

FIVE YEAR FOLLOW-UP CLINIC VISIT

FORM APPROVED
OMB No. 68-R1325
Expires 12/31/79

FORM NUMBER 412

COMPLETE ITEMS 1, 2, 13, 19, 20, 21, 22, and 38 PRIOR TO CLINIC VISIT

1. Program Number: 3,4 5,6,7,8,9 10,11 1 12,13,14,15,16,17

2. Name: (PRINT IN BLOCK CAPITALS) 2 BATCH NUMBER 11811912012122232425 1
Coordinating Center ACROSTIC

3. Date: (Mr., Miss, Mrs., Ms.) Last First Middle
3 Month 26 Day 27 Year 1930 31

4. Time arrived: 4 Hour 5 Minute 6 a.m. 36 p.m.

5. Changes required in identifying information: 48 None 13 HP11A Initiated 7 Hours 8 Minutes

6. Time since last meal? 37 Hours 38 Minutes

COMPLETE THE SECTION BELOW AT TERMINATION OF VISIT BEFORE PARTICIPANT LEAVES

7. Procedures

a. Envelope allocation of participant 14 49
 Referred Care
 Stepped Care

b. Treatment allocation of participant 15 50
 Referred Care
 Stepped Care

c. Results to be sent to care source? 16 51
NO YES → HP03A completed

8. Review of completed HP26 18 53
 Every item on each page is complete and legible. Name and Program Number are correct.

| | Completed | Scheduled | Refused |
|--|---------------------------------------|-------------------------------------|--------------------------|
| <u>17</u> Fasting blood specimen obtained. | <u>19</u> <input type="checkbox"/> 54 | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 1 Hr. post-glucose load specimen obtained. | <u>20</u> <input type="checkbox"/> 55 | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Urinalysis performed. | <u>21</u> <input type="checkbox"/> 56 | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| ECG completed. | <u>22</u> <input type="checkbox"/> 57 | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Chest x-ray completed. | <u>23</u> <input type="checkbox"/> 58 | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

24 59 HP12, Clinical Center Laboratory Report, initiated and entered in Clinic Record. 26

9. Location of examination: Clinic 60 25 In Home Other, specify: FLAG 61

10. Time visit completed: Hour 9 41 Minute 42 : 43 44 a.m. 45 p.m. 11

This section completed by: 46 47 12

11. Blood Pressure Measurements:

a. Pulse: Beats in 30 seconds 62163 ⁽²⁷⁾ $\times 2 =$ 124326 ⁽²⁸⁾ beats/minute

I will be taking six blood pressure readings, four of them while you are seated and two of them just after you stand up.

Cuff size:

regular

large arm

thigh

pediatric

29
67

Pulse obliteration pressure: _____

+30

Peak Inflation level: _____

(Baumanometer)

Maximum Zero _____ +

Peak inflation level: _____

(Random-Zero)

30
FLAG 68

b. Blood pressure readings:

1. (Std)
2. (R-Z)
- Zero
- Corrected
3. (Std)
4. (R-Z)
- Zero
- Corrected

| | Systolic 31 | Diastolic (5th phase) 32 |
|--|--|--|
| 1. (Std) | 69,70,71 | 72,73,74 |
| 2. (R-Z) | 75,76,77 33 | 78,79,80 34 |
| Zero | 81,82 35 | 83,84 36 |
| Corrected | 85,86,87 37 | 88,89,90 38 |
| 3. (Std) | 91,92,93 39 | 94,95,96 40 |
| 4. (R-Z) | 97,98,99 41 | 100,101,102 42 |
| Zero | 103,104 43 | 105,106 44 |
| Corrected | 107,108,109 45 | 110,111,112 46 |
| Sum of Corrected Readings 2 & 4 | 113,114,115 47 | 116,117,118 48 |
| Average of R-Z Readings = SUM of Corrected Readings 2 & 4 Divided by 2 | X | X |

5. (Std) after standing 2 minutes
6. (R-Z) after standing 2 minutes
- Zero
- Corrected

| | Systolic 49 | Diastolic (5th phase) 50 |
|-----------------------------------|--|--|
| 5. (Std) after standing 2 minutes | 119,120,121 | 122,123,124 |
| 6. (R-Z) after standing 2 minutes | 125,126,127 51 | 128,129,130 52 |
| Zero | 131,132 53 | 133,134 54 |
| Corrected | 135,136,137 55 | 138,139,140 56 |

c. Are you now taking, or in the past two days have you taken any medication for high blood pressure?

NO YES

141 57

12. a. Height:

Inches

42,43 58

b. Weight

Pounds

144,145,146 59

c. Percent of ideal weight: (From standard table)

147,148,149 60

Observer: _____

150,151 61

13. Interval Medical History Since Home Interview, HP25, (Date ___/___/___):

a. Since we last saw you at home, have you stayed overnight or longer in the hospital as a patient?

NO 152 (62)

YES

What was the primary reason for this hospitalization?
(FLAG 153) (63)

HP05B signed by participant (if not, specify reason: _____)

HP06 initiated with completion of items 1-3 and 8 of that form

REQUIRED:

b. Since we last saw you at home, have you started any new medicines, or have you stopped taking any medicines?

NO 154 (64)

YES

Describe: (FLAG 155) (65)

14. Now I would like to ask you some questions about the health of your relatives.
 Has any close relative (father, mother, brothers, sisters, children) ever had any of the following diseases?

| | Yes | No | DK | Relationship |
|--------------------------|------------------------------|-------------------------------------|-------------------------------------|-----------------|
| (67) (66) Heart attack | 156 <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | _____ |
| (68) Other heart disease | 157 <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | _____ |
| (69) High blood pressure | 158 <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | _____ |
| (70) Stroke | 159 <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | (FLAG 162) (72) |
| (71) Diabetes | 160 <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | _____ |
| Kidney disease | 161 <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | _____ |

PARTICIPANT MAY NOW BE SENT TO THE LAB FOR DRAWING OF BLOOD SAMPLE

15. a. (1) Have you ever had any pain or discomfort in your chest?

(73) 163 YES NO

Have you ever had any pressure or heaviness in your chest?

(74) 164 YES NO

Skip to 15c

(2) Do you get this pain (or discomfort) when you walk up-hill or hurry?

(75) 165 YES NO Never walks up-hill or hurries

Skip to 15b

(3) Do you get this pain or discomfort when you walk at an ordinary pace on the level?

(76) 166 YES NO

(4) What do you do if you get this pain while you are walking?

(77) 167 Stop or slow down
 Take a nitroglycerin
 Continue at same pace

Skip to 15b

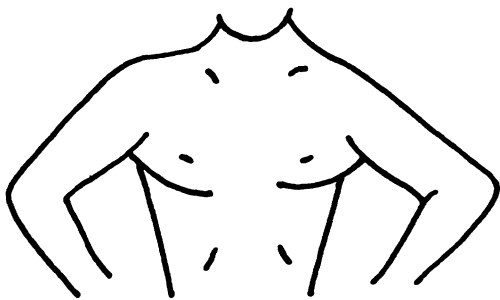
(5) If you stand still, what happens to the pain?

(78) 168 Relieved Not Relieved → Skip to 15b

(6) How soon is the pain relieved?

(79) 169 10 minutes or less More than 10 minutes → Skip to 15b

(7) Will you show me where it was?



- | | YES | NO |
|-------------------------------|-------------------------------|---|
| (a) Sternum (middle or upper) | (80) <input type="checkbox"/> | <input checked="" type="checkbox"/> 170 |
| (b) Sternum (lower) | (81) <input type="checkbox"/> | <input checked="" type="checkbox"/> 171 |
| (c) Left anterior chest | (82) <input type="checkbox"/> | <input checked="" type="checkbox"/> 172 |
| (d) Left arm | (83) <input type="checkbox"/> | <input checked="" type="checkbox"/> 173 |

Did you feel it anywhere else?

(84) 174 NO YES

Record additional information on the diagram above.

Comments:

(85)

FLAG 175

15. b. (1) Have you ever had a severe pain across the front of your chest lasting half an hour or more?

YES NO

86 176 Skip to 15c.

(2) Did you see a doctor because of this pain?

NO YES

87 177
What did he say it was? FLAG 178 88

(3) How many of these attacks have you had?

89 179 180 attacks

Tell me about your first attack:

90 Date 181182183184

Duration 1851 91

Your last attack:

92 186187188189 MO / YR

18901 93

NOTE: For fields 91 and 93:

Duration Codes

| CODE | MINUTES |
|------|------------|
| 0 | DK |
| 1 | 1-30 |
| 2 | 31-45 |
| 3 | 46-60 |
| 4 | 61 or more |

94
FLAG 191

15. c. (1) Do you get pain in either leg on walking?

YES NO

95 192 Skip to 16

(2) Does this pain ever begin when you are standing still or sitting?

YES NO

96 193
Skip to 16

(3) In what part of your leg do you feel it?

(If calves not mentioned, ask, "Anywhere else?" If still not mentioned, indicate "Pain does not include calf.")

Pain includes calf/calves

Pain does not include calf

97 194 Skip to 16

(4) Do you get this pain when you walk uphill or hurry?

YES NO Never walks uphill or hurries

98 195
Skip to 16

(5) Do you get this pain when you walk at an ordinary pace on the level?

YES NO

99 196

(6) Does this pain ever disappear while you are still walking?

YES NO

100 197
Skip to 16

101
FLAG 198

(7) What do you do if you get this pain while walking?

Stop or slacken pace Continue at same pace

102 199 → Skip to 16

(8) What happens to the pain if you stand still?

Relieved Not Relieved

103 200 → Skip to 16

(9) How soon is it relieved?

10 minutes More than 10 minutes

104 201

Comments

105

FLAG 202

16. a. Do you get shortness of breath that requires you to stop and rest?

NO YES

106 203 ↓

Do you get it walking on level ground or climbing a single flight of stairs?

YES NO

107 204

16. b. Do you get shortness of breath when you are lying down flat?

NO YES

108 205 ↓

Does this shortness of breath improve when you sit up, or do you use extra pillows at night to prevent it?

YES NO

109 206

16. c. Do you get severe shortness of breath which wakes you up while lying down asleep?

YES NO

110 207

111

FLAG 208

17. a. (1) Do you usually cough first thing in the morning (on getting up) in the winter?

Include a cough with first smoke or on first going out of doors. Exclude clearing throat or a single cough.

YES NO

112 209

(2) Do you usually cough during the day — or at night — in the winter?

Ignore an occasional cough.

YES NO

113 210 → If no to both questions (1) and (2), skip to 17b

114

FLAG 211

17. a. (3) Do you cough like this on most days (or nights) for as much as three months each year?

YES NO

115 212

17. b. (1) Do you usually bring up any phlegm from your chest first thing in the morning (on getting up) in the winter?

Include: Phlegm with the first smoke, phlegm on first going out of doors and swallowed phlegm. Exclude phlegm from the nose.

YES NO

116 213

(2) Do you usually bring up any phlegm from your chest at least twice during the day – or at night – in the winter?

YES NO

117 214 If no to both questions (1) and (2), skip to 17c

(3) Do you bring up phlegm like this on most days (or nights) for as much as three months each year?

NO YES

118 215

Have you had phlegm like this for 3 years or more?

YES NO

119 216

17. c. (1) Does your chest ever sound wheezing or whistling?

NO YES

120 217

Do you get this most days – or nights?

YES NO

121 218

(2) Have you ever had attacks of shortness of breath with wheezing?

NO YES

122 219

Is (was) your breathing absolutely normal between attacks?

YES NO

123 220

18. In the past two years, have you noticed any decrease in sexual ability?

YES NO

124 221

125

FLAG 222

19.

List all medications to which the participant reported having side effects or reactions on HP25 (Items 61c and e, 62b, and 63b).

| | Medication | Side Effect |
|----------|---------------|-----------------|
| (126) 1. | 223 1224 1225 | (127) 226 1 227 |
| (128) 2. | 228 1229 1230 | (129) 231 1 232 |
| (130) 3. | 233 1234 1235 | (131) 236 1 237 |
| (132) 4. | 238 1239 1240 | (133) 241 1 242 |
| (134) 5. | 243 1244 1245 | (135) 246 1 247 |
| (136) 6. | 248 1249 1250 | (137) 251 1 252 |

Comments:

(138)

FLAG 253

NOTE: Medications in fields 126,128,130,132,134 and 136, and side effects in fields 127,129,131,133,135 and 137 are from Drug Code List.

20. DURING THE PAST 12 MONTHS, the participant has experienced the condition(s) checked below:

Positive responses and additional information as appropriate should be transferred from HP25 Items 26-28 for use by the clinic physician.

| | COMMENT |
|--|----------------|
| (139) a. <input checked="" type="checkbox"/> heart attack or coronary. 254 | FLAG 255 (140) |
| (141) b. <input checked="" type="checkbox"/> stroke or brain hemorrhage. 256 | (142) FLAG 257 |
| (143) c. <input checked="" type="checkbox"/> diabetes. 258 | FLAG 259 (144) |
| (145) d. <input checked="" type="checkbox"/> cancer. 260 | (146) FLAG 261 |
| (147) e. <input checked="" type="checkbox"/> gout. 262 | FLAG 263 (148) |
| (149) f. <input checked="" type="checkbox"/> intestinal bleeding or ulcers. 264 | (150) FLAG 265 |
| (151) g. <input checked="" type="checkbox"/> kidney stones or other kidney trouble 266 | FLAG 267 (152) |
| (153) h. <input checked="" type="checkbox"/> cirrhosis or liver disease. 268 | (154) FLAG 269 |
| (155) <input type="checkbox"/> none of the above 270 | |

Comments on any positive response:

(156)

FLAG 271

21. WITHIN THE PAST 12 MONTHS, the participant has experienced the condition(s) checked below:

Positive responses should be transferred from HP25, Item 29, for use by the clinic physician.

157

- a. skin rash or unusual bruising. 272
- b. swelling or tenderness of the breasts. 273
- c. recurrent stomach pains. 274
- d. waking up too early and having difficulty getting back to sleep. 275
- e. black or tarry stools. 276
- f. bright red blood in the stools. 277
- g. frequent depression that interfered with work, recreation, or sleep. 278
- h. tiredness or fatigue. 279
- i. nightmares. 280
- none of the above. 281

159

158

161

160

163

162

165

164

166

22. WITHIN THE PAST 12 MONTHS, the participant has experienced the condition(s) checked below:

Positive responses should be transferred from HP25, Item 30, for use by the clinic physician.

- a. an illness or injury which kept the participant in bed for a week or more, or sent the participant to the hospital. 282
- b. attacks of headache, racing of the heart, and sweating all at once. 283
- c. headaches so bad that the participant had to stop what he or she was doing. 284
- d. faintness or light-headedness when he or she stands up quickly. 285
- e. heart beating fast or skipping beats. 286
- f. blacking out or losing consciousness. 287
- g. a change in physical appearance that worried the participant – for instance, changes in the skin or development of a lump. 288
- h. worries about physical symptoms which a doctor could not explain. 289
- none of the above. 290

167

168

169

170

171

172

173

174

175

PHYSICAL EXAMINATION

| | Area Examined | | Description of Findings |
|---|---|-------------------------------------|---|
| | Abnormal | Normal | |
| 23. GENERAL APPEARANCE: | <input checked="" type="checkbox"/> 291 176 | <input checked="" type="checkbox"/> | FLAG 292 177 |
| 24. SKIN: | <input checked="" type="checkbox"/> 293 178 | <input checked="" type="checkbox"/> | FLAG 297 182 |
| Xanthomata: | <input checked="" type="checkbox"/> 294 179 | <input checked="" type="checkbox"/> | |
| <input checked="" type="checkbox"/> 295 ¹ Other findings noted, specify: FLAG 296 181 | | | |

Area Examined

Description of Findings

25. EARS, NOSE AND THROAT: (183) 298 Abnormal Normal

(184) 299 Specific findings noted, specify: (185) FLAG 300

(186) FLAG 301

26. EYES: (187)

a. Scleral icterus: (188) YES 302 NO

b. Arteriolar spasm/focal constriction: (189) YES 303 NO

c. A-V nicking: (190) YES 304 NO

d. Hemorrhages: (191) YES 305 NO

(192) 306 Affecting 2 or more quadrants of the same eye?

NO YES

(193) 307 Confirmed by: 308, 309

e. Exudates: (194) Absent 310 Hard Soft (195)

Confirmed by: 311, 312

f. Papilledema: (196) NO 313 YES (197)

Confirmed by: 314, 315

(198) 316 Other findings noted, specify: (199) FLAG 317

(200) FLAG 318

(201) 319 Check if pupils were dilated for funduscopic exam.

27. NECK: (202) 320 Abnormal Normal

a. Abnormal venous distension present: (203) YES 321 NO

b. Carotid Bruit: (204) Right Left Both NONE

322

c. Diminished carotid pulsations: (205) Right Left Both NONE

323

(206) 324 Other findings noted, specify: (207) FLAG 325

(208) FLAG 326

Area Examined

Description of Findings

28. LYMPH NODES: Abnormal 327 Normal

(210) 328 Specific findings noted, specify: (209) _____
 _____ FLAG 329 (211)

(212)
 FLAG 330

29. CHEST AND LUNGS: Abnormal 331 Normal

Râles: (213) 331 YES NO
 (214) 332 NO
 (215) 333 Other findings noted, specify: _____
 _____ FLAG 334 (216)

(217)
 FLAG 335

30. BREASTS (FOR WOMEN): Abnormal 336 Normal

Palpable mass: (218) 336 Right Left Both NONE
 (219) 337
 (220) 338 Other findings noted, specify: _____
 _____ FLAG 339 (221)

(222)
 FLAG 340

31. HEART: Abnormal 341 Normal

a. Abnormal apical impulse: (223) 341 YES NO
 (224) 342
 b. Irregular apical heart rate: (225) 343
 c. Heart rate greater than 100/minute: (226) 344
 d. S 3 gallop: (227) 345
 e. Systolic murmur: (228) 346
 f. Diastolic murmur: (229) 347

(230) 348 Other findings noted, specify: _____
 _____ FLAG 349 (231)

(232)
 FLAG 350

Area Examined

Description of Findings

32. ABDOMEN: Abnormal Normal
233 351

a. Hepatomegaly: YES NO
234 352

b. Upper abdominal bruit: YES NO
235 353

236 354 ¹ Other findings noted, specify: FLAG 355 237

FLAG 356 238

33. EXTREMITIES: Abnormal Normal
239 357

a. Definite ankle edema: YES NO
240 358

b. Pulses present:

| | RIGHT | | | LEFT | | | |
|---|--|-------------------------------------|-------------------------------------|--------------------------|-------------------------------------|-------------------------------------|---|
| | Normal | Diminished | Absent | Normal | Diminished | Absent | |
| 359 posterior tibial | 241 <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | 242 360 |
| 361 dorsalis pedis | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | 244 362 |
| 363 femoral (only if posterior tibial and dorsalis pedis pulses are both missing) | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | 246 364 |

c. Amputation: NONE Right Left Both
247 365

Describe: FLAG 366 248

Done two or more years ago?
 YES NO
249 367

250 368 ¹ Other findings noted, specify: FLAG 369 251

FLAG 370 252

34. PELVIC: (optional) Not Done Abnormal Normal
253 371

Pap smear (To be offered) Not Done Done
254 372

255 373 ¹ Other findings noted, specify: FLAG 374 256

FLAG 375 257

| Area Examined | | | | Description of Findings | |
|---------------|-----------------------|--|--|-------------------------|-------------------|
| 35. | RECTAL (optional) | Not Done <input checked="" type="checkbox"/> 376 Abnormal <input checked="" type="checkbox"/> 377 YES <input checked="" type="checkbox"/> 377 NO <input type="checkbox"/> | Normal <input checked="" type="checkbox"/> 377 NO <input checked="" type="checkbox"/> | | |
| (260) | 378 | For males: Prostate enlarged or irregular: (259) <input checked="" type="checkbox"/> 377 <input type="checkbox"/> Other findings noted, specify: FLAG 379 (261) | | | (262) FLAG 380 |
| 36. | NEUROLOGICAL: | Abnormal <input checked="" type="checkbox"/> 381 Normal <input checked="" type="checkbox"/> | | | |
| | a. Hemiplegia | Right <input checked="" type="checkbox"/> 382 Left <input checked="" type="checkbox"/> 382 Both <input checked="" type="checkbox"/> 382 NONE <input type="checkbox"/> | | | |
| | b. Gross hemiparesis: | Right <input checked="" type="checkbox"/> 383 Left <input checked="" type="checkbox"/> 383 Both <input checked="" type="checkbox"/> 383 NONE <input type="checkbox"/> | | | |
| (267) | 385 | <input type="checkbox"/> Other findings noted, specify: _____ | | | (268) FLAG 386 |

37. OTHER PHYSICAL FINDINGS, SPECIFY:

(269)
 FLAG 387

36c. Has the participant ever had a stroke?

Probably Yes 384 Probably No 384

(266)

Physical examination by: _____ (270) 388 389

38.

Record all drugs which were being taken at the time the HP25 was administered. (Review items 62b and 63b of the HP25.)

| | Being Taken | Not Being Taken |
|---|--------------------------|------------------------------------|
| 1 <input type="checkbox"/> NONE (271) | | |
| a. antihypertensives | | |
| 1. thiazides or thiazide-like compounds | <input type="checkbox"/> | 391 <input type="checkbox"/> (272) |
| 2. spironolactone | <input type="checkbox"/> | 392 <input type="checkbox"/> (273) |
| 3. other diuretics | <input type="checkbox"/> | 393 <input type="checkbox"/> (274) |
| 4. reserpine or other rauwolfia alkaloids | <input type="checkbox"/> | 394 <input type="checkbox"/> (275) |
| 5. guanethidine | <input type="checkbox"/> | 395 <input type="checkbox"/> (276) |
| 6. hydralazine | <input type="checkbox"/> | 396 <input type="checkbox"/> (277) |
| 7. methyldopa | <input type="checkbox"/> | 397 <input type="checkbox"/> (278) |
| 8. propranolol | <input type="checkbox"/> | 398 <input type="checkbox"/> (279) |
| 9. triamterine | <input type="checkbox"/> | 399 <input type="checkbox"/> (280) |
| 10. clonidine | <input type="checkbox"/> | 400 <input type="checkbox"/> (281) |
| 11. prazosin | <input type="checkbox"/> | 401 <input type="checkbox"/> (282) |
| 12. other antihypertensives | <input type="checkbox"/> | 402 <input type="checkbox"/> (283) |
| b. cardiovascular preparations | | |
| 1. digitalis | <input type="checkbox"/> | 403 <input type="checkbox"/> (284) |
| 2. nitroglycerin | <input type="checkbox"/> | 404 <input type="checkbox"/> (285) |
| 3. other cardiovascular preparations | <input type="checkbox"/> | 405 <input type="checkbox"/> (286) |
| c. analgesics | | |
| 1. aspirin-containing compounds | <input type="checkbox"/> | 406 <input type="checkbox"/> (287) |
| 2. other analgesics | <input type="checkbox"/> | 407 <input type="checkbox"/> (288) |
| d. antibiotics | <input type="checkbox"/> | 408 <input type="checkbox"/> (289) |
| e. anticoagulant agents | <input type="checkbox"/> | 409 <input type="checkbox"/> (290) |
| f. antidiabetic agents | | |
| 1. insulin | <input type="checkbox"/> | 410 <input type="checkbox"/> (291) |
| 2. oral hypoglycemics | <input type="checkbox"/> | 411 <input type="checkbox"/> (292) |
| g. antihistamines | <input type="checkbox"/> | 412 <input type="checkbox"/> (293) |
| h. antithrombic agents | <input type="checkbox"/> | 413 <input type="checkbox"/> (294) |
| i. gout medications | <input type="checkbox"/> | 414 <input type="checkbox"/> (295) |
| j. hormonal preparations | | |
| 1. corticosteroids | <input type="checkbox"/> | 415 <input type="checkbox"/> (296) |
| 2. thyroid preparations | <input type="checkbox"/> | 416 <input type="checkbox"/> (297) |
| 3. oral contraceptives | <input type="checkbox"/> | 417 <input type="checkbox"/> (298) |
| 4. other estrogens | <input type="checkbox"/> | 418 <input type="checkbox"/> (299) |
| 5. other hormonal preparations | <input type="checkbox"/> | 419 <input type="checkbox"/> (300) |
| k. hypnotics | <input type="checkbox"/> | 420 <input type="checkbox"/> (301) |
| l. lipid-lowering agents | <input type="checkbox"/> | 421 <input type="checkbox"/> (302) |
| m. tranquilizers | <input type="checkbox"/> | 422 <input type="checkbox"/> (303) |
| n. potassium (supplement) | <input type="checkbox"/> | 423 <input type="checkbox"/> (304) |
| o. other medications | <input type="checkbox"/> | 424 <input type="checkbox"/> (305) |

This check list completed by: _____

425 | 426

306

FLAG 427

307

39. DIAGNOSTIC SUMMARY

a. Physician's Diagnoses: (List significant findings in order of importance.)

FLAG 428

308

39. b. Diagnostic Check List:

| | Present | Suspect | No Evidence | Inactive | | Present | Suspect | No Evidence | Inactive |
|-------------------------------------|--------------------------|-------------------------------------|--------------------------|--------------------------|-----|---------|--------------------------|-------------------------------------|--------------------------|
| Malignant Neoplasm: | | | | | | | | | |
| 429 Breast | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 309 | | | | |
| 430 Lung | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 310 | 473 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 431 GI | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 311 | 474 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 432 GU | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 312 | 475 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 433 Skin | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 313 | 476 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 434 Other, specify: 315 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 314 | 477 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 315 | 478 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 316 | 479 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Endocrine Metabolic Disease: | | | | | 317 | 480 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 436 Diabetes | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 318 | 481 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 437 Gout | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 319 | 482 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 438 Hyperthyroidism | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 320 | 483 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 439 Hypothyroidism | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 321 | 484 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 440 Cushing's syndrome | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 322 | 485 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 441 Pheochromocytoma | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 323 | 486 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 442 Primary aldosteronism | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 324 | 487 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 443 Other, specify: 324 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 325 | 488 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 326 | 489 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 327 | 490 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Mental Disease: | | | | | 328 | 491 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 445 Psychosis | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 329 | 492 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 446 Psychoneurosis | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 330 | 493 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 447 Mental retardation | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 331 | 494 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 448 Alcoholism | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 332 | 495 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 449 Drug addiction | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 333 | 496 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 450 Depression | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 334 | 497 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 451 Attempted Suicide | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 335 | 498 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 452 Other, specify: 333 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 336 | 499 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 337 | 500 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 338 | 501 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 339 | 502 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Neurologic Disease: | | | | | 340 | 503 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 454 Transient Ischemic Attack | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 341 | 504 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 455 Cerebrovascular Accident | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 342 | 505 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 456 Convulsive disorder | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 343 | 506 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 457 Other, specify: 338 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 344 | 507 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 345 | 508 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 346 | 509 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 347 | 510 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 348 | 511 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Musculo-Skeletal Disease: | | | | | 349 | 512 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 459 Arthritis or rheumatism | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 350 | 513 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 460 Other, specify: 341 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 351 | 514 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 352 | 515 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 353 | 516 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 354 | 517 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 355 | 518 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 356 | 519 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 357 | 520 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 358 | 521 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 359 | 522 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 360 | 523 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 361 | 524 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 362 | 525 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 363 | 526 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 364 | 527 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 365 | 528 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 366 | 529 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 367 | 530 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 368 | 531 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 369 | 532 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 370 | 533 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 371 | 534 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 372 | 535 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 373 | 536 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 374 | 537 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 375 | 538 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 376 | 539 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 377 | 540 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 378 | 541 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 379 | 542 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 380 | 543 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 381 | 544 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 382 | 545 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 383 | 546 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 384 | 547 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 385 | 548 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 386 | 549 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 387 | 550 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 388 | 551 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 389 | 552 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 390 | 553 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 391 | 554 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 392 | 555 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 393 | 556 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 394 | 557 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 395 | 558 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 396 | 559 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 397 | 560 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 398 | 561 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 399 | 562 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 400 | 563 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 401 | 564 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 402 | 565 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 403 | 566 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 404 | 567 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 405 | 568 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 406 | 569 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 407 | 570 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 408 | 571 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 409 | 572 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 410 | 573 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 411 | 574 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 412 | 575 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 413 | 576 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 414 | 577 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 415 | 578 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 416 | 579 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 417 | 580 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 418 | 581 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 419 | 582 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 420 | 583 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 421 | 584 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 422 | 585 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 423 | 586 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 424 | 587 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 425 | 588 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 426 | 589 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 427 | 590 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 428 | 591 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 429 | 592 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 430 | 593 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 431 | 594 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 432 | 595 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 433 | 596 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 434 | 597 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 435 | 598 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 436 | 599 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 437 | 600 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 438 | 601 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 439 | 602 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 440 | 603 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 441 | 604 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 442 | 605 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 443 | 606 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 444 | 607 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 445 | 608 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| | | | | | 446 | 609 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | |

40. REVIEW OF RESULTS OF EXAMINATION

a. Review of results of examination and discussion with participant:

- General explanation of high blood pressure 526
- Present status of individual in terms of risk factors: 527
 - Blood pressure and end-organ status 528
 - Smoking (if greater than 10 cigarettes per day) 529
 - Percent of ideal weight (if 140% or greater) 530

b. Are results to be sent to an outside source of care?

NO YES

531

~~Source of Care _____~~

~~_____~~

~~_____~~

Complete HP03A Release of Program Information, signed

c. Serious acute condition?

NO YES

532

Appropriate actions taken to bring condition under control

d. Envelope allocation of participant

Referred Care

533

Stepped Care **413**

e. Treatment allocation of participant

Referred Care

534

Stepped Care → Complete modified HP06

415

Physician or Therapist Signature _____

535 | 536