	F511 |_|
Left Sternum	F512 |_|	F513 |_|	F514 |_|	F515 |_|	F516 |_|
Base	F517 |_|	F518 |_|	F519 |_|	F520 |_|	F521 |_|

F522 \|_\| **Diastolic murmur(s)** (0=No, 1=Yes, 2=Maybe, 9=Unknown)

if yes, fill ☞ F523 \|_\| Valve of origin for diastolic murmur(s) (0=No, 1=Mitral, 2=Aortic, 3=Both, 4=Other, 8=N/A, 9=Unk)

Comments_____

EXAM 6 ,

Physical Exam--Breasts and Abdomen

|6|0|3|1|1|8| FORM NUMBER (SCREEN 18)

	Breast Abnormality (complete for men and women)
F524	**Breast Abnormality** (0=No, 1=Yes, 9=Unknown)
if Yes, fill☞	F525 **Localized mass**
	F526 **Axillary nodes**

Breast Surgery (complete for men and women)			
F527	**Breast Surgery** (0=No, 1=Yes, 9=Unknown)		
if Yes, fill☞	**Left**	**Right**	
	F528	F529	**Procedure** Use lowest code: (0=No, 1=Radical mastectomy, 2=Simple mastectomy, 3=Biopsy, 4=Lump removal, 5=Cosmetic, 9=Unknown)

Comments about abnormality: _____

_____

Abdominal Abnormalities		
F530 __	**Liver enlarged**	(0=No, 1=Yes, 2=Maybe, 9=Unknown)
F531 __	**Surgical scar**	
F532 __	**Abdominal aneurysm**	
F533 __	**Bruit**	
F534 __	**Surgical gallbladder scar**	
F535 __	**Other abdominal abnormality:**	(0=No, 1=Yes, 2=Maybe, 9=Unknown)

_____

_____

EXAM 6

Physical Exam--Peripheral Vessels--Part I

|6|0|3|1|9| FORM NUMBER (SCREEN 19)

Left	Right	Varicosities	
_|F536	_|F537	**Stem**	0=No abnormality 1=Uncomplicated 2=With skin changes 3=With ulcer 9=Unknown
_|F538	_|F539	**Reticular**	
_|F540	_|F541	**Spider**	

Left	Right	Lower Extremity Abnormalitiess	
F542	F543	**Ankle edema**	(0=No, 1=Yes, 2=Maybe, 8=absent due to amputation 9=Unknown)
F544	F545	**Foot cold**	
F546	F547	**Amputation**	
F548	F549	**Amputation level**	(0=No, 1=Toes only, 2=Ankle, 3=Knee,4=Hip, 8=Not applicable, 9=Unknown)

Comments_____

EXAM 6

Physical Exam--Peripheral Vessels--Part II

|6|0|3|2|0| **FORM NUMBER** **(SCREEN 20)**

Artery	Pulse (0=Normal, 1=Abnormal, 9=Unknown)		Bruit (0=Normal, 1=Abnormal, 9=Unknown)	
	Left	Right	Left	Right
Radial	F550 |__|	F551 |__|		
Femoral	F552 |__|	F553 |__|	F554 |__|	F555 |__|
Mid-Thigh			F556 |__|	F557 |__|
Popliteal			F558 |__|	F559 |__|
Post Tibial	|__| F560	|__| F561		
Dorsalis Pedis	|__| F562	|__| F563		

(For intermittent claudication and chronic venous insufficiency - See history questions)

Comments_____

EXAM 6

Physical Exam--Neurological and Final Blood Pressure

|6|0|3|2|1| FORM NUMBER (SCREEN 21)

Neurological Exam			
Left	Right		
|__|F564	|__|F565	Carotid Bruit	
F566 |__|		Speech disturbance	Coding entire section (0=No, 1=Yes, 2=Maybe, 9=Unknown)
F567 |__|		Disturbance in gait	
F568 |__|		Localized muscle weakness	
F569 |__|		Visual disturbance	
F570 |__|		Abnormal reflexes	
F571 |__|		Cranial nerve abnormality	
F572 |__|		Cerebellar signs	
F573 |__|		Sensory impairment	

Stroke and Parkinson's Disease Physical Exam Opinions	
|__|F574 1st Examiner believes residual of stroke	(0=No,1=Yes,2=Maybe,9=Unknown)
|__|F575 1st Examiner believes Parkinson's Disease	

Comments about Neurological findings_____

_____

_____

_____

_____

_____

Physician Blood Pressure (second reading)	Systolic	Diastolic
	F576 |__|__|__|	F577 |__|__|__|
	to nearest 2 mm Hg	to nearest 2 mm Hg

EXAM 6

Electrocardiograph--Part I

|6|0|3|2 |2 | **FORM NUMBER** **(SCREEN 22)**

F578 |__|
if Yes, fill out rest of form

ECG done (0=No, 1=Yes)

Rates and Intervals

F579 |__|__|__| **Ventricular rate per minute** (999=Unknown)

F580 |__|__| **P-R Interval** **(hundreths of a second)** (99=FullyPaced, Atrial Fib, or Unknown)

F581 |__|__| **QRS interval** **(hundreths of second)** (99=Fully Paced, Unknown)

F582 |__|__| **Q-T interval** **(hundreths of second)** (99=Fully Paced, Unknown)

F583 |__|__|__|__| **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

F584 |__|

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

F585 |__| **IV Block** (0=No, 1=Yes, 9=Fully paced or Unknown)

if yes, fill to right

F586 |__| **Pattern** (1=Left, 2=Right, 3=Indeterminate)

F587 |__| **Complete** **(QRS interval=.12 sec or greater)**(0=No, 1=Yes, 9=Unknown)

F588 |__| **Incomplete** **(QRS interval = .10 or .11 sec)** (0=No, 1=Yes, 9=Unknown)

F589 |__| **Hemiblock** (0=No, 1=Left Ant, 2=Left Post, 9=Fully paced or Unknown)

F590 |__| **WPW Syndrome** (0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unknown)

Arrhythmias

F591 |__| **Atrial premature beats** (0=No, 1=Atr, 2=Atr Aber, 9=Unknown)

F592 |__| **Ventricular premature beats** (0=No, 1=Simple, 2=Multifoc, 3=Pairs, 4=Run, 5=R on T, 9=Unk)

F593 |__|__| **Number of ventricular premature beats in 10 seconds** (see 10 second rhythm strip)

EXAM 6 ,

Electrocardiograph-Part II

|6|0|3|2|3| FORM NUMBER (SCREEN 23)

	Myocardial Infarction Location	
F594 |__|	Anterior	(0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unknown)
F595 |__|	Inferior	
F596 |__|	True Posterior	
	Left Ventricular Hypertrophy Criteria	
F597 |__|	R > 20mm in any limb lead	(0=No, 1=Yes, 9=Fully paced, Complete LBBB or Unk)
F598 |__|	R > 11mm in AVL	
F599 |__|	R in lead I plus S ≥ 25mm in lead III	
	Measured Voltage	
*|F|600	R AVL in mm (at 1 mv = 10 mm standard) Be sure to code these voltages	
*|F|601	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	
F|602	R≥ 25mm	(0=No, 1=Yes, 9=Fully paced, Complete LBBB or Unk)
F|603	S≥= 25mm	
F|604	R or S ≥ 30mm	
F|605	R + S ≥ 35mm	
F|606	Intrinsicoid deflection ≥ .05 sec	
F|607	ST depression	
	Hypertrophy, enlargement, and other ECG Diagnoses	
F608 |__|	Nonspecific S-T segment abnormality	(0=No, 1=Yes, 2=Maybe, 9=Paced or Unk)
F|609	Nonspecific T-wave abnormality	
F610 |__|	U-wave present	
F611 |__|	Atrial enlargement (0=None, 1=Left, 2=Right, 3=Both, 9=Atrial fib. or Unknown)	
F612 |__|	RVH (0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unknown; If complete RBBB present, RVH=9)	
F613 |__|	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 6 ,

Clinical Diagnostic Impression--Part I

|6|0|3|2|4| FORM NUMBER (SCREEN 24)

Coronary Heart Disease First Examiner Opinions		
F614	Angina Pectoris	0=No, 1=Yes, 2=Maybe, 9=Unknown
F615	Coronary Insufficiency	
F616	Myocardial Infarct	

Other Heart Diagnoses First Examiner Opinions		
F617	Rheumatic Heart Disease	0=No, 1=Yes, 2=Maybe, 9=Unknown
F618	Aortic Valve Disease	
F619	Mitral Valve Disease	
F620	Other Heart Disease (includes congenital)	
F621	Congestive Heart Failure	
F622	Arrhythmia	
F623	Functional Class-New York Heart Assoc. Classification 0=None 1=Ordinary physical activity, does not cause symptoms 2=Ordinary physical activity, results in symptoms 3=Less than ordinary physical activity results in symptoms 4=Any physical activity results in symptoms	

Comments CDI Heart

EXAM 6

Clinical Diagnostic Impression--Part II

|6|0|3|2|5| FORM NUMBER (SCREEN 25)

Peripheral Vascular Disease First Examiner Opinions

|F624	Intermittent Claudication	0=No, 1=Yes, 2=Maybe, 9=Unknown
|F625	Other Peripheral Vascular Disease	
|F626	Stem Varicose Veins	
|F627	Phlebitis	
|F628	Other Vascular Diagnosis	

(Specify)_____

Cerebrovascular Disease First Examiner Opinions

|F629	Stroke	0=No, 1=Yes, 2=Maybe, 9=Unknown
|F630	Transient Ischemic Attack (TIA)	
|F631	Dementia	
|F633	Parkinson's Disease	
|F633	Other Neurological Disease	

(Specify)_____

Comments CDI Neurological_____

EXAM 6

Clinical Diagnostic Impression--Part III

|6|0|3|2|6| FORM NUMBER (SCREEN 26)

Non Cardiovascular Diagnoses First Examiner Opinions		
|FG34	Diabetes Mellitus	0=No, 1=Yes, 2=Maybe, 9=Unknown
|F635	Urinary Tract Disease	
|F636	Prostate Disease	
|F637	Renal Disease	
|F638	Emphysema	
|F639	Chronic Bronchitis	
|F640	Pneumonia	
|F641	Asthma	
|F642	Other Pulmonary Disease	
|F643	Gout	
|F644	Degerative joint disease	
|F645	Rheumatoid arthritis	
|F646	Gallbladder disease	
|F647	Other non C-V diagnosis (for cancer, see special screen)	

Comments CDI Other Diagnoses_____

EXAM 6 ,

Second Examiner Opinions in Interim

|6|0|3|2|7| FORM NUMBER (SCREEN 27)

F648	2nd Examiner ID Number	2nd Examiner Last Name

Coronary Heart Disease Second Examiner Opinions

F649	Congestive Heart Failure	0=No, 1=Yes, 2=Maybe, 9=Unknown
F650	Cardiac Syncope	
F651	Angina Pectoris	
F652	Coronary Insufficiency	
F653	Myocardial Infarct	

Comments about chest and heart disease

Intermittent Claudication Second Examiner Opinions

F654	Intermittent Claudication	0=No, 1=Yes, 2=Maybe, 9=Unknown

Comments about peripheral vascular disease

Cerebrovascular Disease Second Examiner Opinions

F655	Stroke	0=No,1=Yes, 2=Maybe, 9=Unknown
F656	TIA	

Comments about possible Cerebrovascular Disease

EXAM 6 ,

Cancer Screening Information

|6|0|1|1|0|3 FORM NUMBER

Women Only

F657 Yes No Unsure Unknown Man circle, and if yes, fill to right

Have you ever had a mammogran?

19 |__|__| F658 Year of last mammogram? (00=not done, 99=Unknown)

|__| F659 How many mammograms have you had in the past five years? (0=None, 1-5 for number, 6=6+, 9=Unknown)

F660 Yes No Unsure Unknown Man circle, and if yes, fill to right

A clinical breast exam is when a doctor, nurse, or other health professional feels the breast for lumps. Have you ever had a clinical breast exam?

19 |F661| Year of last breast exam? (00=not done, 99=Unknown)

|F662 How many breast exams have you had in the past five years? (0=None, 1-5 for number, 6=6+, 9=Unknown)

F663 Yes No Unsure Unknown Man circle, and if yes, fill to right

A Pap smear is a test for cancer of the cervix. Have you ever had a Pap smear?

19 |F664| Year of last Pap smear? (00=not done, 99=Unknown)

|F665 How many Pap smears have you had in the past five years? (0=None, 1-5 for number, 6=6+, 9=Unknown)

Men Only

F666 Yes No Unsure Unknown Woman circle, and if yes, fill to right

Have your ever had a blood test for prostate cancer? (Prostate specific antigen)

19 |F667| Year when blood test for prostate cancer last done? (00=not done, 99=Unknown)

|F668 How many times was a blood test for prostate cancer done during the past five years? (0=None, 1-5 for number, 6=6+, 9=Unknown

Men and Women

F669 Yes No Unsure Unknown circle, and if yes, fill to right

Have you ever had a rectal exam?

19 |F670| Year of last rectal exam? (00=not done, 99=Unknown)

|F671 How many rectal exams during the past five years? (0=None, 1-5 for number, 6=6+, 9=Unknown)

F672 Yes No Unsure Unknown circle, and if yes, fill to right

Have you ever had your stool tested for blood?

19 |F673| Year when stool last tested for blood? (00=not done, 99=Unknown)

|F674 How many times stool tested for blood during the past five years? (0=None, 1-5 for number, 6=6+, 9=Unknown)

F675 Yes No Unsure Unknown circle, and if yes, fill to right

Have you ever had a sigmoidoscopy exam? (tube with light that looks up the rectum)

19 |F676| Year when sigmoidoscopy last done? (00=not done, 99=Unknown)

F677 How many times was a sigmoidoscopy done during the past five years? (0=None, 1-5 for number, 6=6+, 9=Unknown)

EXAM 6 ,

Prostate Symptoms

|6|0|1|1|0|4 FORM NUMBER

Men Only								
Questions to be answered **Circle best answer for each question**	**Not at all**	**Less than 1 time in five**	**Less than half the time**	**About half the time**	**More than half the time**	**Almost always**	**Female**	**Unknown**
	0	**1**	**2**	**3**	**4**	**5**	**8**	**9**
1. Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating? F678	0	1	2	3	4	5	8	9
2. Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating F679	0	1	2	3	4	5	8	9
3. Over the past month, how often have you found you stopped and started again several times when you urinated? F680	0	1	2	3	4	5	8	9
4. Over the past month, how often have you found it difficult to postpone urination? F681	0	1	2	3	4	5	8	9
5. Over the past month, how often have you had a weak urinary stream? F682	0	1	2	3	4	5	8	9
6. Over the past month, how often have you had to push or strain to begin urination? F683	0	1	2	3	4	5	8	9
7. Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning? F684	0	1	2	3	4	5	8	9

American Urological Assocation Symptom Index for prostate hypertrophy after Barry, Fowler, O'Leary 1992

EXAM 6 ,

Awareness of Coronary Factors

|6|0|1|1|0|5 FORM NUMBER

Heart Disease and Factors for Self and Family

	Father (circle best answers below)	Mother (circle best answers below)
Did your parents...	**Father's Name** F685 (first) F686 (last)	**Mother's Name** F694 (first) F695 (last)
Ever have high blood pressure	No Yes Unsure Unknown F687	No Yes Unsure Unknown F696
Ever have high blood cholesterol (>240 mg/dL)	No Yes Unsure Unknown F688	No Yes Unsure Unknown F697
Ever have diabetes mellitus	No Yes Unsure Unknown F689	No Yes Unsure Unknown F698
Have a heart attack before age 55	No Yes Unsure Unknown F690	No Yes Unsure Unknown F699
Have heart bypass surgery before age 55	No Yes Unsure Unknown F691	No Yes Unsure Unknown F700
Have a stroke before age 65	No Yes Unsure Unknown F692	No Yes Unsure Unknown F701
Die of heart disease	No Yes Unsure Unknown F693	No Yes Unsure Unknown F702

	Yourself (circle best answers below)	Current or most recent Spouse Spouse's Name F709 Age F710 F711 (circle best answers below)
Did you or your spouse...		
Ever have high blood pressure	No Yes Unsure Unknown F703	No Yes Unsure Unknown F712
Ever have high blood cholesterol (>240 mg/dl)	No Yes Unsure Unknown F704	No Yes Unsure Unknown F713
Ever have diabetes mellitus	No Yes Unsure Unknown F705	No Yes Unsure Unknown F714
Have a heart attack before age 55	No Yes Unsure Unknown F706	No Yes Unsure Unknown F715
Have heart bypass surgery before age 55	No Yes Unsure Unknown F707	No Yes Unsure Unknown F716
Have a stroke before age 65	No Yes Unsure Unknown F708	No Yes Unsure Unknown F717
Die of heart disease		No Yes Unsure Unknown F718

Framingham Heart Study
Lipid and Glucose Data

Id: Exam Date

F726 Total Cholesterol (mg/dL)

Cholesterol to HDL Ratio

F725 HDL Cholesterol (mg/dL)

HDL-3 Cholesterol (mg/dL)

F727 Triglycerides (mg/dL)

F724 Glucose - Baseline (mg/dL)

Glucose - 2 Hour (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

Triglycerides over 200 (mg/dL) are considered elevated.

Glucose Tolerance Test

Level	Baseline sample	Level	2 Hour sample
<50	Hypoglycemia	<50	Hypoglycemia
50-110	Normal	<50-140	Normal
110-140	Borderline hyperglycemia	140-200	Borderline hyperglycemia
>140	Definite hyperglycemia (follow-up recommended)	>200	Definite hyperglycemia (follow-up recommended)