

THREE YEAR FOLLOW-UP

FORM APPROVED
OMB No. 68 R 1325

COMPLETE ITEMS 1, 2, AND 10a. AT CENTER PRIOR TO HOUSEHOLD VISIT.

FORM NUMBER
1, 2

1 A ACROSTIC

1. Program Number:

3, 4

5, 6, 7, 8, 9

10, 11

12, 13, 14, 15, 16, 17
Coordinating Center

2 18, 19, 20, 21, 22, 23, 24, 25 BATCH NO.

2. Name:

(Mr., Miss, Mrs.)

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?

37 7 NO YES
2 2 → COMPLETE HP11A

5. Location of interview:

8 In Home
38

At Place of Employment

Other, specify:

3 Month Day Year
Date of Interview: 26, 27 28, 29 19 30, 31

4 Hour 5 Minute 6
Time Interview Begun: 32, 33 : 34, 35 a.m. p.m.
36

Time Interview Completed: 39, 40 : 41, 42 a.m. p.m.
9 10 11 43

Interviewer:

12 44, 45

6. In the past 12 months, has anyone joined this household, for example, someone moving in or a new baby?

NO YES →
 (13) 46

Enter names of new household members, relationship to current head, sex, and birthdate.

NAME	SEX	DATE OF BIRTH	RELATIONSHIP
(14) [Flag]		4/0	

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

(15) 48

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

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

49 (16) Less than one month 1-6 months 7-12 months More than 12 months

b. How many times during the past 12 months have you had your blood pressure measured?

50, 51 (17)

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.

9. During the past 12 months, 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)

YES Suspect DK NO → Skip to b.
 (18) 52

1. When were you told this? (53, 54) (19) (55, 56) 19 (57, 58)

2. What was the doctor's or clinic's name? _____ (20) [Flag] 59 1/0
 Address? _____

3. Were you hospitalized for this? YES NO (21) 60

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

REQUIRED:

HP08 initiated with completion of Items 1-3 and 8 of that form

b. stroke or brain hemorrhage?

YES Suspect DK NO → Skip to c.

1. When were you told this? 19

2. What was the doctor's or clinic's name? _____
Address? _____

3. Were you hospitalized for this? YES NO DK

HP05B signed by participant (If not, specify reason: _____
_____))
REQUIRED:
 HP08 initiated with completion of Items 1-3 and 8 of that form

4. Did you have weakness or paralysis?

YES 70 NO DK

5. Difficulty with speech?

71

6. Difficulty with vision?

72

7. Other difficulties?

73

If yes, specify: _____

8. Did any of these problems last longer than 24 hours?

75

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

YES Suspect DK NO → Skip to d.

1. When were you told this? 19

2. What was the doctor's or clinic's name? _____
Address? _____

3. Were you hospitalized for this? YES NO DK

HP05B signed by participant (If not, specify reason: _____
_____))
REQUIRED:
 HP08 initiated with completion of Items 1-3 and 8 of that form

d. cancer?

YES Suspect

YES Suspect

DK

NO

36

85

Skip to 10.
Month

37
Day

Year

NOTE: For field 38 codes are from Drug Code List

1. When were you told this?

86, 87

88, 89

19 90, 91

38

92 93

2. What part of the body was affected? Specify: _____

What was the doctor's or clinic's name? _____

39

94 1/0

Address? _____

3. Were you hospitalized for this?

YES

NO

40

95

HPO5B signed by participant (If not, specify reason: _____)

_____)

REQUIRED for hospitalization:

HPO8 initiated with completion of Items 1-3 and 8 of that form

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

NO

YES

41

96

Is it still Dr. _____? (Fill in before interview from HP19, Item 45)

NO

YES

42

97

Skip to 10c.

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

43

98 4/0

Dr. _____
First Middle Last

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?

Month 99, 100

44

Year 19 101, 102

→ SKIP to 11

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

_____ 0, 1, or
_____ 103

No source of care specified → Skip to 11

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

Month 104, 105

46

Year 19 106, 107

11. 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?

(47) 108 1/0

Mr., Miss, Mrs.LastFirstMiddle

For married female contact person, first name of spouse: _____

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

City or TownStateZip CodeTelephone No.Area Code

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

Pulse: number of beats in 30 seconds (48) 1'09 1'10 × 2 = (49) 1'11 1'12 1'13 beats / minute

Blood Pressure Readings:

Cuff size: (50)

regular

large arm

thigh

pediatric

Pulse obliteration pressure: _____ ✓ (51)

+ 30 115

Peak inflation level: _____ ✓
(Baumanometer)

→ FLAG = 1 if items checked are filled out.

→ FLAG = 0 if anything is missing

	Systolic	Diastolic (5th phase)
(1) (Standard)	(52) 116 117 118	(53) 119 120 121
(2) (Standard)	(54) 122 123 124	(55) 125 126 127
(3) (Standard)	(56) 128 129 130	(57) 131 132 133

SUM of Readings 2 & 3 (58) 134 135 136 (59) 137 138 139

Average of Readings = SUM of Readings 2 & 3 Divided by 2

(60) 140 141 142 (61) 143 144 145

If average diastolic is greater than or equal to 105, and participant is not active Stepped Care → 03A completed

Remarks: _____

(62) 146 1/0

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

13. 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? 147, 148, 149 times 63

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

14. During the past 12 months, have you stayed overnight or longer in the hospital as a patient?

YES 64 NO → Skip to 15.

How many times have you been hospitalized DURING THE PAST 12 MONTHS? 150 65 15, 152 times

Check Items 9 a-d 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 66 153 1/0 Address _____	Name 71 165 1/0 Address _____
b. On what date did you enter the hospital?	Month 154, 155 Day 156, 157 67 19 Year 158, 159	Month 166, 167 Day 168, 169 72 19 Year 170, 171
c. How many nights were you in the hospital?	160, 161, 162 68 nights	172, 173, 174 73 nights
d. What was the primary reason for this hospitalization?	69 163 1/0	74 175 1/0
e. What doctor/clinic decided you should go to the hospital?	Name: 70 164 <input type="checkbox"/> None (Emergency visit and admission)	Name: 75 176 <input type="checkbox"/> None (Emergency visit and admission)

HP058 signed by participant (If not, specify reason: _____)

REQUIRED:

HP08 initiated with completion of Items 1-3 and 8 of that form

NOTE: Flags in fields 70 and 75 have value of 2 if "none" has been checked.

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?

177 More than once 76 Once only Never → Why not? (Record verbatim) 77 178 1/0

78 179, 180 times Skip to 15 b. Skip to 16

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

79
181

b. Do you now have an appointment to see your doctor in the future about your high blood pressure?

NO YES (80) 182 When? Month Day Year 19 (81)

16. a. In the last 12 months, have you taken medicine prescribed by a doctor FOR YOUR HIGH BLOOD PRESSURE?

YES (82) NO → Skip to 18
189

b. At any time during the last 12 months, have you had any adverse reactions to any medicine you were taking for your high blood pressure?

YES (83) Suspect DK NO → Skip to d.
190

c.	Medication (A)	DK	Adverse Reaction	Date	Stopped Taking Medication?		
					NO	YES, Doctor's Orders	YES, Own Decision
1.	(84) 191 192 193	(85) 194	(86) 195 196		<input checked="" type="checkbox"/> (87) 197	<input checked="" type="checkbox"/> 198	<input checked="" type="checkbox"/> 199
2.	(88) 198-200	(89) 201	(90) 202-203		<input type="checkbox"/> (91) 204	<input type="checkbox"/>	<input type="checkbox"/>
3.	(92) 205-207	(93) 208	(94) 209-210		<input type="checkbox"/> (95) 211	<input type="checkbox"/>	<input type="checkbox"/>
4.	(96) 212-214	(97) 215	(98) 216-217		<input type="checkbox"/> (99) 218	<input type="checkbox"/>	<input type="checkbox"/>
5.	(100) 219-221	(101) 222	(102) 223-224		<input type="checkbox"/> (103) 225	<input type="checkbox"/>	<input type="checkbox"/>
6.	(104) 226-228	(105) 229	(106) 230-231		<input type="checkbox"/> (107) 232	<input type="checkbox"/>	<input type="checkbox"/>

d. Are you still taking medicines FOR YOUR HIGH BLOOD PRESSURE? NOTE: Codes for medications and adverse reactions are from Drug Code List

NO (108) YES → Skip to f.
233

e. What blood pressure medicines did you take? Why did you stop taking the medicine?

1.	Medicine (A)	Ran out; never refilled	Adverse Reactions; made feel bad	Cost too much	Doctor's orders	Other; Specify
(109) 234 235	(110) 236	(111) 237	(112) 238	(113) 239	(114) 240	(115) 241
(116) 242-243	(117) 244	(118) 245	(119) 246	(120) 247	(121) 248	(122) 249
(123) 250-251	(124) 252	(125) 253	(126) 254	(127) 255	(128) 256	(129) 257
(130) 258-259	(131) 260	(132) 261	(133) 262	(134) 263	(135) 264	(136) 265

f. For how many weeks during the past year did you take any blood pressure medicine? (137) 266 267 weeks

g. How long has it been since you last took any blood pressure medication? (138) 268 269 270 days

For participants no longer taking blood pressure medication → Skip to 18

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

NO YES

(139) 271

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

Check appropriate reason(s) for not seeing medicine:

- Out of medicine 272
- Participant could not find medicine 273
- Participant refused to show medicine 274
- Medicine not recorded for other reason; indicate: 275

(144) 276 1/0

Can you tell me what blood pressure medicines you're now taking? NOTE: Blood pressure medication codes in fields 145-148 are from Drug Code list.

b. Record ALL prescription blood pressure medicines below.

	(A) 1	(A) 2	(A) 3	(A) 4	
Name of Medication	277, 278, (145)	279, 280, (146)	281, 282, (147)	283, 284, (148)	
Name of Pharmacy	}				
Pharmacy Telephone No.		(149) <input type="checkbox"/> 285	(150) <input type="checkbox"/> 286	(151) <input type="checkbox"/> 287	(152) <input type="checkbox"/> 288
Prescription No.		<input type="checkbox"/> 1/0	<input type="checkbox"/> 1/0	<input type="checkbox"/> 1/0	<input type="checkbox"/> 1/0
Date of Prescription					
Recommended Dosage (Ask if not on label)					
Were any pills taken today?	YES <input checked="" type="checkbox"/> (153) 289 NO <input type="checkbox"/>	YES <input checked="" type="checkbox"/> (154) 290 NO <input type="checkbox"/>	YES <input checked="" type="checkbox"/> (155) 291 NO <input type="checkbox"/>	YES <input checked="" type="checkbox"/> (156) 292 NO <input type="checkbox"/>	
Were any pills taken yesterday?	YES <input checked="" type="checkbox"/> (157) 293 NO <input type="checkbox"/>	YES <input checked="" type="checkbox"/> (158) 294 NO <input type="checkbox"/>	YES <input checked="" type="checkbox"/> (159) 295 NO <input type="checkbox"/>	YES <input checked="" type="checkbox"/> (160) 296 NO <input type="checkbox"/>	
Medication seen or not seen?	Seen <input checked="" type="checkbox"/> (161) 297 Not seen <input type="checkbox"/>	Seen <input checked="" type="checkbox"/> (162) 298 Not seen <input type="checkbox"/>	Seen <input checked="" type="checkbox"/> (163) 299 Not seen <input type="checkbox"/>	Seen <input checked="" type="checkbox"/> (164) 300 Not seen <input type="checkbox"/>	
Have you had any adverse reactions from this medicine?	YES <input checked="" type="checkbox"/> (165) 301 NO <input type="checkbox"/>	YES <input checked="" type="checkbox"/> (166) 302 NO <input type="checkbox"/>	YES <input checked="" type="checkbox"/> (167) 303 NO <input type="checkbox"/>	YES <input checked="" type="checkbox"/> (168) 304 NO <input type="checkbox"/>	
Adverse Reactions:	305, 306, (169)	307, 308, (170)	309, 310, (171)	311, 312, (172)	

NOTE: Codes for adverse reactions in fields 169-172 are from Drug Code list.

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

(173) 313 1/0 FLAG IF ADDITIONAL MEDICATIONS

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

NO YES (174) 314

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

NO DK YES (175) 315

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

1 2 3 4 1/0

316 317 318 319

(176) (177) (178) (179)

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

YES NO

(180) → Skip to bottom of page.
320

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

YES NO

(181) → Can you tell me what (other) prescription medicines you're now taking?
321

List all other prescription medicines in 18 b.

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

NOTE: Non-blood pressure medication codes in fields 182-185 are from Drug Code list. (A) 3 (A) 4

	(A) 1	(A) 2	(A) 3	(A) 4	
Name of Medication	322 (182)	323 (183)	324 (184)	325 (185)	
Name of Pharmacy	}				
Pharmacy Telephone No.					
Prescription No.		(186) 326 1/0	(187) 327 1/0	(188) 328 1/0	(189) 329 1/0
Date of Prescription					
Recommended Dosage (Ask if not on label)					
Were any pills taken today?	YES (190) NO 330 <input checked="" type="checkbox"/>	YES (191) NO 331 <input checked="" type="checkbox"/>	YES (192) NO 332 <input checked="" type="checkbox"/>	YES (193) NO 333 <input checked="" type="checkbox"/>	
Were any pills taken yesterday?	YES (194) NO 334 <input checked="" type="checkbox"/>	YES (195) NO 335 <input checked="" type="checkbox"/>	YES (196) NO 336 <input checked="" type="checkbox"/>	YES (197) NO 337 <input checked="" type="checkbox"/>	
Medication seen or not seen?	Seen (198) Not seen 338 <input checked="" type="checkbox"/>	Seen (199) Not seen 339 <input checked="" type="checkbox"/>	Seen (200) Not seen 340 <input checked="" type="checkbox"/>	Seen (201) Not seen 341 <input checked="" type="checkbox"/>	
Have you had any adverse reactions from this medicine?	YES (202) NO 342 <input checked="" type="checkbox"/>	YES (203) NO 343 <input checked="" type="checkbox"/>	YES (204) NO 344 <input checked="" type="checkbox"/>	YES (205) NO 345 <input checked="" type="checkbox"/>	
Adverse Reactions:	346 347 (206)	348 349 (207)	350 351 (208)	352 353 (209)	

NOTE: Codes for adverse reactions in fields 206-209 are from Drug Code list.

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

(210) 354 1/0 FLAG IF ADDITIONAL MEDICATIONS

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

NO YES 355
 (211) → Who? _____

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

FORM
1 2 50

12 13 14 15 16 17 ACROSTIC

18 19 20 21 22 23 24 25
BATCH NO.

FORM APPROVED
OMB NO. 68 R 1325

THREE YEAR FOLLOW-UP SURVEY

2. I.D. 3 4 5 6 7 8 9 10 11

1. Name _____ Is this name correct?
() Yes () No
Correct name (please print)
↓
2a. _____

3. Address _____
House No. Street Name or RR No. Apt. No.

City or Town State Zip Code

Is this address correct? () Yes () No
Correct address (please print)
↓
3a. _____
House No. Street Name or RR No. Apt. No.

City or Town State Zip Code

4. Telephone No. (_____) _____ Is this phone number correct?
Area Code () Yes () No
Correct phone
↓
4a. (_____) _____
Area Code

5. Please provide 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. (please print)

26-43	44-55	56
Last	First	Middle
If above person is a married female, list first name of husband _____		
57-62	63-81	
House No.	Street Name or RR No.	Apt. No.
82-94	95-96	97-101
City or Town	State	Zip Code
		Telephone No. (_____) 102-111
		Area Code

CONTACT INFORMATION