

FORM NUMBER

TWO YEAR FOLLOW-UP CLINIC VISIT

1. Program Number: 1, 2 3, 4 5, 6, 7, 8, 9 10, 11 1, 2, 13, 14, 15, 16, 17 ACROSTIC
2 18, 19, 20, 21, 22, 23, 24, 25 BATCH

2. Name: (PRINT IN BLOCK CAPITALS)

(Mr., Miss, Mrs., Ms.) Last First Middle

3. Date: 3 Month 26, 27 Day 28, 29 19 30, 31 Year
4. Time arrived: 4 Hour 32, 33 : 5 Minute 34, 35 a.m. 6 36 p.m. 2

5. Changes required in identifying information: None 1
7 37 HP11A Initiated 2

COMPLETE THE SECTION BELOW AT TERMINATION OF VISIT BEFORE PARTICIPANT LEAVES

6. Procedures

a. Envelope allocation of participant

8 Regular Care
38 2 Stepped Care

b. Treatment allocation of participant

9 Regular Care
39 2 Stepped Care

10 Active → Modified HP06 and HP06A completed
40 2 Stepped Care refusal

• Change of status?

11 2 NO
4 1 YES →

Initial treatment visit scheduled: 12 Month 42, 43 Day 44, 45 19 46, 47 Year 48, 49 Hour 50, 51 Minute 52 a.m. p.m.
 Appointment slip given

Modified HP06 and HP06A completed (for participants with HP05's)

16 c. Participant never came for a Second Clinic Visit → Modified HP04 completed

53 d. Results to be sent to care source?
NO YES
17 2 7 → HP03A completed
54

7. Review of completed HP20:

- Every item on each page is complete and legible. ECG completed
- Name and Program Number are correct. Chest x-ray completed.
- Fasting blood specimen obtained. HP12, Clinical Center Laboratory Report, initiated and entered in Clinic Record.
- Urinalysis performed.

8. Time visit completed: 18 Hour 55, 56 : 19 Minute 57, 58 20 59 a.m. p.m. 2

This section completed by: _____ 21 60, 61

9. Blood Pressure Measurements:

a. Pulse: Beats in 30 seconds $\frac{62 + 63}{2} \times 2 = \frac{125}{2} \times 2 = 125$ 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.

Pulse obliteration pressure: _____ 67 (24)

_____ +30

Peak Inflation level: _____

(Baumanometer)

Maximum Zero _____ + _____

Peak inflation level: _____

(Random-Zero)

Cuff size:

Regular Large arm Thigh

1 2 3

4 OTHER

FLAG

1

0

If all lines complete
Otherwise

b. Blood pressure readings:

1. (Std)

(20) Systolic 69, 70, 71

(27) Diastolic (5th phase) 72, 73, 74

2. (R-Z)

(28) 75, 76, 77

(29) 78, 79, 80

Zero

(30) 81, 82

(31) 83, 84

Corrected

(34)

(32) 85, 86, 87

(33) 88, 89, 90

3. (Std)

(34) 91, 92, 93

(35) 94, 95, 96

4. (R-Z)

(36) 97, 98, 99

(37) 100, 101, 102

Zero

(38) 103, 104

(39) 105, 106

Corrected

(40) 107, 108, 109

(41) 110, 111, 112

Sum of Corrected Readings 2 & 4

(42) 113, 114, 115

(43) 116, 117, 118

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

5. (Std) after standing
2 minutes

(44) 119, 120, 121

(45) 122, 123, 124

6. (R-Z) after standing
2 minutes

(46) 125, 126, 127

(47) 128, 129, 130

Zero

(48) 131, 132

(49) 133, 134

Corrected

(50) 135, 136, 137

(51) 138, 139, 140

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

NO YES

(52) 2 /

10. a. Height:

Inches

(53) 42, 43

b. Weight:

Pounds

(54) 144, 145, 146

c. Percent of ideal weight:

(From standard table)

(55) 47, 48, 49

Observer:

(56) 50, 51

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

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

(57) YES NO
152 / 2

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

(58) YES NO
153 / 2
Skip to 11c

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

YES NO Never walks up-hill or hurries
(59) / 2 3
154 Skip to 11b

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

(60) YES NO
155 / 2

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

(61) / Stop or slow down
2 Take a nitroglycerin
156 3 Continue at same pace
Skip to 11b

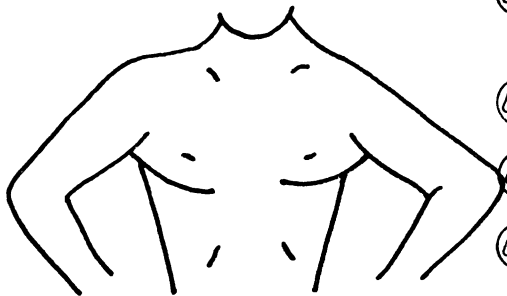
(5) If you stand still, what happens to the pain?

(62) Relieved Not Relieved
157 / 2 → Skip to 11 b

(6) How soon is the pain relieved?

(63) 10 minutes or less More than 10 minutes
158 / 2 → Skip to 11b

(7) Will you show me where it was? YES NO



(64) (a) Sternum 159 / 2
(middle or upper)

(65) (b) Sternum 160 / 2
(lower)

(66) (c) Left anterior chest 161 / 2

(67) (d) Left arm 162 1 2

Did you feel it anywhere else?

(68) YES NO
163 / 2

Record additional information on the diagram above.

Comments:

(69) 10

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

(70) YES NO
165 → Skip to 11c

(2) Did you see a doctor because of this pain?
YES NO

(71)
166 What did he say it was? (72) 1/67 1/0

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

(73) 168, 169 attacks

Tell me about your first attack: Date Duration
(74) 170, 171, 172, 173 (75) 174

Your last attack: (76) 175, 176, 177, 178 (77) 179
MO / YR

Comments

NOTE: For fields 75 and 77:

Duration Code

Code	Minutes
0	DK
1	1-30
2	31-45
3	46-60
4	61 or more

(78) 180 0

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

(79) YES NO
181 → Skip to 12

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

(80) YES NO
182
Skip to 12

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

(81) (If calves not mentioned, ask, "Anywhere else?" If still not mentioned, indicate "Pain does not include calf.")
183

Pain includes calf/calves / Pain does not include calf 2 → Skip to 12

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

(82) YES NO Never walks uphill or hurries
184
Skip to 12

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

(83) YES NO
185

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

(84) YES NO
186
Skip to 12

(85) 187 0

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

86 Stop or slacken pace / Continue at same pace 2 → Skip to 12

188

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

87 Relieved / Not Relieved 2 → Skip to 12

189

(9) How soon is it relieved?

88 10 minutes / More than 10 minutes 2

190

Comments:

89 191 6

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

YES NO

90 1 2 → Skip to 12b

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

YES NO

91 1 2

193

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

YES NO

92 1 2 Skip to 12c

194

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

YES NO

93 1 2

195

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

YES NO

94 1 2

196

95 197 6

13. 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

96 1 2

198

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

Ignore an occasional cough.

YES NO

97 1 2 → If no to both questions (1) and (2), skip to 13b.

199

98 200 6

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

YES NO
④⑨

201

13. 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
①①①

202

(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
①①①

203

If no to both questions (1) and (2), skip to 13c.

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

YES NO
①①②

204

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

YES NO
①①③

205

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

YES NO
①①④

206

Do you get this most days—or nights?

YES NO
①①⑤

207

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

YES NO
①①⑥

208

Is (was) your breathing absolutely normal between attacks?

YES NO
①①⑦

209

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

YES NO
①①⑧

210

Comments

①①⑨
211


15.

List all medications to which the participant reported having side effects or reactions on HP19 (Items 40c and e, 41b, and 42b).

	Medication	Side Effect
1.	(110) 212, 213, 214	(111) 215, 216
2.	(112) 217, 218, 219	(113) 220, 221
3.	(114) 222, 223, 224	(115) 225, 226
4.	(116) 227, 228, 229	(117) 230, 231
5.	(118) 232, 233, 234	(119) 235, 236

NOTE: Code for medication and side effect are from Drug Code List

Comments


(120) 237  0

16. 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 HP19, Items 13-15, for use by the clinic physician

	Initial diagnosis by HDFP Physician	Confirmation by HDFP Physician	Both
(121) a. <input type="checkbox"/> heart attack or coronary. 238	<input type="checkbox"/>	(122) <input checked="" type="checkbox"/> 239	<input checked="" type="checkbox"/>
(123) b. <input type="checkbox"/> stroke or brain hemorrhage. 240	<input type="checkbox"/>	(124) <input type="checkbox"/> 241	<input type="checkbox"/>
(125) c. <input type="checkbox"/> diabetes. 242	<input type="checkbox"/>	(126) <input type="checkbox"/> 243	<input type="checkbox"/>
(127) d. <input type="checkbox"/> cancer. 244	<input type="checkbox"/>	(128) <input type="checkbox"/> 245	<input type="checkbox"/>
(129) e. <input type="checkbox"/> gout. 246	<input type="checkbox"/>	(130) <input type="checkbox"/> 247	<input type="checkbox"/>
(131) f. <input type="checkbox"/> intestinal bleeding or ulcers. 248	<input type="checkbox"/>	(132) <input type="checkbox"/> 249	<input type="checkbox"/>
(133) g. <input type="checkbox"/> kidney stones or other kidney trouble 250	<input type="checkbox"/>	(134) <input type="checkbox"/> 251	<input type="checkbox"/>
(135) h. <input type="checkbox"/> cirrhosis or liver disease. 252	<input type="checkbox"/>	(136) <input type="checkbox"/> 253	<input type="checkbox"/>
(137) <input type="checkbox"/> none of the above 254	<input type="checkbox"/>		<input type="checkbox"/>

Comments on any positive response:

(138) 255  0

17. Within the past 12 months, the participant has experienced the condition(s) checked below:

Positive responses should be transferred from HP19, Item 16, for use by the clinic physician.

- (137) a. skin rash or unusual bruising. 256
- (140) b. swelling or tenderness of the breasts. 257
- (141) c. recurrent stomach pains. 258
- (142) d. waking up too early and having difficulty getting back to sleep. 259
- (143) e. black or tarry stools. 260
- (144) f. bright red blood in the stools. 261
- (145) g. frequent depression that interfered with work, recreation, or sleep. 262
- (146) h. tiredness or fatigue. 263
- (147) i. nightmares. 264
- (148) j. none of the above. 265

18. Within the past 12 months, the participant has experienced the condition(s) checked below:

Positive responses should be transferred from HP19, Item 17, for use by the clinic physician.

- (149) a. an illness or injury which kept the participant in bed for a week or more, or sent the participant to the hospital. 266
- (150) b. attacks of headache, racing of the heart, and sweating all at once. 267
- (151) c. headaches so bad that the participant had to stop what he or she was doing. 268
- (152) d. faintness or light-headedness when he or she stands up quickly. 269
- (153) e. heart beating fast or skipping beats. 270
- (154) f. blacking out or losing consciousness. 271
- (155) g. a change in physical appearance that worried the participant—for instance, changes in the skin or development of a lump. 272
- (156) h. worries about physical symptoms which a doctor could not explain. 273
- (157) i. none of the above. 274

PHYSICAL EXAMINATION

Area Examined		Description of Findings														
19. GENERAL APPEARANCE:	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; text-align: center;">Abnormal</td> <td style="width: 50%; text-align: center;">Normal</td> </tr> <tr> <td style="text-align: center;">(158) 1 <input type="checkbox"/></td> <td style="text-align: center;">2 <input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;">275</td> <td></td> </tr> </table>	Abnormal	Normal	(158) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	275		(159) 6 276								
Abnormal	Normal															
(158) 1 <input type="checkbox"/>	2 <input type="checkbox"/>															
275																
20. SKIN:	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; text-align: center;">Abnormal</td> <td style="width: 50%; text-align: center;">Normal</td> </tr> <tr> <td style="text-align: center;">(160) 1 <input type="checkbox"/></td> <td style="text-align: center;">2 <input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;">277</td> <td></td> </tr> <tr> <td style="text-align: center;">Xanthomata:</td> <td style="text-align: center;">YES NO</td> </tr> <tr> <td style="text-align: center;">(161) 1 <input type="checkbox"/></td> <td style="text-align: center;">2 <input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;">278</td> <td></td> </tr> <tr> <td colspan="2"> <input type="checkbox"/> Other findings noted, specify: <div style="display: flex; justify-content: space-between; margin-top: 5px;"> (162) 279 (163) 280 FLAG Y 1/6 </div> </td> </tr> </table>	Abnormal	Normal	(160) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	277		Xanthomata:	YES NO	(161) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	278		<input type="checkbox"/> Other findings noted, specify: <div style="display: flex; justify-content: space-between; margin-top: 5px;"> (162) 279 (163) 280 FLAG Y 1/6 </div>		(164) 6 281
Abnormal	Normal															
(160) 1 <input type="checkbox"/>	2 <input type="checkbox"/>															
277																
Xanthomata:	YES NO															
(161) 1 <input type="checkbox"/>	2 <input type="checkbox"/>															
278																
<input type="checkbox"/> Other findings noted, specify: <div style="display: flex; justify-content: space-between; margin-top: 5px;"> (162) 279 (163) 280 FLAG Y 1/6 </div>																

Area Examined

Description of Findings

21. EARS, NOSE AND THROAT: Abnormal Normal
(165) 1 2
282

(166) Specific findings noted, specify: _____
 283 (167) 284 b

(168) b
 285

22. EYES: Abnormal Normal
(169) 1 2 286

a. Scleral icterus: YES NO
(170) 1 2 287

b. Arteriolar spasm/focal constriction: YES NO
(171) 1 2 288

c. A-V nicking: YES NO
(172) 1 2 289

d. Hemorrhages: YES NO
(173) 1 2 290

Affecting 2 or more quadrants of the same eye?

NO YES
(174) 2 1 291

Confirmed by:

(175) 292 293

e. Exudates: Absent Hard Soft Both
(176) 1 2 3 294 4

Confirmed by:

(177) 295 296

f. Papilledema: NO YES
(178) 2 297 1

Confirmed by: (179) 298 299

(182) b
 302

(180) Other findings noted, specify: _____
 300 (181) 301 b

(183) 303 Check if pupils were dilated for fundoscopic exam.

23. NECK: Abnormal Normal
(184) 1 2 304

a. Abnormal venous distension present: YES NO
(185) 1 2 305

b. Carotid bruits: Right Left BOTH NONE
(186) 1 2 3 4 306

c. Diminished carotid pulsations: Right Left BOTH NONE
(187) 1 2 3 4 307

(188) Other findings noted, specify: _____
 308 (189) 309 b

(190) b
 310

Area Examined

Description of Findings

28. ABDOMEN: Abnormal Normal
(215) 1 2 335
 a. Hepatomegaly: YES NO
(216) 1 2 336
 b. Upper abdominal bruit: YES NO
(217) 1 2 337

(218) Other findings noted, specify: _____
 338 _____ (219) P! _____
 339

(220) P! _____
 340

29. EXTREMITIES: Abnormal Normal
(221) 1 2 341
 a. Definite ankle edema: YES NO
(222) 1 2 342
 b. Pulses present:

	RIGHT			LEFT		
	Nor- mal	Dimin- ished	Ab- sent	Nor- mal	Dimin- ished	Ab- sent
posterior tibial	(223) 1 <input type="checkbox"/> 343	2 <input type="checkbox"/>	3 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/> 344	3 (224) <input type="checkbox"/>
dorsalis pedis	(225) 1 <input type="checkbox"/> 345	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 346	(226) <input type="checkbox"/>
femoral (only if posterior tibial and dorsalis pedis pulses are both missing)	(227) 1 <input type="checkbox"/> 347	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 348	(228) <input type="checkbox"/>

c. Amputation: Right Left NONE BOTH
(229) 1 2 3 4
 349

Describe: _____
 (230) P! _____
 350

Done two or more years ago?

YES NO
 (231) 1 2 351

(232) Other findings noted, specify: _____
 352 _____ (233) P! _____
 353

(234) P! _____
 354

30. PELVIC: Not Done Abnormal Normal
(235) 3 1 2
 355
 Pap smear (must be done if no
results available from smear
within last 18 months) Normal Abnormal Positive
(236) 1 2 3
 356

(237) Other findings noted, specify: _____
 357 _____ (238) P! _____
 358

(239) P! _____
 359

Area Examined

Description of Findings

31. RECTAL:

Not Done
 (240)
 360

Abnormal

Normal

For males: Prostate enlarged or irregular:

(241) YES
 361

NO

(242)
 362

Other findings noted, specify:

(243)
 363

(244)
 364

32. NEUROLOGICAL:

(245) Abnormal 365

Normal

a. Hemiplegia:

(246) Right 366

Left

NONE

BOTH

b. Gross hemiparesis:

(247) Right 367

Left

NONE

BOTH

(248)
 368

Other findings noted, specify:

(249)
 369

(250)
 370

33. OTHER PHYSICAL FINDINGS, SPECIFY:

(251)
 371

Physical examination by: _____

(252)

37 373
 21 3

34.

Record all drugs which were being taken at the time the HP19 was administered. (Review Items 41b and 42b of the HP19.)

	Being Taken	Not Being Taken
(253) None <input checked="" type="checkbox"/> 1		
a. antihypertensives	1	2
(254) 1. thiazides or thiazide-like compounds 375	<input type="checkbox"/>	<input type="checkbox"/>
(255) 2. spironolactone 376	<input type="checkbox"/>	<input type="checkbox"/>
(256) 3. other diuretics 377	<input type="checkbox"/>	<input type="checkbox"/>
(257) 4. reserpine or other rauwolfia alkaloids 378	<input type="checkbox"/>	<input type="checkbox"/>
(258) 5. guanethidine 379	<input type="checkbox"/>	<input type="checkbox"/>
(259) 6. hydralazine 380	<input type="checkbox"/>	<input type="checkbox"/>
(260) 7. methyldopa 381	<input type="checkbox"/>	<input type="checkbox"/>
(261) 8. propranolol 382	<input type="checkbox"/>	<input type="checkbox"/>
(262) 9. other antihypertensives 383	<input type="checkbox"/>	<input type="checkbox"/>
b. cardiovascular preparations		
(263) 1. digitalis 384	<input type="checkbox"/>	<input type="checkbox"/>
(264) 2. nitroglycerin 385	<input type="checkbox"/>	<input type="checkbox"/>
(265) 3. other cardiovascular preparations 386	<input type="checkbox"/>	<input type="checkbox"/>
c. analgesics		
(266) 1. aspirin-containing compounds 387	<input type="checkbox"/>	<input type="checkbox"/>
(267) 2. other analgesics 387	<input type="checkbox"/>	<input type="checkbox"/>
(268) d. antibiotics 389	<input type="checkbox"/>	<input type="checkbox"/>
(269) e. anticoagulant agents 390	<input type="checkbox"/>	<input type="checkbox"/>
f. antidiabetic agents		
(270) 1. insulin 391	<input type="checkbox"/>	<input type="checkbox"/>
(271) 2. oral hypoglycemics 392	<input type="checkbox"/>	<input type="checkbox"/>
(272) g. antihistamines 393	<input type="checkbox"/>	<input type="checkbox"/>
(273) h. antithrombic agents 394	<input type="checkbox"/>	<input type="checkbox"/>
(274) i. gout medications 395	<input type="checkbox"/>	<input type="checkbox"/>
j. hormonal preparations		
(275) 1. corticosteroids 396	<input type="checkbox"/>	<input type="checkbox"/>
(276) 2. thyroid preparations 397	<input type="checkbox"/>	<input type="checkbox"/>
(277) 3. oral contraceptives 398	<input type="checkbox"/>	<input type="checkbox"/>
(278) 4. other hormonal preparations 399	<input type="checkbox"/>	<input type="checkbox"/>
(279) k. hypnotics 400	<input type="checkbox"/>	<input type="checkbox"/>
(280) l. lipid-lowering agents 401	<input type="checkbox"/>	<input type="checkbox"/>
(281) m. tranquilizers 403	<input type="checkbox"/>	<input type="checkbox"/>
(282) n. other medications (283) 404	<input type="checkbox"/>	<input type="checkbox"/>

This checklist completed by: _____

(284) 405 406

35. DIAGNOSTIC SUMMARY

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

(285) 
407

35. b. Diagnostic Check List:

		1 Present	2 Suspect	3 No Evidence	4 Inactive			1 Present	2 Suspect	3 No Evidence	4 Inactive
Malignant Neoplasm:						Circulatory Disease:					
(284) Breast	408	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(330) Rheumatic	452	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(287) Lung	409	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(331) Other valvular	453	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(288) GI	410	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(332) Ischemic heart disease	454	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(289) GU	411	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(333) Hypertensive heart	455	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(290) Skin	412	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(334) Peripheral vascular	456	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(291) Other, specify: 413		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(335) Cerebrovascular	457	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>FLAG '10</u> (292) 414 '10						(336) Secondary Hypertension	458	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine Metabolic Disease:						(337) Myocardial infarction	459	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(293) Diabetes	415	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(338) Acute Coronary Insufficiency	460	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(294) Gout	416	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(339) Angina pectoris	461	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(295) Hyperthyroidism	417	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(340) Congestive heart failure	462	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(296) Hypothyroidism	418	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(341) Dissecting aneurysm	463	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(297) Cushing's syndrome	419	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(342) Non-dissecting Aneurysm	464	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(298) Pheochromocytoma	420	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(343) Other, specify: 465		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(299) Primary aldosteronism	421	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>FLAG '10</u> (344) 466					
(300) Other, specify: 422		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Digestive Disease:					
<u>FLAG '10</u> (301) 423						(345) Peptic ulcer	467	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Disease:						(346) Colitis	468	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(302) Psychosis	424	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(347) Ileitis	469	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(303) Psychoneurosis	425	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(348) Gall bladder disease	470	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(304) Mental retardation	426	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(349) Cirrhosis	471	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(305) Alcoholism	427	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(350) Other liver disease	472	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(306) Drug addiction	428	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(351) Pancreatitis	473	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(307) Depression	429	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(352) Other, specify: 474		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(308) Attempted Suicide	430	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>FLAG '10</u> (353) 475					
(309) Other, Specify: 431		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genito-Urinary Conditions:					
<u>FLAG '10</u> (310) 432						(354) Nephritis/Nephrosis	476	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurologic Disease:						(355) Pregnancy	477	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(311) Transient Ischemic Attack	433	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(356) Urinary tract infection	478	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(312) Cerebrovascular Accident	434	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(357) Nephrolithiasis	479	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(313) Convulsive disorder	435	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(358) Other, specify: 480		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(314) Other, specify: 436		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>FLAG '10</u> (359) 481					
<u>FLAG '10</u> (315) 437						Dermatologic:					
Musculo-Skeletal Disease:						(360) Allergic dermatitis	482	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(316) Arthritis or rheumatism	438	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(361) Photosensitization	483	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(317) Other, specify: 439		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(362) Other, specify: 484		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>FLAG '10</u> (318) 440						<u>FLAG '10</u> (363) 485					
Hematologic Disease:						Injuries & Adverse Effects:					
(319) Anemia	441	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(364) Accidental Injury, Auto	486	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(320) Other, specify: 442		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(365) Accidental Injury, Work	487	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>FLAG '10</u> (321) 443						(366) Accidental Injury, Home	488	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Disease:						(367) Other Accidental Injury, specify: 489		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(322) Chronic obstructive lung disease	444	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(368) Violent Injury (i.e. assault)	490	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(323) Asthma	445	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(369) Other, specify: 491		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(324) Tuberculosis	446	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>FLAG '10</u> (370) 492					
(325) Other, specify: 447		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Diseases, Specify:					
<u>FLAG '10</u> (326) 448						(371) 493	494	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensory Disease:						(372) 495	496	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye						(373) 497	498	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(327) Glaucoma	449	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(374) 499	500	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(328) Other, Specify: 450		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(375) 501	502	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>FLAG '10</u> (329) 451						(376) 503	504	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

36. REVIEW OF RESULTS OF EXAMINATION

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

- 383 General explanation of high blood pressure 505
- 384 Present status of individual in terms of risk factors: 504
- 385 Blood pressure and end-organ status 507
- 386 Smoking (if greater than 10 cigarettes per day) 508
- 387 Percent of ideal weight (if 140% or greater) 509

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

YES NO

389 1 2

510

<p>Source of Care _____</p> <p>_____</p> <p><input type="checkbox"/> Complete HP03A Release of Program Information, signed</p>
--

c. Serious acute condition?

NO YES

389 2 1 →

511

<input type="checkbox"/> Appropriate actions taken to bring condition under control

d. Envelope allocation of participant

- 390 Regular Care
- 512 Stepped Care

e. Treatment allocation of participant

- 391 Regular Care
- 513 Stepped Care →

Complete modified HP06 and HP06A

f. Stepped Care refusal

- 392 Participant refusal 514
- 393 Explanation of Program, including continuing participant eligibility 515
- 394 Agrees to participate 516
- 395 Participant to contact source of care 517
- 396 Program to contact source of care 518
- 397 No source of care to contact 519
- 398 Continuing refusal to participate 520
- 399 Care source refusal 521
- 400 Explanation of Program, including continuing participant eligibility 522
- 401 Continuing willingness to participate 523
- 402 Participant to contact care source 524
- 403 Program to contact care source 525
- 404 Participant refusal 526
- 405 Care source not to be contacted (Program decision) 527
- 406 Participant will participate 528
- 407 Participant will not participate 529

408

Physician or Therapist Signature _____

530 531