

FOUR YEAR FOLLOW-UP

OMB No. 68 R 1325

COMPLETE ITEMS 1, 2, 6a, 6b, AND 8a AT CENTER PRIOR TO HOUSEHOLD VISIT.

FORM NUMBER 1 1 2

ACROSTIC

1. Program Number:

3 4

5 6 7 8 9

10 11

1

12 13 14 15 16 17

Coordinating Center

2

18 19 20 21 22 23 24 25

BATCH NUMBER

2. Name:

(Mr., Miss, Mrs., Ms.)

Last

First

Middle

3. Current address:

House No.

Street Name or RR No.

Apt. No.

City or Town

State

Zip Code

4. Telephone No.

Area Code

INTERVIEWER: Has identifying information (Items 1-4) changed since last contact?

7

No

Yes

2

1

→ COMPLETE HP11A

37

5. Location of interview:

In Home

8

At Place of Employment

2

Other, specify:

3

3

Month

26 27

Day

28 29

Year

19 30 31

4

Hour

32 33

5

Minute

34 35

6

Time Interview Begun:

a.m. p.m.
36

Time Interview Completed:

39 40

41 42

a.m. p.m.

43

12

Interviewer:

44 45

6. a. AT THE TIME OF OUR HOME VISIT ABOUT TWO YEARS AGO, the following people were listed as living in your household. As I read their names, please tell me whether they now live in this household.

INTERVIEWER: Read the names of everyone EXCEPT those listed as "Not in household by HP19" or "Deceased by HP19." Last interview form: HP _____ DATE: _____

NOTE: In fields 13-142, if a box is checked value is 1. If box is not checked, value is blank.

Line number from HP01	Eligible at HP01	Relationship code from HP01	Name change by HP19	Not in household by HP19	Deceased by HP19	Name from HP01	Address					Comments (Enter different address, new name, or date and place of death as appropriate.)
							Living with participant	Moved during past two years	Living at different address	Name change	Deceased	
01	46	47	48	49	50	(13) ↔ (17)	51	52	53	54	55	(18) ↔ (22)
02	56	57	58	59	60	(23) ↔ (27)	61	62	63	64	65	(28) ↔ (32)
03	66	67	68	69	70	(33) ↔ (37)	71	72	73	74	75	(38) ↔ (42)
04	76	77	78	79	80	(43) ↔ (47)	81	82	83	84	85	(48) ↔ (52)
05	86	87	88	89	90	(53) ↔ (57)	91	92	93	94	95	(58) ↔ (62)
06	96	97	98	99	100	(63) ↔ (67)	101	102	103	104	105	(68) ↔ (72)
07	106	107	108	109	110	(73) ↔ (77)	111	112	113	114	115	(78) ↔ (82)
08	116	117	118	119	120	(83) ↔ (87)	121	122	123	124	125	(88) ↔ (92)
09	126	127	128	129	130	(93) ↔ (97)	131	132	133	134	135	(98) ↔ (102)
10	136	137	138	139	140	(103) ↔ (107)	141	142	143	144	145	(108) ↔ (112)

Line 11 146-155 (113) ↔ (122)
 Line 12 156-165 (123) ↔ (132)
 Line 13 166-175 (133) ↔ (142)

Highest line No. on HP01: (143)
 176 177

NO FURTHER INFORMATION REQUIRED FOR THESE PERSONS

HP11A Completed HP07 Completed for Age-Eligibles

INTERVIEWER: Had any HP01 household members moved out by the time of the HP19?
 NO YES
 ASK: At the time of our last visit (to your home), the following people were no longer living in your household. As I read their names, please tell me where they are now living.
 ↓
 Skip to Part b Read only the names of those listed as "Not in household by HP19."

144

178

6. b. No new household members since HP01. Skip to 6c.

At the time of our last home visit, the following members of your household were also listed. As I read their names would you please tell me whether they now live in this household?

INTERVIEWER: The following people had joined this household since the HP01. Read all the names except those listed as "Not in household by HP19."

Relationship to head	Sex	Date of birth	Not in household by HP19	Name	Living with participant	Living at different address	Name change	Deceased	Comments
		<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

INTERVIEWER: Had any persons who joined the household since the HP01 moved out by the time of the HP19?

No Yes

 → ASK: At the time of our last visit (to your home), the following people were no longer living in your household. As I read their names, please tell me where they are now living.

↓

Skip to part c

Read only the names of those listed as "Not in household by HP19."

6. c. IN THE PAST (YEAR/TWO YEARS), has anyone joined this household, for example, someone moving in or a new baby?

145

NO YES

→

179

Enter names of new household members above, enter relationship to current head, sex, and birthdate, and check box in the "Living with participant" column.

7. What is your current work status?

- Working full or part-time
- Not working but looking for work and worked during the past two years
- Retired or disabled
- Not retired or disabled but not working for more than two years
- Housewife or full-time student

180

146

8. a. At the time of our last visit (to your home), you were _____ (marital status from HP19, Item 8)

b. Has this changed?

- NO 147
- YES 181

- c. What is your marital status now?
- Married
 - Separated
 - Widowed
 - Divorced
- 148 182

I'd like to ask a few questions about your blood pressure.

9. a. About how many months has it been since you LAST had your blood pressure taken at the doctor's office or clinic?

- Less than one month 149
- 1-6 months 183
- 7-12 months 182
- More than 12 months Skip to 10

b. How many times DURING THE PAST 12 MONTHS have you had your blood pressure measured?

(Do not count times while a patient in a hospital.) 184 | 185 | 186 times 150

The following questions ask about your medical history DURING THE PAST 12 MONTHS. They are routine questions that we ask everyone, and they may or may not apply to you.

10. DURING THE PAST 12 MONTHS THAT IS, SINCE (TODAY'S DATE) IN 197 _____, have you been told by a doctor, nurse, therapist, or medical assistant that you had any of the following:

a. Heart attack or coronary (myocardial infarction, coronary thrombosis, or coronary occlusion)

- NO 151
 - DK 187
 - YES Suspect 152
1. When were you told this? Month Day Year 188 | 189 190 | 191 192 | 193

2. What was the doctor's or clinic's name? 153 1 0 FLAG 194 Address? _____

3. Were you hospitalized for this? YES 195 NO 154

HPOS signed by participant (If not, specify reason: _____)

REQUIRED:

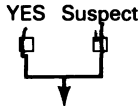
HPOS initiated with completion of Items 1-3 and 8 of that form

155

10. b. stroke or brain hemorrhage?

NO
2

DK
3
196



156

Month

Day

Year

1. When were you told this? 197 | 198 | 199 | 200 | 201 | 202

2. What was the doctor's or clinic's name? 157 1 0 FLAG 203

Address? _____

3. Were you hospitalized for this? YES NO
 204 157

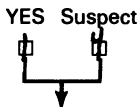
HPO5B signed by participant (If not, specify reason: _____)
_____))
REQUIRED:
 HPO8 initiated with completion of Items 1-3 and 8 of that form

- | | | | |
|----------------------------------------------------------------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| | YES | NO | DK |
| 4. Did you have weakness or paralysis? | 159 205 <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Difficulty with speech? | 160 206 <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. Difficulty with vision? | 161 207 <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7. Other difficulties?
If yes, specify: 163 1 0 FLAG 209 162 208 <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8. Did any of these problems last longer than 24 hours? | 164 210 <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |

c. Diabetes (sugar in your urine or high blood sugar)?

NO
2
165

DK
3
211



166

Month

Day

Year

1. When were you told this? 212 | 213 | 214 | 215 | 216 | 217

2. What was the doctor's or clinic's name? 167 1 0 FLAG 218

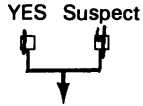
Address? _____

3. Were you hospitalized for this? NO YES
 219

HPO5B signed by participant (If not, specify reason: _____)
_____))
REQUIRED:
 HPO8 initiated with completion of Items 1-3 and 8 of that form

10. d. cancer?

(169) NO 2 DK 3
220



(170)

Month Day Year
221 222 223 224 19 225 226

NOTE: Code for field 171 from Drug Code List

1. When were you told this?
2. What part of the body was affected? Specify: (171) 227, 228
- What was the doctor's or clinic's name? (172) 1 0 FLAG 229
- Address? _____

3. Were you hospitalized for this? YES NO
230 173

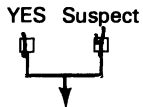
HPOS signed by participant (If not, specify reason: _____)

REQUIRED for hospitalization:

HPOS initiated with completion of Items 1-3 and 8 of that form

e. kidney stones or other kidney disease?

(171) NO 2 DK 3
238



(175)

Month Day Year
232 233 234 235 19 236 237

1. When were you told this?
2. What was the doctor's or clinic's name? (176) 1 0 FLAG 238
- Address? _____

3. Were you hospitalized for this? NO YES
239 171

HPOS signed by participant (If not, specify reason: _____)

REQUIRED

HPOS initiated with completion of Items 1-3 and 8 of that form

Now I would like to ask you about your weight.

(178)

11. How much do you weigh (without heavy clothes on)? 240 241 242 pounds

12. Now I would like to take your pulse and blood pressure:

180

Pulse: number of beats in 30 seconds 177 243, 244 × 2 = 245, 246, 247 beats / minute

Blood Pressure Readings:

- 248
- 181
- Cuff size:
- 1 regular
 - 2 large arm
 - 3 thigh
 - 4 pediatric

Pulse obliteration pressure: _____

_____ +30 _____

Peak inflation level: _____

(Baumanometer) _____

Maximum Zero _____ + _____

Peak inflation level: _____

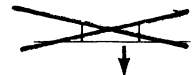
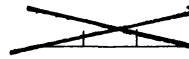
(Random-Zero) _____

182

1 0 FLAG 249

		Systolic	Diastolic (5th phase)
(1)	(Std)	183 250 251 252	184 253 254 255
(2)	(R-Z)	185 256 257 258	186 259 260 261
	Zero	187 262 263	188 264 265
	Corrected	189 266 267 268	190 269 270 271
(3)	(Std)	191 272 273 274	192 275 276 277
(4)	(R-Z)	193 278 279 280	194 281 282 283
	Zero	195 284 285	196 286 287
	Corrected	197 288 289 290	198 291 292 293
	SUM of Corrected Readings 2 & 4	199 294 295 296	200 297 298 299

Average of R-Z Readings = SUM
of Corrected Readings 2 & 4
Divided by 2



If average R-Z diastolic is ≥ 105, and participant is not active Stepped Care → ~~HP03A~~ completed

Remarks: 201 1 0 FLAG 300

Now I would like to ask you about hospitalizations DURING THE PAST 12 MONTHS.

13. DURING THE PAST 12 MONTHS, have you stayed overnight or longer in the hospital as a patient?

NO YES
 2 1 1
 ↓ ↓
 301

Skip to 14 How many times have you been hospitalized DURING THE PAST 12 MONTHS? 302 303 times

Check Items 10 a-e to be sure that any hospitalizations mentioned there are included here. Discuss, starting with the MOST RECENT hospitalization (No. 1) and work back through time. Record only the two most recent events.

Let's begin with the most recent hospitalization.

	HOSPITALIZATION NO. 1 (most recent)	HOSPITALIZATION NO. 2
a. What is the name and address of the hospital?	Name 204 1 FLAG 304 Address _____	Name 209 1 FLAG 316 Address _____
b. On what date did you enter the hospital?	205 Month Day Year 305 306 307 308 19 309 310	210 Month Day Year 317 318 319 320 19 321 322
c. How many nights were you in the hospital?	206 311 312 313 nights	211 323 324 325 nights
d. What was the primary reason for this hospitalization?	207 1 FLAG 314	212 1 FLAG 326
e. What doctor/clinic decided you should go to the hospital?	Name: 208 1 FLAG 315 <input checked="" type="checkbox"/> None (Emergency visit and admission)	Name: 213 2 FLAG 327 <input checked="" type="checkbox"/> None (Emergency visit and admission)

HPOSB signed by participant (If not, specify reason: _____)

REQUIRED:

HPOSB initiated with completion of Items 1-3 and 8 of that form.

Now I want to talk to you about the kind of medical care you may have received IN THE PAST 12 MONTHS.

14. DURING THE PAST 12 MONTHS, that is, since _____ today's date _____ a year ago, about how many times have you seen or talked to a medical doctor, nurse, therapist, or medical assistant for any of your own health reasons, including high blood pressure, but not including hospitalizations? 214 328 329 330 times → if "none," skip to 15b.

Now I would like to ask about any medical care you have received DURING THE PAST 12 MONTHS FOR YOUR HIGH BLOOD PRESSURE.

15. a. DURING THE PAST 12 MONTHS, about how many times have you seen a doctor, nurse, therapist, or medical assistant ABOUT YOUR HIGH BLOOD PRESSURE?

215 Once only 331 2 More than once 216 1 Never 3 → Was there a reason you didn't see a medical person about your high blood pressure? (Record verbatim) _____

217 333 334 times

Did the same person (doctor, nurse, therapist, or medical assistant) treat you on each visit? YES NO DK

218 335

17. a. Do you have your current blood pressure medicine bottles around that I might see?

270 YES
411

NO
2

INTERVIEWER: List all prescription blood pressure medications currently being taken in 17b.

Check appropriate reason(s) for not seeing medicine:

- 271 Out of medicine 412
- 272 Participant could not find medicine 413
- 273 Participant refused to show medicine 414
- 274 Medicine not recorded for other reason; indicate: 275 FLAG 416

Can you tell me what blood pressure medicines you're now taking? NOTE: Codes for blood pressure medications in fields 276-279 and side effects in fields 300-303 are from Drug Code List.

b. Record ALL prescription blood pressure medicines below.

	1	2	3	4
Name of Medication	276 [417, 418]	277 [419, 420]	278 [421, 422]	279 [423, 424]
Name of Pharmacy				
Pharmacy Telephone No.				
Prescription No.	280 <input type="checkbox"/> FLAG 425	281 FLAG 426 <input type="checkbox"/>	282 FLAG 427 <input type="checkbox"/>	283 FLAG 428 <input type="checkbox"/>
Date of Prescription				
Recommended Dosage (Ask if not on label)				
Were any pills taken today?	YES 429 <input type="checkbox"/> 284 NO <input type="checkbox"/>	YES 430 <input type="checkbox"/> 285 NO <input type="checkbox"/>	YES 431 <input type="checkbox"/> 286 NO <input type="checkbox"/>	YES 432 <input type="checkbox"/> 287 NO <input type="checkbox"/>
Were any pills taken yesterday?	YES 433 <input type="checkbox"/> 288 NO <input type="checkbox"/>	YES 434 <input type="checkbox"/> 289 NO <input type="checkbox"/>	YES 435 <input type="checkbox"/> 290 NO <input type="checkbox"/>	YES 436 <input type="checkbox"/> 291 NO <input type="checkbox"/>
Medication seen or not seen?	Seen 437 <input type="checkbox"/> 292 Not seen <input type="checkbox"/>	Seen 438 <input type="checkbox"/> 293 Not seen <input type="checkbox"/>	Seen 439 <input type="checkbox"/> 294 Not seen <input type="checkbox"/>	Seen 440 <input type="checkbox"/> 295 Not seen <input type="checkbox"/>
Have you had any reactions (side effects) from this medicine?	YES 441 <input type="checkbox"/> 296 NO <input type="checkbox"/>	YES 442 <input type="checkbox"/> 297 NO <input type="checkbox"/>	YES 443 <input type="checkbox"/> 298 NO <input type="checkbox"/>	YES 444 <input type="checkbox"/> 299 NO <input type="checkbox"/>
Reactions (side effects):	300 [445, 446]	301 [447, 448]	302 [449, 450]	303 [451, 452]

Be sure to have included ALL prescription blood pressure medicines, seen or not seen.

304 FLAG 453
If additional medications

c. Do you have any problems remembering to take your blood pressure medicines?

585 YES NO
 1 2
454

d. Do you have any other problems with your blood pressure medicines?

306 NO DK YES
2 3 1

307 FLAG 456

Describe the problems for me. (IDENTIFY drug item number from 17b.)

18. a. Are you taking ANY OTHER prescription medicines?

NO YES (309)
 2 1
 457

Do you have the medicine bottles around that I might see?

(309) YES NO

1 2 → Can you tell me what (other) prescription medicines you're now taking?

458

List all other prescription medicines in 18b.

NOTE: Codes for non-blood pressure medication in fields 310-313, side effects in fields 334-337 are from Drug Code List

b. List all other prescriptions - seen and not seen - in 18b.

	1	2	3	4
Name of Medication	(310) 14591	(311) 14601	(312) 14611	(313) 14621
Name of Pharmacy				
Pharmacy Telephone No.				
Prescription No.	(314) 10 FLAG 463	(315) FLAG 1 464 10	(316) FLAG 1 465 10	(317) FLAG 1 466 10
Date of Prescription				
Recommended Dosage (Ask if not on label)				
Were any pills taken today?	YES 467 <input type="checkbox"/> (318) NO <input type="checkbox"/>	YES 468 <input type="checkbox"/> (319) NO <input type="checkbox"/>	YES 469 <input type="checkbox"/> (320) NO <input type="checkbox"/>	YES 470 <input type="checkbox"/> (321) NO <input type="checkbox"/>
Were any pills taken yesterday?	YES 471 <input type="checkbox"/> (322) NO <input type="checkbox"/>	YES 472 <input type="checkbox"/> (323) NO <input type="checkbox"/>	YES 473 <input type="checkbox"/> (324) NO <input type="checkbox"/>	YES 474 <input type="checkbox"/> (325) NO <input type="checkbox"/>
Medication seen or not seen?	Seen 475 <input type="checkbox"/> (326) Not seen <input type="checkbox"/>	Seen 476 <input type="checkbox"/> (327) Not seen <input type="checkbox"/>	Seen 477 <input type="checkbox"/> (328) Not seen <input type="checkbox"/>	Seen 478 <input type="checkbox"/> (329) Not seen <input type="checkbox"/>
Have you had any reactions (side effects) from this medicine?	YES 479 <input type="checkbox"/> (330) NO <input type="checkbox"/>	YES 480 <input type="checkbox"/> (331) NO <input type="checkbox"/>	YES 481 <input type="checkbox"/> (332) NO <input type="checkbox"/>	YES 482 <input type="checkbox"/> (333) NO <input type="checkbox"/>
Reactions (side effects):	(334) 1483, 1484	(335) 1485, 1486	(336) 1487, 1488	(337) 1489, 1490

Be sure to have included all other prescription medicines, seen or not seen.

(338) 10 FLAG 491

If additional Medications

19. Can you give me the name, address, and telephone number of someone, not in your household, who will know where you are if we should need to contact you?

(339) 10 FLAG 492

Mr., Miss, Mrs.

Last

First

Middle

For married female contact person, first name of spouse:

House No.

Street Name or RR No.

Apt. No.

City or Town

State

Zip Code

Telephone No.

Area Code

20. a. Do you now have a personal physician?

NO YES **340**
2 1
493

b. May I have the name, address, and telephone number of your doctor?

Dr. _____
First **341** Middle **0** Last **FLAG 494**

House No. Street Name or RR No. Apt. No.

City or Town State Zip Code

Telephone No.: _____ / _____
Area Code

c. When did you last see him? **342** Month Year
495 496 19 497 498

SKIP to Item 21

d. Where do you usually go for medical care? (Record answer verbatim).

344
 No source of care
500 specified → Skip to bottom of page

343 **0** FLAG 499

e. When did you last go there for medical care?

345 Month Year
501 502 19 503 504

21. During the fall and winter of 1976-77 (Interviewer: If this question is being asked after August 1, 1977, say "That is, a year ago."), were you immunized against the flu (i.e., did you get the flu vaccine)?

YES **346** NO 2 DK 3
1
505

INTERVIEWER: Did another person sit in on any part of the interview?

347 NO YES
2 1 → Who? _____

506
CHECK FORM FOR COMPLETENESS. RECORD TIME INTERVIEW COMPLETED ON PAGE ONE. THANK RESPONDENT.

SOCIAL SECURITY NUMBER VERIFICATION

Our records show that your social security number is as follows:

Place label with social security number here

(348)

| 507, 509, 510, 511, 512, 513, 514, 515, 516 |

2. Is this correct? Yes (349) No → make correction above
 1 2

S07

3. a. Have you ever had a social security number under a different name (including maiden name)?

No (350) Yes → Name: (351) [10] FLAG S18

S17

b. Was the number the same as above?

(352) Yes No DK
 1 2 3

S19