EXAM 8 **28**

Medical History—Hospitalizations, ER Visits, MD Visits

Offspring EXAM8 **DATE** _____

NOTE: THE FORM USED FOR THE OMNI 1 EXAM 3 COHORT WAS SIMILAR TO THE OFFSPRING EXAM 8 FORM.

OMB NO=0925-0216 12/31/2007

Last exam on:

Last Health History Update on:

Health Care

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

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

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

MD01

Medical History—Medications

OMB NO=0925-0216 12/31/2007

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

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

MD02

Medical History – Prescription and Non-Prescription Medications

OMB NO=0925-0216 12/31/2007

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

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

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

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

Continue on the next page ⇢

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

OMB NO=0925-0216 12/31/2007

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

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

Medication Name (Print first 20 letters)	**Strength** (include mg, IU, etc)	**Number per** (day/week/month) (circle one)		**Prn** (0 = no, 1 = yes, 9 = unkn)
Example	**100 / mg**	**1**	**(D)WM**	**0**
			DWM	
	/		**DWM**	
	/		**DWM**	
	/		**DWM**	
	/		**DWM**	
	/		**DWM**	
	/		**DWM**	
	/		**DWM**	
	/		**DWM**	

MD04

Medical History–Female Reproductive History. Part 1.

OMB NO=0925-0216 12/31/2007

If participant is male, leave questions blank

h024 If yes, fill☞

1. Since your last exam have you taken or used oral contraceptive pills, shots, or hormone implants for birth control or medical indications (not post menopausal hormone replacement)? **(0=no, 1=yes, now, 2=yes, not now, 9=unknown)**

What is the name of the current or most recent **oral contraceptive, shot or implant used?**

_____ **h025** **Name**

_____ **h026** ____ **Strength**

h027 **Form** **(1=pill, 2=shot, 3=patch, 4=implant)**

h028/h029 ____/_____, **h030/h031** ____/_____ **Duration of use** **(mo/yr began, mo/yr ended, year – 4 digits)** **99/9999=Unknown,** 88/8888=current user

h773 If yes, fill☞

2,Have you ever been pregnant? **(0=no, 1=yes, 9=Unkn))**

h774 **Number of pregnancies?**

h775 **Number of live births?**

h776 **How old were you at the end of your first term pregnancy?** **99=unknown**

h777 **How old were you at the end of your last term pregnancy?** **99=unknown**

h778 **During any of these pregnancies, were you told you had high blood pressure (hypertension)? (0=no,1=yes,1st pregnancy only,2=yes, not 1st pregnancy,3=yes,1st & subsequent pregnancy, 9=unknown)**

h779 **During any of these pregnancies, were you told you had high blood sugar (gestational diabetes)? (0=no,1=yes,1st pregnancy only,2=yes, not 1st pregnancy,3=yes,1st & subsequent pregnancy, 9=unknown)**

h032 If yes, fill☞

3. Have you had a hysterectomy (uterus/womb removed)since your last exam? **(0=no, 1=yes, 9=unknown)**

h033 **Age at hysterectomy?**

h034/h035 _ _/_ _ _ _ **Date of surgery (mo/yr)** **Use 4 digits for year** **99/9999=Unknown**

h036 If yes, fill☞

4. Since your last exam have you had an operation to remove one or both of your ovaries? **(0=no, 1=yes, one ovary removed, 2=yes, two ovaries removed, 3=yes, unknown number of ovaries removed, 4=yes, part of an ovary removed, 9=unknown)**

h037 **Age when ovaries removed? If more than one surgery,** use age at last surgery

Medical History–Female Reproductive History. Part 2.

OMB NO=0925-0216 12/31/2007

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

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

IF PERIODS NOT STOPPED (pre-menopausal, pregnant, breast feeding!)

h039/ h040/ h041 _____/_____/_____	**When was the first day of your last menstrual period?** (Use 4 digits for year, 99/9999=Unknown)
h042	**How many periods have you had in past 12 months?**

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

h043			**a) Age when periods stopped** (00=not stopped, 99 = unknown) If periods now induced by hormones, code age when periods naturally stopped
h044			**b) Was your menopause natural or the rest of surgery, chemotherapy, or radiation?** (1 = natural, 2 = surgical, 3 = chemo/radiation, 4 = other, 9 =unknown)
h045			**c) Since your last exam have you taken hormone replacement therapy?** (estrogen/progesterone) (0 = no, 1 = yes, now, 2 = yes, not now. 9 = unknown)
If yes, fill☞	h046		**What age did you begin hormone replacement therapy?** 99 =unknown
	h047 years h048 months		**For how long did you take hormones?** 99 = unknown
	h049		**Estrogen use?** (0 = no, 1 = yes, now, 2 = yes, not now, 9 = unknown)
	If yes, fill☞	h050	_____Name of most recent estrogen preparation
		h051	_____Strength
		h052	_____Number of days per month taken
	h053		**Progesterone use?** (0 = no, 1 = yes, now, 2 = yes, not now, 9 = unknown)
	If yes, fill☞	h054	_____Name of most recent progesterone preparation
		h055	_____Strength
		h056	_____Number of days per month taken
h057			**d) Have you used Evista (raloxifene) or Nolvadex (tamoxifen) or other selective estrogen receptor modulator (SERM)?** (0 = no, 1 = yes, now, 2 = yes, not now, 9 = unknown)
If yes, fill☞	h058		**Number of months used**
	h059		**Current use?** (0 = no, 1 = yes, raloxifene, 2 = yes, tamoxifen, 3 = yes, other, 9 = unknown)

MD06

Medical History--Smoking

OMB NO=0925-0216 12/31/2007

Cigarettes

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

Other

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

Medical History –Alcohol Consumption

OMB NO=0925-0216 12/31/2007

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

Drink? 0=No, 1=Yes, 9=Unk	Beverage	If yes, complete for number of drinks in a typical week/month over past year. *Code EITHER per week OR per month as appropriate.*	Number of drinks: Per week OR Per month 999=Unknown	
h071	Beer	12oz bottle, glass, can	**h072**	**h073**
h074	Wine	4oz glass	**h075**	**h076**
h077	Liquor/spirits	1 ¼ oz jigger	**h078**	**h079**

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

Medical History—Respiratory Symptoms. Part I

OMB NO=0925-0216 12/31/2007

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

MD09

Medical History—Respiratory Symptoms. Part II

OMB NO=0925-0216 12/31/2007

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

Comments_____

_____

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

MD11

Medical History—Chest pain

OMB NO=0925-0216 12/31/2007

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

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

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

Comments_____

_____

_____

MD12

Medical History—Atrial Fibrillation/Syncope

OMB NO=0925-0216 12/31/2007

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

h141	**Since your last exam have you fainted or lost consciousness?** If event immediately preceded by head injury or accident code 0=No)		Code: 0=No,1=Yes, 2=Maybe,9=Unknown
if yes, fill all☞	h142	Number of episodes in the past two years	999=Unknown
	_____/_____ h143/h144	Date of first episode (use 4 digits for year, i.e. 1998)	mo/yr, 99/9999=Unknown
	h145	Usual duration of loss of consciousness	(minutes, 999=Unkn) 1=1 min or less
	h146	**Did you have any injury caused by the event?** (0=No,1=Yes, 2=Maybe,9=Unkn)	
	h147	**ER/hospitalized or saw M.D**. (0=No, 1=Hosp/ER, 2=Saw M.D., 9=Unkn) Hospitalized at: _____ M.D. seen: _____	
h148	**History (since your last exam) of having a head injury with loss of consciousness** (0=No, 1=Yes, 2=Maybe, 9=Unknown)		
if yes, fill☞	____/_____/_____ h149/h150/h151	Date of serious head injury with loss of consciousness (00/00/0000 =none, 99/99/9999=unk, Use 4 digits for year)	
h152	**History of a seizure disorder**. Since your last exam have you had a seizure? (0=No, 1=Yes, 2=Maybe, 9=Unknown)		
if yes, fill☞	____/_____/_____ h153/h154/h155	Date of most recent seizure (99/99/9999=unk) code four digit year	
	h156	Are you being treated for a seizure disorder? (0=No, 1=Yes, 2=Maybe, 9=Unknown)	

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

Comments:_____

Medical History—Cerebrovascular, Neurological and Venous Diseases

OMB NO=0925-0216 12/31/2007

Cerebrovascular Episodes Since Your Last Exam		
h161	**Sudden muscular weakness**	Code: 0=No, 1=Yes, 2=Maybe, 9=Unknown
h162	**Sudden speech difficulty**	
h163	**Sudden visual defect**	
h164	**Sudden double vision**	
h165	**Sudden loss of vision in one eye**	
h166	**Sudden numbness, tingling**	
if yes, fill ☞	h167 **Numbness and tingling is positional**	
h168	**Head CT or MRI scan other than for the FHS date:** _h168a_-_h168b__-_h168c__ **Place** h168d	0=No, 1=Yes, 2=both, 9=Unkn
h169	**Seen by neurologist**(write in who and when below)	Code: 0=No, 1=Yes, 2=Maybe, 9=Unknown
h170	**Have you been told by a doctor you had a stroke or TIA (transient ischemic attack, mini-stroke)?**	
h171	**Have you been told by a doctor you have Parkinson Disease?**	
h172	**Have you been told by a doctor you have memory problems, dementia or Alzheimer's disease?**	
h173	**Do you feel or do other people think that you have memory problems that prevent you from doing things you've done in the past?**	

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

Neurology Comments: _____

_____

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

MD14

Medical History--Peripheral Arterial Disease

OMB NO=0925-0216 12/31/2007

Peripheral Arterial Disease

h183 **Do you have discomfort in your legs while walking?** (0=No, 1=Yes, 9=Unkn)

if yes fill☞

h184 **If walking on level ground, how many city blocks until symptoms develop** (00=no, 99=unknown) where 10 blocks =1 mile, code as no if more than 98 blocks required to develop symptoms

h185 **Year symptoms started** (Use 4 digits for year ,00=no, 9999=unkn)

Left	Right	Claudication symptoms (0=No, 1=Yes, 9=Unkn)
h186	h187	Discomfort in calf while walking
h188	h189	Discomfort in lower extremity (not calf) while walking
h190		Occurs with first steps (code worse leg)
h191		After walking a while (code worse leg)
h192		Related to rapidity of walking or steepness
h193		Forced to stop walking
h194		Time for discomfort to be relieved by stopping (minutes) (00=No relief with stopping, 88=Not Applicable, 99=Unknown)
h195		Number of days/month of lower limb discomfort (00=No,88=N/A,99=Unk)

h196 **Have you had back pain in the last 12 month?** 0=No, 1=all days, 2=most of the days, 3=some days, 4=a few days

if yes, fill ☞

h197 **What happens to back and any leg pain that goes with it when you walk?** 0=no change, 1=gets worse, 2=gets better, 9=Unknown

h198 **What happens to back and any pain that goes with it when you sit?**

h199 **Have you ever been told by a doctor that you have intermittent claudication or peripheral arterial disease?** 0=No, 1=Yes, 9=Unknown

h200 **Has a doctor ever told you you had spinal stenosis?**

if yes, fill ☞

h201 **Have you had a CT or MRI of your spine?**
Date __h202___-_h203___-__h204_ Location_h204a_____

PAD First Opinion

h205 **Intermittent Claudication** 0=No, 1=Yes, 2=Maybe, 9=Unkn.

Comments Peripheral Vascular Disease / Venous Disease_____

_____

Medical History-- CVD Procedures

OMB NO=0925-0216 12/31/2007

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

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

Comments_____

_____

OMB NO=0925-0216 12/31/2007

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

Write in protocol modification:

_____

Cancer Site or Type

h237 **Since your last exam have you had cancer or a tumor?**
(0=No and skip to next screen; If 1=Yes, 2=Maybe, 9=Unknown please continue)

Code for table:
0=No, 1=Yes, Cancerous, 2=Maybe, Possible Cancer, 3=Benign, 9=Unknown

Code	Site of Cancer or Tumor	Year First Diagnosed	Name Diagnosing M.D.	City of M.D.
h238	Esophagus			
h239	Stomach			
h240	Colon			
h241	Rectum			
h242	Pancreas			
h243	Larynx			
h244	Trachea/Bronchus/Lung			
h245	Leukemia			
h246	Skin			
h247	Breast			
h248	Cervix/Uterus			
h249	Ovary			
h250	Prostate			
h251	Bladder			
h252	Kidney			
h253	Brain			
h254	Lymphoma			
h255	Other/Unknown _____			

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

Physical Exam—Respiratory, Heart, Abdomen

OFFSITE VISIT – leave page BLANK

OMB NO=0925-0216 12/31/2007

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

Heart				
h259	**S3 Gallop**			0=No 1=Yes 9=Unknown
h260	**S4 Gallop**			
h261	**Systolic Click**			0=No, 1=Yes 2=Maybe 9=Unknown
h262	**Neck vein distention at 90 degrees** (sitting upright)			
h263 **if yes, fill out below**	**Systolic murmur(s)** (0=No, 1=Yes, 2=Maybe, 9=Unknown)			
Murmur Location	**Grade** 0=No sound 1 to 6 for grade of sound heard 9=Unknown	**Type** 0=None 1=Ejection 2=Regurgitant 3=Other 9=Unknown	**Radiation** 0=None 1=Axilla 2=Neck 3=Back 4=Rt. chest 9=Unknown	**Origin** 0=None, indet. 1=Mitral 2=Aortic 3=Tricuspid 4=Pulm 9=Unknown
Apex	h264	h265	h266	h267
Left Sternum	h268	h269	h270	h271
Base	h272	h273	h274	h275
h276 **if yes, fill** ☞	**Diastolic murmur(s)** (0=No, 1=Yes, 2=Maybe, 9=Unknown)			
	h277 Valve of origin for diastolic murmur(s) (0=No, 1=Mitral, 2=Aortic, 3=Both, 4=Other, 8=N/A, 9=Unk)			

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

Comments about respiratory, heart, and abdominal abnormalities

_____

_____

_____

MD18

Physical Exam--Peripheral Vessels—Veins and Arterial pulses

OFFSITE VISIT – leave page BLANK

OMB NO=0925-0216 12/31/2007

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

Comments_____

_____

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

Comments_____

_____

_____

MD19

Physical Exam—Neurological Exam

OFFSITE VISIT – leave page BLANK

OMB NO=0925-0216 12/31/2007

Neurological Exam			
Left	**Right**		
h298	**h299**	**Carotid Bruit**	Coding (0=No, 1=Yes, 2=Maybe, 9=Unknown)
	h300	**Speech disturbance**	
	h301	**Disturbance in gait**	
	h302	**Other neurological abnormalities on exam** Specify_____	

MD20

h303	**OFFSITE ONLY** **MD Id#** _____ **MD Name**

	Rates and Intervals
h304	**Ventricular rate per minute** (999=Unknown)
h305	**P-R Interval (hundredths of a second)** (99=Fully Paced, Atrial Fib, or Unknown)
h306	**QRS interval (hundredths of second)** (99=Fully Paced, Unknown)
h307	**Q-T interval (hundredths of second)** (99=Fully Paced, Unknown)
h308	**QRS angle (put plus or minus as needed)** (e.g. -045 for minus 45 degrees, +090 for plus 90, 99999 =Fully paced or Unknown)
	Rhythm--predominant
h309	**0 or 1 = Normal sinus,** (including s.tach, s.brady, s arrhy, 1 degree AV block) **3 = 2nd degree AV block, Mobitz I (Wenckebach)** **4 = 2nd degree AV block, Mobitz II** **5 = 3rd degree AV block / AV dissociation** **6 = Atrial fibrillation / atrial flutter** **7 = Nodal** **8 = Paced** **9 = Other or combination of above (list)**_____
	Ventricular conduction abnormalities
h310	**IV Block** (0=No, 1=Yes, 9=Fully paced or Unknown)
if yes, fill ☞	**h311** **Pattern** (1=Left, 2=Right, 3=Indeterminate, 9=Unknown)
	h312 **Complete (QRS interval=.12 sec or greater)**(0=No, 1=Yes, 9=Unknown)
	h313 **Incomplete (QRS interval = .10 or .11 sec)** (0=No, 1=Yes, 9=Unknown)
h314	**Hemiblock** (0=No, 1=Left Ant, 2=Left Post, 9=Fully paced or Unknown)
h315	**WPW Syndrome** (0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unknown)
	Arrhythmias
h316	**Atrial premature beats** (0=No, 1=Atr, 2=Atr Aber, 9=Unknown)
h317	**Ventricular premature beats** (0=No, 1=Simple, 2=Multifoc, 3=Pairs, 4=Run, 5=R on T, 9 =Unk
h318	**Number of ventricular premature beats in 10 seconds** (see 10 second rhythm strip)

Electrocardiograph-Part II

OMB NO=0925-0216 12/31/2007

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

Comments and Diagnosis_____

_____

Clinical Diagnostic Impression--Part I

OMB NO=0925-0216 12/31/2007

Heart Diagnoses First Examiner Opinions		
h339	Rheumatic Heart Disease	0=No, 1=Yes, 2=Maybe, 9=Unknown
h340	Aortic Valve Disease	
h341	Mitral Valve Disease	
h342	Other Heart Disease (includes congenital)	
h343	Arrhythmia	

Peripheral Vascular Disease First Examiner Opinions		
h344	Other Peripheral Vascular Disease	0=No, 1=Yes, 2=Maybe, 9=Unknown
h345	Other Vascular Diagnosis (Specify)_____	

Neurologic Disease First Examiner Opinions		
h346	Stroke/ TIA	0=No, 1=Yes, 2=Maybe, 9=Unknown
h347	Dementia	
h348	Parkinson's Disease	
h349	Adult Seizure Disorder	
h350	Other Neurological Disease (Specify)_____	

Comments CDI

_____

_____

_____

_____

_____

_____

MD23

Clinical Diagnostic Impression--Part II

Non Cardiovascular Diagnoses First Examiner Opinions

OMB NO=0925-0216 12/31/2007

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

Comments CDI Diagnoses

MD24

Second Examiner Opinions

OFFSITE VISIT – leave page BLANK

OMB NO=0925-0216 12/31/2007

h380	2nd Examiner ID Number	_____2nd Examiner Last Name

Coronary Heart Disease Second Examiner Opinions (Provide initiators, qualities, radiation, severity, timing, presence after procedures done)		
h381	Congestive Heart Failure	0=No, 1=Yes, 2=Maybe, 9=Unknown
h382	Cardiac Syncope	
h383	Angina Pectoris	
h384	Coronary Insufficiency	
h385	Myocardial Infarct	

Comments about chest and heart disease

_____

_____

_____

Intermittent Claudication Second Examiner Opinions (Provide initiators, qualities, radiation, severity, timing, presence after procedures done)		
h386	Intermittent Claudication	0=No, 1=Yes, 2=Maybe, 9=Unknown

Comments about peripheral vascular disease

_____

_____

_____

Cerebrovascular Disease Second Examiner Opinions (Provide initiators, qualities, severity, timing, presence after procedures done)		
h387	Stroke	0=No, 1=Yes, 2=Maybe, 9=Unknown
h388	TIA	

Comments about possible Cerebrovascular Disease

_____

_____

_____

MD25

Numerical Data--Part I

OMB NO=0925-0216 12/31/2007

Basic Information

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

Regional Anthropometry

(Code boxes below with 9's if not done or unknown)

h402	**Examiner's Number for anthropometry**		
h403	**Waist Girth at umbilicus** (inches, to next lower 1/4 inch)	h404 **Protocol modification**	0=No 1=Yes 8=Offsite
h405	**Waist Girth at iliac crest** (inches, to next lower 1/4 inch)	h406 **Protocol modification**	
h407	**Sagittal abdominal diameter** (to nearest 0.1 cm)	h408 **Protocol modification**	
h409	**Are you fasting ≥ 8 hours?**		

Comments on all protocol modifications:

_____

_____

_____

TECH01

OMB NO=0925-0216 12/31/2007

Exam 8 Procedures Sheet

h410	**Informed Consent Signed**	0=No, 1=Yes, 2=Consent signed, may qualify for waiver, 3=Waiver used, 4=Other
h411	**Anthropometry**	0=No, 1=Yes, 8=Offsite visit
h412	**Sociodemographic Questions**	
h413	**SF-12 Health Survey**	
h414	**CES-D Scale**	
h415	**Exercise Questionnaire**	
h416	**Mini-Mental Status Exam**	
h417	**Urine Specimen**	
h418	**Blood Draw**	
h419	**ECG**	
h420	**Observed performance** (Timed walk hand grip)	
h421	**Tonometry /ECHO/Carotid**	
h422	**Ankle-brachial blood pressure by Doppler**	
h423	**Spirometry**	
h424	**Post bronchodilator Spirometry**	
h425	**Diffusion Capacity**	
h426	**Reason Spirometry not done**	1=Major Surgery , 2=Heart Attack, 3=Stroke, 4=Aneurysm, 5=BP>210/110, 6=Refused, 7=Test Aborted, 8=Other, 10=equipment problems
h427	**Reason post bronchodilator test not done**	
h428	**Reason Diffusion not done**	

Exit Interview

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

TECH02

For Participants Wish to Complete Their Exam on a Second Visit

OMB NO=0925-0216 12/31/2007

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

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

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

Exam 8 Procedures Sheet

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

TECH02a

Rosow-Breslau Scale

OMB NO=0925-0216 12/31/2007

h458	**Examiner's Number** for Socio-demographics

Socio-demographics

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

Use of Nursing and Community Services

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

Rosow-Breslau Questions

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

CES-D Scale

The questions below ask about your feelings.

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

TECH03

Katz Activities of Daily Living Scale

OMB NO=0925-0216 12/31/2007

h473	**Examiner's Number** for Activities of Daily Living

During the Course of a Normal Day, Can you do the following activities independently or do you need human assistance or the use of a device? Coding: 0=No help needed, independent, 1=Uses device, independent, 2=Human assistance needed, minimally dependent, 3=Dependent, 4=Do not do during a normal day, 9=Unknown

h474	**Dressing** (undressing and redressing) Devices such as: velcro, elastic laces;
h475	**Bathing** (including getting in and out of tub or shower) Devices such as: bath chair, long handled sponge, hand held shower, safety bars
h476	**Eating** Devices such as: rocking knife, spork, long straw, plate guard.
h477	**Transferring** (getting in and out of a chair) Devices such as: sliding board, grab bars, special seat**;**
h478	**Toileting Activities** (using bathroom facilities and handle clothing) Devices such as: special toilet seat, commode;

TECH04

Physical Activity Questionnaire--Framingham Heart Study
Tech-administered

OMB NO=0925-0216 12/31/2007

h479	**Examiner ID**

Rest and Activity for a Typical Day (Activities must equal 24 hours)	**Number of hours**
Sleep--Number of hours that you typically sleep?	h480
Sedentary Number of hours typically sitting?	h481
Slight Activity - Number of hours with activities such as standing, walking?	h482
Moderate Activity - Number of hours with activities such as housework (vacuum, dust, yard chores, climbing stairs; light sports such as bowling, golf)?	h483
Heavy Activity - Number of hours with activities such as heavy household work, heavy yard work such as stacking or chopping wood, exercise such as intensive sports--jogging, swimming etc?	h484
Total number of hours (should be the total of above items)	**24**

h485 **What is your normal walking pace outdoors?**

0 = Unable to walk
1 = Easy, casual, slow (less than 2 miles per hour)
2 = Normal, average (2 to 2.9 miles per hour)
3 = Brisk pace (3 to 3.9 miles per hour)
4 = Very brisk pace (4 to 4.9 miles per hour)
9 = Unknown

h486 **How many flights of stairs (not steps) do you climb daily?**(10 stairs per flight)

0 = No flights
1 = 1-2 flights
2 = 3-4 flights
3 = 5-9 flights
4 = 10-14 flights
5 = >15 flights
9 = Unknown

TECH05

Physical Activity Questionnaire--Framingham Heart Study

Tech-administered

OMB NO=0925-0216 12/31/2007

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

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

TECH06

Nagi Questions

OMB NO=0925-0216 12/31/2007

h568	**Examiner's Number** for Activities - Part B

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** **(6) Unable to Assess Difficulty Because not Done as Part of Daily Activities** **(9) Unknown**	
h569	**Pulling or pushing large objects like a living room chair**
h570	**Either stooping, crouching, or kneeling**
h571	**Reaching or extending arms below shoulder level**
h572	**Reaching or extending arms above shoulder level**
h573	**Either writing, or handling, or fingering small objects**
h574	**Standing in one place for long periods, say 15 minutes**
h575	**Sitting for long periods, say 1 hour**
h576	**Lifting or carrying weights under 10 pounds (like a bag of potatoes)**
h577	**Lifting or carrying weights over 10 pounds (like a very heavy bag of groceries)**

TECH07

Falls/Fractures

OMB NO=0925-0216 12/31/2007

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

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

Cognitive Function--Part I

OMB NO=0925-0216 12/31/2007

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

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

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

TECH09

Cognitive Function --Part II

OMB NO=0925-0216 12/31/2007

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

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

TECH10

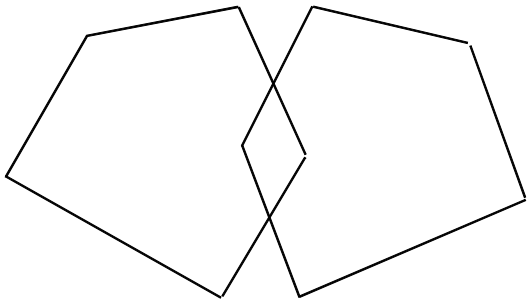
OMB NO=0925-0216 12/31/2007

Sentence and Design Handout for Participant

PLEASE WRITE A SENTENCE

_____
_____
_____
_____
_____
_____

PLEASE COPY THIS DESIGN



Observed Performance - Part 1

OMB NO=0925-0216 12/31/2007

h604	**Examiner's Number**

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

TECH11

Observed Performance - Part 2

OMB NO=0925-0216 12/31/2007

h613	**Examiner's Number**

MEASURED WALKS

Walking aid used: 0=No aid, 1=Cane, 2=Walker, 3=Wheelchair, 4=Other, 9=Unknown **h614**

First Walk

Was this test completed? (0=No, 1=Yes, 8=Not attempted, 9=Unknown) **h615**

If not attempted or completed, why not?
1=Physical limitation 3=Other _____write in **h616**
2=Refused 9=Unknown

Walk time (in seconds, 99.99=Unknown) **h617**

Second Walk

Was this test completed? (0=No, 1=Yes, 8=Not attempted, 9=Unknown**)** **h618**

If not attempted or completed, why not?
1=Physical limitation 3=Other _____write in **h619**
2=Refused 9=Unknown

Walk time (in seconds, 99.99=Unknown) **h620**

Quick Walk

Was this test completed? (0=No, 1=Yes, 8=Not attempted, 9=Unknown) **h621**

If not attempted or completed, why not?
1=Physical limitation 3=Other _____write in **h622**
2=Refused 9=Unknown

Walk time (in seconds, 99.99=Unknown) **h623**

Doppler Ankle Brachial Blood Pressure Measurements. Tech- Obtained

OMB NO=0925-0216 12/31/2007

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

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

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

REPEAT SYSTOLIC BLOOD PRESSURE MEASUREMENTS (reverse order)

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

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

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

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

EXCLUSIONS:

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

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

TECH13

Respiratory Disease Questionnaire - Technician Administered

OMB NO=0925-0216 12/31/2007

Respiratory Diagnoses

h646 **Examiner ID**

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

If yes, fill ☞

h648	Do you still have it?	0=No 1=Yes 88=N/A
h649	Was it diagnosed by a doctor or other health professional?	
h650	At what age did it start? **(Age in years)**	
h651	If you no longer have it, at what age did it stop? **(Age in years)**	
h652	Have you received medical treatment for this in the past 12 months?	

h653 **2. Since your last exam have you had hay fever** (allergy involving the nose and/or eyes)**?** 0=No 1=Yes

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

4. Since your last exam have you had ….

	Condition?	Health professional DX?	Age condition began
	(0=No, 1=Yes)		99=Unk
Chronic Bronchitis	h655	h656	h657
Emphysema	h658	h659	h660
COPD Chronic obstructive pulmonary disease	h661	h662	h663
Sleep Apnea	h664	h665	h666
Pulmonary Fibrosis	h667	h668	h669

Inhaler Use

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

If yes, fill ☞

h671	Do you use any of these medications- Albuterol, Proventil, Ventolin, Combivent, Maxair, Volmax, Xopenex, Bronkoometer, pirbuterol, levalbuterol, or metaproterenol		0=No 1=Yes
If yes, fill ☞	h672	How many hours ago did you last use the medication, either by inhaler or nebulizer? **(Time in hours)**	
h673	Do you take any of the following inhalers? Serevent, Advair, Foradil, salmeterol, or formoterol		0=No 1=Yes
If yes, fill ☞	h674	How many hours ago did you last use the medication? **(Time in hours)**	

TECH14

OMB NO=0925-0216 12/31/2007

Triggered airway symptoms

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

h675	Start to cough?	0=No 1=Yes
h676	Start to wheeze?	
h677	Get a feeling of tightness in your chest?	
h678	Start to feel short of breath?	
h679	Get a runny or stuffy nose or start to sneeze?	
h680	Get itching or watering eyes?	

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

h681	Start to cough?	0=No 1=Yes
h682	Start to wheeze?	
h683	Get a feeling of tightness in your chest?	
h684	Start to feel short of breath?	
h685	Get a runny or stuffy nose or start to sneeze?	
h686	Get itching or watering eyes?	
h687	**3. Do you currently have a cat, dog, or other furry pets living in your home?**	0=No 1=Yes

TECH15

Proxy form

OMB NO=0925-0216 12/31/2007

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

TECH016

Sociodemographic questions - Part I Self-administered

OMB NO=0925-0216 12/31/2007

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

TECH17

Sociodemographic Questionnaire. Part II. Self-administered

h710	What is your current occupation? **Write in** _____
h711	Using the occupation coding sheet choose the code that best describes your occupation.

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

Sociodemographic Questionnaire. Part III Self-administered.

1. Where were you born? *(check only ONE)*

h780 1. One of the 50 US states
If checked, fill ☛ **Please specify state** **h781**
h782 2. Puerto Rico
If checked, fill ☛ **How many years have you lived in the United States?** **h783**
h784 3. Another Country
If checked, fill ☛ **Please specify country** **h785**
How many years have you lived in the United States? **h786**

2. Where was your mother born? *(check only ONE)*

h787 1. One of the 50 US states
If checked, fill ☛ **Please specify state** **h788**
h789 2. Puerto Rico
h790 3. Another Country
If checked, fill ☛ **Please specify country** **h791**

3. Where was your father born? *(check only ONE)*

h792 1. One of the 50 US states
If checked, fill ☛ **Please specify state** **h793**
h794 2. Puerto Rico
h795 3. Another Country
If checked, fill ☛ **Please specify country** **h796**

4. Which is your native language? *(check ALL that apply)*

h797 1. English
h798 2. Spanish
h799 3. Other
If checked, fill ☛ **Please specify** **h800**

5. What language is generally spoken in your home? *(check ALL that apply)* **(*)**

h801 1. English
h802 2. Spanish
h803 3. Other
If checked, fill ☛ **Please specify** **h804**

6. Would you say that you use mostly English or mostly your native language or both about the same? *(check only ONE)* **(*)**

h805 1	**h806 2**	**h807 3**	**h808 4**	**h809 5**
Only English	**Only native language**	**Mostly English**	**Mostly native language**	**Both about the same**

***Acculturations questions with permission from Tropp LR, et al. *Educational and Psychological Measurement* 1999;59:351-367.**

This questionnaire asks for your views about your health. This information will help you keep track of how you feel and how well you are able to do your usual activities.

Please answer every question by marking one box. If you are unsure about how to answer a question, please give the best answer you can.

---

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

Excellent	Very good	Good	Fair	Poor
☐	☐	☐	☐	☐

The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

		Yes, limited a lot	Yes, limited a little	No, not limited at all
h715	**2**. **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐	☐	☐
h716	**3**. Climbing **several** flights of stairs	☐	☐	☐

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

		Yes	No
h717	**4**. **Accomplished less** than you would like	☐	☐
h718	**5**. Were limited in the **kind** of work or other activities	☐	☐

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

		Yes	No
h719	**6. Accomplished less** than you would like	☐	☐
h720	**7**. Didn't do work or other activities as **carefully** as usual	☐	☐

TECH19

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

OMB NO=0925-0216 12/31/2007

h721 8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

Not at all	A little bit	Moderately	Quite a bit	Extremely
☐	☐	☐	☐	☐

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks …

		All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
h722	9. Have you felt calm and peaceful?	☐	☐	☐	☐	☐	☐
h723	10. Did you have a lot of energy?	☐	☐	☐	☐	☐	☐
h724	11. Have you felt downhearted and blue?	☐	☐	☐	☐	☐	☐

h725 12. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐	☐	☐	☐	☐

TECH20

Sleep Questionnaire. Part 1
Self-administered

OMB NO=0925-0216 12/31/2007

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

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

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

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

Sleep Questionnaire. Part 2
Self-administered

OMB NO=0925-0216 12/31/2007

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

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

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

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

TECH22

Referral Tracking

OMB NO=0925-0216 12/31/2007

h747 if yes fill below	Was further medical evaluation recommended for this participant? 0=No, 1=Yes, 9=Unknown

RESULT	**Reason for further evaluation**: 0=No, 1=Yes, 9=Unknown
h748	**Blood Pressure** result ____/_____ mmHg Phone call > 200/110 Expedite ≥ 180/100 Elevated > 140/90
h749	**Abnormal Urine** result _____
	Write in abnormality
h750	**ECG abnormality**_____
h751	**Clinic Physician** _____ **identified medical problem**
h752	**Other**_____ _____

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

TECH23

OMB NO=0925-0216 12/31/2007

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

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

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

ID number of person completing the referral**:** _____
h768

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

_____

_____

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

TECH24