

4. [ASK WOMEN ONLY – 55 YEARS OR YOUNGER:
ENTER CODE 4 IF FEMALE 56 YEARS OR >;
ENTER CODE 5 IF MALE]
Have you had a menstrual period within the
past two weeks? No longer menstruating 1
Yes 2
No 3
Female 56/older 4
Male 5
Don't Know 7
Refused 8
Missing 9

B. GIRTH MEASUREMENTS

5. Waist girth (to the nearest inch) in/8

6. Hip girth (to the nearest inch) in/8

IF INCLUDED IN THE HEIGHT/WEIGHT/BMI COMPARABILITY STUDY, RECORD MEASUREMENTS USING BOTH THE BALANCE BEAM SCALE/WALL MEASURE OF STANDING HEIGHT AND THE TANITA BODY COMPOSITION SCALE AND HEIGHT ROD. FOR BALANCE BEAM MEASURES, BMI IS CALCULATED AUTOMATICALLY. ENTER THE BMI MEASUREMENT FROM THE TANITA OUTPUT

7. Was this participant's height, weight, and BMI measured by:
- | | | | |
|--|----------------------|------------------------------|---|
| | <input type="text"/> | Complete Section C ONLY | |
| | | Balance beam/wall only | 1 |
| | <input type="text"/> | Complete Section D ONLY | |
| | | Tanita body composition only | 2 |
| | <input type="text"/> | Complete Section C AND D | |
| | | Both | 3 |
| | | Don't Know | 7 |
| | | Refused | 8 |
| | | Missing | 9 |

C. BALANCE BEAM/WALL MEASUREMENT

8. Standing height (to nearest inch): 8a feet 8b inches
IF UNABLE TO MEASURE, ENTER 999
IF REFUSED, ENTER 888

9. Weight (to nearest tenth of pound): Pounds
 IF UNABLE TO MEASURE, ENTER 999.9
 IF REFUSED, ENTER 888.8

10. Body mass index (to nearest tenth of percent) Kg/m²
 IF UNABLE TO MEASURE, ENTER 99.9
 IF REFUSED, ENTER 88.8

D. TANITA MEASUREMENTS

11. Body Type Standard 1
 Athletic 2

12. Height (TANITA) 12a Feet 12b Inches
 IF UNABLE TO MEASURE, ENTER 99
 IF REFUSED, ENTER 88

13. Weight (TANITA) (to the nearest tenth of pound) Pounds
 IF UNABLE TO MEASURE, ENTER 999.9
 IF REFUSED, ENTER 888.8

14. Body Mass Index (TANITA)
 IF UNABLE TO MEASURE, ENTER 99.9
 IF REFUSED, ENTER 88.8

15. Percent Body Fat (to the nearest tenth of a percent)
 IF UNABLE TO MEASURE, ENTER 999.9
 IF REFUSED, ENTER 888.8

16. Basal Metabolic Rate 16a.
 IF UNABLE TO MEASURE, ENTER 99999
 IF REFUSED, ENTER 88888 16b.

17. Impedance Ω
 IF UNABLE TO MEASURE, ENTER 9999
 IF REFUSED, ENTER 8888

18. Fat Mass (to the nearest tenth of a percent) %
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IF UNABLE TO MEASURE, ENTER 999.9
IF REFUSED, ENTER 888.8

19. Fat Free Mass (to the nearest tenth of a pound) Pounds
IF UNABLE TO MEASURE, ENTER 999.9
IF REFUSED, ENTER 888.8

20. Total Body Water (to the nearest tenth of a pound) Pounds
IF UNABLE TO MEASURE, ENTER 999.9
IF REFUSED, ENTER 888.8

E. DESIRABLE RANGE

21. Desirable Percent Body Fat - %
IF UNABLE TO MEASURE, ENTER 99
IF REFUSED, ENTER 88

22. Desirable Fat Mass
(to the nearest tenth of a percent)
IF UNABLE TO MEASURE, ENTER 99.9
IF REFUSED, ENTER 88.8

F. GOAL SETTING

23. Target Percent Body Fat %
IF UNABLE TO MEASURE, ENTER 99
IF REFUSED, ENTER 88

24. Predicted Fat Mass Pounds
(to the nearest tenth of a pound)
IF UNABLE TO MEASURE, ENTER 99.9
IF REFUSED, ENTER 88.8

25. Fat to Lose Pounds
(to the nearest tenth of a pound)
IF UNABLE TO MEASURE, ENTER 999.9
IF REFUSED, ENTER 888.8

G. ADMINISTRATIVE INFORMATION

26. Date of data collection: / /
m m d d y y y y

27. Method of data collection: Computer 1
Paper form 2

28. Data collected: In Clinic 1
Off site 2

29. Code number of person completing this form:

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Finger Stick

FORM CODE: FST
VERSION A 10/07/2005

ID NUMBER:

CONTACT YEAR

LAST NAME:

INITIALS:

INSTRUCTIONS: This form should be completed during the participant's visit. ID Number, Contact Year, and Name must be entered above. Whenever numerical responses are required, enter the number so that the last digit appears in the rightmost box. Enter leading zeroes where necessary to fill all boxes. If a paper form is used and a number is entered incorrectly, mark through the incorrect entry with an "X". Code the correct entry clearly above the incorrect entry. For "multiple choice" and "yes/no" type questions, circle the number corresponding to the most appropriate response. If a number is circled incorrectly, mark through it with an "X" and circle the correct response.

A. FINGER STICK

1. Do you have any bleeding disorders? Yes 1
- No 2
- Don't know 7
- Refused 8
- Missing 9

2. [IF YES, REVIEW SPECIAL PRECAUTIONS AND SPECIFY IN ITEM 2a]

3a. Date of finger stick: / /
m m d d y y y y

3b. Time of finger stick:
h h m m

4. Number of finger stick attempts:

B. GLUCOSE

5. Glucose mg/dl

C. LIPIDS

6. Cholesterol mg/dl

7. Triglycerides mg/dl

8. HDL mg/dl

9. LDL mg/dl

10. Non HDL mg/dl

D. ADMINISTRATIVE

11. Method of data collection: Computer 1
Paper form 2

12. Data Collected: In Clinic 1
Off Site 2

13. Code number of person completing this form:



Health History Form

FORM CODE: HHX
VERSION A 08/16/2005

ID NUMBER:

CONTACT YEAR:

LAST NAME:

INITIALS:

A. PERSONAL HEALTH HISTORY

"I would like to ask you a few questions about your health."

1. Compared to other people your age, would you say that your health is excellent, good, fair, or poor?
- | | |
|------------|---|
| Excellent | 1 |
| Good | 2 |
| Fair | 3 |
| Poor | 4 |
| Don't Know | 7 |
| Refused | 8 |
| Missing | 9 |

2. Since this time last year, would you say your health is
- | | |
|----------------|---|
| Better | 1 |
| Worse | 2 |
| About the same | 3 |
| Don't know | 7 |
| Refused | 8 |
| Missing | 9 |

3. What was your weight at birth?
- | | | | |
|----|---|----|---|
| 3a | <input type="text"/> <input type="text"/> | 3b | <input type="text"/> <input type="text"/> |
| | pounds | | ounces |
| | Don't know | | 77 |
| | Refused | | 88 |
| | Missing | | 99 |

4a. Were you breast fed?	Yes	1	
	No	2	Go to Item 5a
	Don't Know	7	
	Refused	8	
	Missing	9	

IF YES:

4b. For how long?	< 6 weeks	1
	6 -11 weeks	2
	3- 6 months	3
	> 6 months	4
	Don't know	7
	Refused	8
	Missing	9

ASK WOMEN IF ONLY

5a. Have you ever had a tubal-ligation (had one or more of your tubes tied)?.....	Yes	1	
	No	2	Go to Item 6
	Don't Know	7	
	Refused	8	
	Missing	9	

IF YES:

5b. How old were you when you had a tubal-ligation?.....

--	--	--

age

Don't know	777
Refused	888
Missing	999

ASK WOMEN ONLY IF < 55 YEARS OLD AND "NO" TO ITEM 4a

6. Are you currently pregnant?	Yes	1
	No	2
	Don't Know	7
	Refused	8
	Missing	9

ASK MEN ONLY:

7. Have you ever had a vasectomy?.....	Yes	1
	No	2
	Don't Know	7
	Refused	8
	Missing	9

B. PERSONAL HEALTH PROBLEMS

"Now I am going to read a list of some health problems. I am interested in any new health problems you may have learned about since your last Jackson Heart Study exam, that is in (mm/dd/yyyy). For each one, please tell me if your health care provider has told you for the first time since [date of JHS exam] that you have this problem."

Since your last Jackson Heart Study exam has your doctor or health professional ever said you have:

8a. High blood pressure or hypertension? :	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

Go to Item 9a

8b. How old were you when you were told that you had high blood pressure or hypertension?
age

Don't know	777
Refused	888
Missing	999

9a. High blood cholesterol?	Yes	1	
	No	2	
	Don't know	7	
	Refused	8	
	Missing	9	

9b. How old were you when you were told that you had high blood cholesterol?

--	--	--

age

Don't know	777
Refused	888
Missing	999

10a. Heart attack?	Yes	1	
	No	2	
	Don't know	3	
	Refused	8	
	Missing	9	

10b. How old were you when you were told that you had a heart attack?

--	--	--

age

Don't know	777
Refused	888
Missing	999

11a. Stroke?	Yes	1	
	No	2	
	Don't know	7	
	Refused	8	
	Missing	9	

11b. How old were you when you were told that you
 had a stroke? age

- Don't know 777
- Refused 888
- Missing 999

Since your last Jackson Heart Study exam [date], has your doctor or health professional ever said you have:

12a. Sugar in the blood or diabetes? Yes 1
 No 2
 Don't know 7
 Refused 8
 Missing 9

Go to Item 13a

12b. How old were you when you were told that you
 had sugar in the blood or diabetes? age

- Don't know 777
- Refused 888
- Missing 999

13a. Kidney problem?..... Yes 1
 No 2
 Don't know 7
 Refused 8
 Missing 9

Go to Item

13b. How old were you when you were told that you
 had a kidney problem?..... age

- Don't know 777
- Refused 888
- Missing 999

14a. Cancer?	Yes	1	
	No	2	<div style="border: 1px solid black; padding: 5px; display: inline-block;">Go to Item 15a</div>
	Don't know	7	
	Refused	8	
	Missing	9	

14b. How old were you when you were told that you had cancer.....

--	--	--

age

Don't know	777
Refused	888
Missing	999

15a. Chronic lung disease (other than asthma), such as COPD, bronchitis or emphysema?	Yes	1	
	No	2	<div style="border: 1px solid black; padding: 5px; display: inline-block;">Go to Item</div>
	Don't know	7	
	Refused	8	
	Missing	9	

15b. How old were you when you were told that you had chronic lung disease?.....

--	--	--

age

Don't know	777
Refused	888
Missing	999

16a. Asthma?	Yes	1	
	No	2	<div style="border: 1px solid black; padding: 5px; display: inline-block;">Go to Item 17a</div>
	Don't know	3	
	Refused	8	
	Missing	9	

16b. How old were you when you were told that you had asthma?

--	--	--

age

- Don't know 777
- Refused 888
- Missing 999

17a. A blood circulation problem?.....

- Yes 1
- No 2
- Don't know 7
- Refused 8
- Missing 9

Go to Item 18a

17b. How old were you when you were told that you had a blood circulation problem?

--	--	--

age

- Don't know 777
- Refused 888
- Missing 999

18a. Have you stayed overnight as a patient in a hospital during the past year?

- Yes 1
- No 2
- Don't know 7
- Refused 8
- Missing 9

Go to Item 19

18b. Reason:

C. HEALTH BEHAVIORS

19. What is the most that you have ever weighed
(WOMEN: except when you were pregnant)?

- Pounds
- Don't know 777
 - Refused 888
 - Missing 999

19a. How old were you when you weighed this much?

- Age
- Don't know 777
 - Refused 888
 - Missing 999

20. What did you weigh when you were age 18?

- Pounds
- Don't know 777
 - Refused 888
 - Missing 999

21. Do you consider yourself now to be overweight, underweight, or about the right weight?

- Overweight 1
- Underweight 2
- About right weight 3
- Don't know 7
- Refused 8
- Missing 9

22. Have you ever been on a diet to lose weight? Yes 1

- No 2
- Don't know 7
- Refused 8
- Missing 9

Go to Item 23

- 22a. Are you on such a diet now? Yes 1
 No 2
 Don't Know 7
 Refused 8
 Missing 9

23. During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?

- Yes 1
 No 2
 Don't know 7
 Refused 8
 Missing 9

Go to Item 24

23a. When you are exercising in your usual fashion, how would you rate your level of exertion (degree of effort)? Using this card, give me a number from 0 to 10 that represent how much exertion or effort you use. [GIVE RESPONDENT CARD].

24. During the past year, how often did you watch television [GIVE RESPONDENT CARD]

- Less than 1 hour per week 1
 At least 1 hour a week but
 Less than 7 hours a week 2
 At least 1 hour a day but
 Less than 2 hours a day 3
 At least 2 hours a day but
 Less than 4 hours a day 4
 4 hours or more a day 5
 Don't know 7
 Refused 8
 Missing 9

D. HEALTH CARE ACCESS

25. When was the last time you saw a health care provider for treatment of a medical problem?
[HAND RESPONSE CARD]

Within the past year	1
At least 1 year, but less than 2 years ago	2
At least 2 years, but less than 4 years ago	3
5 or more years ago	4
Never	5
Don't know	7
Refused	8
Missing	9

26. When was the last time you saw a health care provider for a routine physical exam or general checkup, that is when you were not sick or pregnant? [HAND REPOSENSE CARD]

Within the past year	1
At least 1 year but, less than 2 year ago	2
At least 2 years, but less than 4 years ago	3
5 or more years ago	4
Never	5
Don't know	7
Refused	8
Missing	9

27. Overall how hard has it been for you to get the health services you have needed? Would you say it has been very hard, fairly hard, not too hard, or not hard at all?

Very hard	1
Fairly hard	2
Not too hard	3
Not hard at all	4
Don't know	7
Refused	8
Missing	9

ADMINISTRATIVE INFORMATION

28. Date of data collection:

		/			/				
--	--	---	--	--	---	--	--	--	--

m m d d y y y y

29. Method of data collection: Computer 1
Paper 2

30. Data Collected In-Clinic 1
Off - Site 2

31. Code number of person completing this form:

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7. During the past month, excluding naps, how many hours of actual sleep did you get at night (or day, if you work at night) on average? This may be different from the number of hours spent in bed..... Hours
 (Don't Know = 77, Refused = 88, Missing =99)

B. CHEST PAIN ON EFFORT

8. Since your last Jackson Heart Study exam on (mm/dd/yyyy) have you had any pain or discomfort in your chest? Yes 1

Go to Item 32	No	2
	Don't Know	7
	Refused	8
	Missing	9

9. Do you get it when you walk uphill or hurry?..... Yes 1

Go to Item 29	No	2
	Never hurries or walks uphill	3
	Don't Know	7
	Refused	8
	Missing	9

10. Do you get it when you walk at an ordinary pace on the level? Yes 1

Go to Item 29	No	2
	Don't know	7
	Refused	8
	Missing	9

11. What do you do if you get it while you are walking? Stop or slow down 1

[RECORD "STOP OR SLOW DOWN" IF SUBJECT CARRIES ON AFTER TAKING NITROGLYCERIN]	Carry on	2
	Don't Know	7
	Refused	8
	Missing	9

12. If you stand still, what happens to it? Relieved 1

- Not relieved 2
- Go to Item 29 — Don't Know 7
- Refused 8
- Missing 9

13. How soon? 10 minutes or less 1

- More than 10 minutes 2
- Go to Item 29 — Don't Know 7
- Refused 8
- Missing 9

14. Will you show me where it was? [CIRCLE "1" OR "2" FOR ALL AREAS]

	<u>Yes</u>	<u>No</u>	<u>Don'tKnow</u>	<u>Refused</u>	<u>Missing</u>
14a. Sternum (upper or middle).....	1	2	7	8	9
14b. Sternum (lower).....	1	2	7	8	9
14c. Left anterior chest.....	1	2	7	8	9
14d. Left arm	1	2	7	8	9
14e. Other	1	2	7	8	9

14f. Specify:.....

15. Do you feel it anywhere else? [IF "YES", RECORD ABOVE] Yes 1

- No 2
- Don't Know 7
- Refused 8
- Missing 9

16. Did you see a doctor because of this pain or discomfort?..... Yes 1

- No 2
- Go to Item 18 — Don't know 7
- Refused 8
- Missing 9

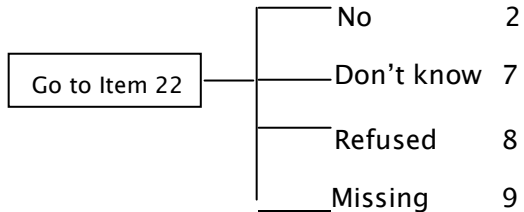
17. What did the doctor say it was?	Angina	1
	Heart attack	2
	Other Heart Disease	3
	Other	4

18. Have you been hospitalized because of this pain?	Yes	1
	No	2
	Don't Know	7
	Refused	8
	Missing	9

19. How long ago did you start getting this pain? Within the past:	1 month	1
	6 months	2
	1 year	3
	2 years	4
	Over 2 years	5
	Don't Know	7
	Refused	8
	Missing	9

“The next 3 questions on chest pain refer to 3 aspects: how often it occurs, how severe it is, and how long it lasts.”

20. Within the past 2 months, has your chest discomfort occurred more often?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

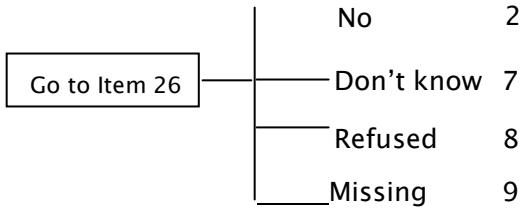


21. Has it occurred at least twice as often as before? Yes 1
 No 2
 Don't know 7
 Refused 8
 Missing 9

22. Within the past 2 months, has the pain become more severe? Yes 1
 No 2
 Don't know 7
 Refused 8
 Missing 9

23. Within the past 2 months, has the pain lasted longer when it occurs? Yes 1
 No 2
 Don't know 7
 Refused 8
 Missing 9

24. Do you ever use nitroglycerin to relieve the pain? Yes 1
 No 2
 Don't know 7
 Refused 8
 Missing 9

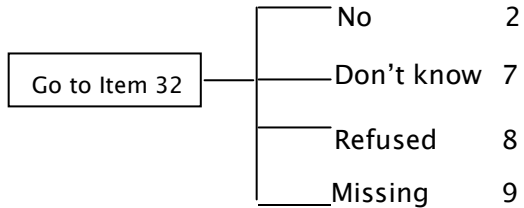


25. Within the past 2 months, has the pain required more nitroglycerin to relieve it? Yes 1
 No 2
 Don't know 7
 Refused 8
 Missing 9

26. Within the past 2 months, have you started getting the pain with less exertion? Yes 1
 No 2
 Don't know 7
 Refused 8
 Missing 9
27. Within the past 2 months have you started getting the pain when sitting still? Yes 1
 No 2
 Don't know 7
 Refused 8
 Missing 9
28. Within the past 2 months, have you started getting the pain when sleeping? Yes 1
 No 2
 Don't know 7
 Refused 8
 Missing 9

C. POSSIBLE INFARCTION

29. Since your last Jackson Heart Study exam, have you ever had a severe pain across the front of your chest lasting for half an hour or more? Yes 1
 No 2
 Don't know 7
 Refused 8
 Missing 9



30. Did you see a doctor because of this pain? Yes 1
 No 2
 Don't know 7
 Refused 8
 Missing 9

6. Have you participated in any intense physical activity in the past 2 hours?
- | | |
|------------|---|
| Yes | 1 |
| No | 2 |
| Don't Know | 7 |
| Refused | 8 |
| Missing | 9 |

7. Do you take any medications for high blood pressure?
- | | |
|------------|---|
| Yes | 1 |
| No | 2 |
| Don't Know | 7 |
| Refused | 8 |
| Missing | 9 |

[IF YES, ASK 7a]

- 7a. Have you taken your blood pressure medication in the past 2 hours?
- | | |
|------------|---|
| Yes | 1 |
| No | 2 |
| Don't Know | 7 |
| Refused | 8 |
| Missing | 9 |

Go to Item

C. PRELIMINARY MEASUREMENTS

8. Right Arm Circumference (cm):.....

9. Cuff Size:
 {arm circumference in brackets}.....
- | | |
|------------------------|---|
| Small adult {<24 cm} | 1 |
| Regular Arm {24-32 cm} | 2 |
| Large Arm {33-41 cm} | 3 |
| Thigh {>41 cm} | 4 |

10. Heart Rate (30 seconds):.....

11a. Time of Day:

h	h	m	m

[IF PARTICIPANT IS INCLUDED IN BLOOD PRESSURE COMPARABILITY STUDY, OBTAIN BLOOD PRESSURE USING BOTH RANDOM ZERO AND OMRON MEASUREMENTS.]

12. The participants' blood pressure was determined by :

Random Zero Only 1

Omron Only 2

Both 3

D. RANDOM ZERO CALIBRATION

13. Pulse Obliteration Pressure:.....

14. Maximum Zero:.....

+ 30

15. Peak Inflation Level
{Computation--Item #10
+ Item #11 + 30}:.....

E. FIRST RANDOM ZERO BLOOD PRESSURE MEASUREMENT

16. Systolic:.....

17. Diastolic:.....

68. Zero Reading:.....

F. SECOND RANDOM ZERO BLOOD PRESSURE MEASUREMENT

19. Systolic:.....

20. Diastolic:.....

21. Zero Reading:.....

G. COMPUTED NET AVERAGE OF FIRST AND SECOND RANDOM ZERO BLOOD PRESSURE MEASUREMENTS
(See Worksheet)

22. Systolic:.....

23. Diastolic:.....

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H. OMRON CALIBRATION:

24. P – Set Level:..... |

I. FIRST OMRON BLOOD PRESSURE MEASUREMENT

25. Systolic:..... mm/hg
|

J. SECOND OMRON BLOOD PRESSURE MEASUREMENT

27. Systolic mm/hg
|

K. COMPUTED NET AVERAGE OF FIRST AND SECOND OMRON BLOOD PRESSURE MEASUREMENTS

29. Systolic

--	--	--

 mm/hg

30. Diastolic.....

--	--	--

 mm/hg

L. ADMINISTRATIVE INFORMATION

31. Date of data collection:.....

		/			/				
m	m		d	d		y	y	y	y

32. Method of Data Collection: Computer 1
Paper Form 2

33. Data Collected: In Clinic 1
Off Site 2

34. Code number of random zero technician.....

--	--	--

--	--	--

35. Code number of Omron technician:

- Don't know 7
- Refused 8
- Missing 9

Go to Item 5

4b. Follow up SMBP call scheduled for:

					/				
m	m		d	d		m	m	m	m

4c. Time of day:

- Early morning 1
- Late morning 2
- Early afternoon 3
- Late afternoon 4

5. Did the participant successfully complete a SMBP measurement? Yes

- Yes 1
- No 2
- Don't know 7
- Refused 8
- Missing 9

6. Date SMBP Dispensed:

					/				
m	m		d	d		m	m	m	m

7. SMBP Serial Number:

--	--	--	--	--	--	--	--	--	--

B. SMBP PRELIMINARY

8. Arm [RIGHT ARM PREFERRED]: Left

- Left 1
- Right 2
- Don't know 7
- Refused 8
- Missing 9

9. Is right arm used?

- Yes 1
- No 2

Go to Item 11

Don't Know	7
Refused	8
Missing	9

10a. Unable to use right arm: Dialysis graft 1

Mastectomy on nondominant side 2

Infection 3

Other (specify) 4

Don't know 7

Refused 8

Missing 9

10b. Specify:

11. Is SMBP being done?..... Yes 1

No 2

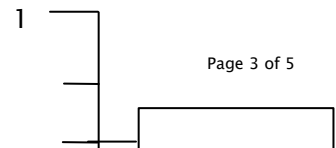
Don't know 7

Refused 8

Missing 9

Go to Item 13

12a. Unable to use SMBP: Exceeded maximum cuff size 1



Other (Specify)	2
Don't know	7
Refusal (specify)	8
Missing	9

12b. Specify:

C. SMBP MEASUREMENT (BY PARTICIPANT)

13. First SMBP

13a. Systolic:

--	--	--

 mm Hg

13b. Diastolic:

--	--	--

 mm Hg

14. Second SMBP

14a. Systolic:

--	--	--

 mm Hg

14b. Diastolic:

--	--	--

 mm Hg

15. Average of First and Second SMBP

15a. Systolic:

--	--	--

 mm Hg

15b. Diastolic

--	--	--

 mm Hg

16. Time of SMBP Measurement.....

h	h	m	m

ADMINISTRATIVE INFORMATION

		/			/				
m	m		d	d		m	m	m	m

17. Date of data collection

18. Method of data collection: Computer 1
Paper form 2

19. Data collected: In clinic 1
Off site 2

20. Code number of person completing this form: |



Stroke Symptoms Form

FORM CODE: SSF
 VERSION: 07/29/2005

ID NUMBER:

CONTACT YEAR:

LAST NAME:

INITIALS:

INSTRUCTIONS: This form should be completed during the participant's visit. ID Number, Contact Year, and Name must be entered above. Whenever numerical responses are required, enter the number so that the last digit appears in the rightmost box. Enter leading zeroes where necessary to fill all boxes. If a number is entered incorrectly, mark through the incorrect entry with an "X". Code the correct entry clearly above the incorrect entry. For "multiple choice" and "yes/no" type questions, circle the letter corresponding to the most appropriate response. If a letter is circled incorrectly, mark through it with an "X" and circle the correct response.

A. STROKE HISTORY

1. Since your last Jackson Heart Study exam in (mm/dd /yyyy), have you been told by a physician that you had a stroke? Yes 1
- No 2
- Don't know 7
- Refused 8
- Missing 9

2. When did this stroke occur? /

m m y y y y

B. SUDDEN LOSS OR CHANGE OF SPEECH

3. In the past 5 years, since your last Jackson Heart Study exams, have you had any sudden loss or changes in speech lasting 24 hours or longer? Yes 1
- No 2
- Don't know 7
- Refused 8
- Missing 9

4. Did the episode come on suddenly?.....	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

5. Do any of the following describe your change in speech?
[READ ALL CHOICES]

	<u>Yes</u>	<u>No</u>	<u>D on 't Kn</u> <u>ow</u>	<u>Refused</u>	<u>Missing</u>
5a. Slurred speech like you were drunk?	1	2	7	8	9
5b. Could talk but the wrong words came out?	1	2	7	8	9
5c. Know what you wanted to say, but the words would not come out?	1	2	7	8	9
5d. Could not think of the right words?	1	2	7	8	9
5e. [IF MORE THAN ONE OF ITEMS A–D INDICATED, ASK “WHICH OF THESE MOST CLOSELY DESCRIBES THE PROBLEMS?”].....					
			Slurred speech		1
			Wrong words came out		2
			Words would not come out		3
			Could not think of the right		4

6. While you were having your episode of change in speech,
did any of the following occur? [INCLUDE ALL THAT APPLY]

6a. Numbness or tingling?	Yes	1
	<div style="border: 1px solid black; display: inline-block; padding: 2px;">Go to Item 6c</div> — No	2
	Don't know	7
	Refused	8
	Missing	9

6b. Did you have difficulty on:	The right side only	1
[READ ALL CHOICES]		
	The left side only	2
	Both sides	3
	Don't know	7
	Refused	8
	Missing	9

6c. Paralysis or weakness?	Yes	1
	<input type="checkbox"/> No	2
	Don't know	7
	Refused	8
	Missing	9

6d. Did you have difficulty on:	The right side only	1
[READ ALL CHOICES]		
	The left side only	2
	Both sides	3
	Don't know	7
	Refused	8
	Missing	9

6e. Lightheadedness, dizziness, or loss of balance?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

6f. Blackouts or fainting?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9
6g. Seizures or convulsions?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9
6h. Headache?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9
6i. Visual disturbances?	Yes	1
	Go to Item 7 — No	2
	Don't know	7
	Refused	8
	Missing	9

6j. Did you have: [READ ALL CHOICES UNTIL A POSITIVE RESPONSE IS GIVEN]

Double vision	01
Vision loss in right eye only	02
Vision loss in left eye only	03
Total loss of vision in both eyes	04
Trouble in both eyes seeing to the right	05
Trouble in both eyes seeing to the left	06
Trouble in both eyes seeing to both sides or straight ahead	07
Don't know	77
Refused	88
Missing	99

C. SUDDEN LOSS OF VISION

7. In the past 5 years, since your last Jackson Heart Study exam, have you had any sudden loss of vision, or blurring, lasting 24 hours or longer? Yes 1

Go to Item 11a	No	2
	Don't know	7
	Refused	8
	Missing	9

8. Did the episode come on suddenly?..... Yes 1

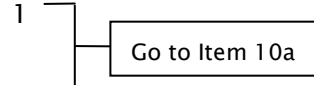
No 2

Don't know 7

Refused	8
Missing	9

9a. During the episode, which of the following parts of your vision were affected?
[READ ALL CHOICES]

- Only the right eye 1
- Only the left eye 2
- Both eyes 3
- Don't know 7
- Refused 8
- Missing 9



9b. Did you have:
[READ ALL CHOICES UNTIL A POSITIVE RESPONSE IS GIVEN]

- Trouble seeing to the right, but not the left 1
- Trouble seeing to the left, but not the right 2
- Trouble seeing both sides or straight ahead 3
- Don't know 7
- Refused 8
- Missing 9

10. While you were having your loss of vision, did any of the following occur? [INCLUDE ALL THAT APPLY]

- 10a. Speech disturbance? Yes Y
- No N
 - Don't know 7
 - Refused 8
 - Missing 9

10b. Numbness or tingling?	Yes	1
	<input type="checkbox"/> No	2
	Don't know	7
	Refused	8
	Missing	9

10c. Did you have difficulty on:	The right side only	1
[READ ALL CHOICES]		
	The left side only	2
	Both sides	3
	Don't know	7
	Refused	8
	Missing	9

10d. Paralysis or weakness?	Yes	1
	<input type="checkbox"/> No	2
	Don't know	7
	Refused	8
	Missing	9

10e. Did you have difficulty on:	The right side only	1
[READ ALL CHOICES]		
	The left side only	2
	Both sides	3
	Don't know	7

	Refused	8
	Missing	9
10f. Lightheadedness, dizziness, or loss of balance?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9
10g. Blackouts or fainting?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9
10h. Seizures or convulsions?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9
10i. Headache?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

10j. Flashing lights?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

D. DOUBLE VISION

11a. In the past 5 years, since your last Jackson Heart Study visit, have you had a sudden spell of double vision, which lasted 24 hours or longer?	Yes	1
---	-----	---

Go to Item 14	No	2
	Don't know	7
	Refused	8
	Missing	9

11b. If you closed one eye, did the double vision go away?	Yes	1
--	-----	---

Go to Item 14	No	2
	Don't know	7
	Refused	8
	Missing	9

12. Did the episode come on suddenly?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

13. While you were having your double vision did any of the following occur? [INCLUDE ALL THAT APPLY]

13a. Speech disturbance? Yes 1
No 2
Don't know 7
Refused 8
Missing 9

13b. Numbness or tingling? Yes 1
 Go to Item 13d — No 2
Don't know 7
Refused 8
Missing 9

13c. Did you have difficulty on: The right side only 1
[READ ALL CHOICES]
The left side only 2
Both sides 3
Don't know 7
Refused 8
Missing 9

13d. Paralysis or weakness? Yes 1
 Go to Item — No 2
Don't know 7
Refused 8
Missing 9

13e. Did you have difficulty on.....	The right side only	1
[READ ALL CHOICES]		
	The left side only	2
	Both sides	3
	Don't know	7
	Refused	8
	Missing	9

13f. Lightheadedness, dizziness, or loss of balance?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

13g. Blackouts or fainting?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

13h. Seizures or convulsions?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

13i. Headache?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

E. SUDDEN NUMBNESS OR TINGLING

14. In the past 5 years, since your last Jackson Heart Study exam, have you ever had sudden numbness, tingling, or loss of feeling on one side of your body, including your face, arm, or leg which lasted 24 hours or longer?

	Yes	1
	No	2
Go to Item 20	Don't know	7
	Refused	8
	Missing	9

15. Did the feeling of numbness or tingling occur only when you kept your arms or legs in a certain position?

Yes	1	Go to Item 20
No	2	
Don't know	7	
Refused	8	
Missing	9	

16. Did the episode come on suddenly?

Yes	1
No	2
Don't know	7
Refused	8
Missing	9

17. During the episode of sudden numbness or tingling, which part or parts of your body were affected?
[READ ALL CHOICES]

	<u>Yes</u>	<u>No</u>	<u>Don't Know</u>	<u>Refused</u>	Missing
17a. Left arm or hand?	1	2	7	8	9
17b. Left leg or foot?	1	2	7	8	9
17c. Left side of face?	1	2	7	8	9
17d. Right arm or hand?.....	1	2	7	8	9
17e. Right leg or foot?	1	2	7	8	9
17f. Right side of face?.....	1	2	7	8	9
17g. Other?	1	2	7	8	9

18. During this episode, did the abnormal sensation start in one part of your body and spread to another, or did it stay in the same place?

Started in one part and spread to another	1
Stayed in one part	2
Don't know	7
Refused	8
Missing	9

19. While you were having your episode of numbness, tingling or loss of sensation, did any of the following occur?
[INCLUDE ALL THAT APPLY]

19a. Speech disturbance?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

19b. Paralysis or weakness?	Yes	1
	<input type="checkbox"/> No	2
	Don't know	7
	Refused	8
	Missing	9

Go to Item 19d

19c. Did you have difficulty on:	The right side only	1
[READ ALL CHOICES]		
	The left side only	2
	Both sides	3
	Don't know	7
	Refused	8
	Missing	9

19d. Lightheadedness, dizziness, or loss of balance?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

19e. Blackouts or fainting?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

19f. Seizures or convulsions?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9
19g. Headache?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9
19h. Pain in the numb or tingling arm, leg or face?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9
19i. Visual disturbances?	Yes	1
	<input type="checkbox"/> No	2
	Don't know	7
	Refused	8
	Missing	9

Go to Item 20

19j. Did you have: [READ ALL CHOICES UNTIL A POSITIVE RESPONSE IS GIVEN]

Double vision	01
Vision loss in right eye only	02
Vision loss in left eye only	03
Total loss of vision in both eyes	04
Trouble in both eyes seeing to the right	05
Trouble in both eyes seeing to the left	06
Trouble in both eyes seeing to both sides or straight ahead	07
Don't know	77
Refused	88
Missing	99

F. SUDDEN PARALYSIS OR WEAKNESS

20. In the past 5 years, since your last Jackson Heart Study exam, have you had any sudden episode of paralysis or weakness on one side of your body, including your face, arm, or leg which lasted at least 24 hours?

Yes	1
No	2
Don't know	7
Refused	8
Missing	9

Go to Item 25

21. Did the episode come on suddenly? Yes 1
 No 2

Don't know	7
Refused	8
Missing	9

22. During this episode, which part or parts of your body were affected? [READ ALL CHOICES]

	<u>Yes</u>	<u>No</u>	<u>Don't Know</u>	<u>Refused</u>	<u>Missing</u>
22a. Left arm or hand?	1	2	7	8	9
22b. Left leg or foot?	1	2	7	8	9
22c. Left side of face?	1	2	7	8	9
22d. Right arm or hand?	1	2	7	8	9
22e. Right leg or foot?	1	2	7	8	9
22f. Right side of face?	1	2	7	8	9
22g. Other?.....	1	2	7	8	9

23. During this episode, did the paralysis or weakness start in one part of your body and spread to another, or did it stay in the same place?

Started in one part and spread to another	1
Stayed in one part	2
Don't know	7
Refused	8
Missing	9

24. While you were having your episode of paralysis or weakness, did any of the following occur? [INCLUDE ALL THAT APPLY]

24a. Speech disturbances?	Yes	1
	No	2

Don't know 7

Refused 8

Missing 9

24b. Numbness or tingling? Yes 1

Go to Item 24d — No 2

Don't know 7

Refused 8

Missing 9

24c. Did you have difficulty on: The right side only 1
[READ ALL CHOICES]

The left side only 2

Both sides 3

Don't know 7

Refused 8

Missing 9

24d. Lightheadedness, dizziness, or loss of
balance?..... Yes 1

No 2

Don't know 7

Refused 8

Missing 9

24e. Blackouts or fainting? Yes 1

No 2

	Don't know	7
	Refused	8
	Missing	9
24f. Seizures or convulsions?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9
24g. Headache?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9
24h. Pain in the weak arm, leg or face?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9
24i. Visual disturbances?	Yes	1
	<input type="button" value="Go to Item 25"/> No	2
	Don't know	7
	Refused	8

	Missing	9
24j. Did you have: [READ ALL CHOICES UNTIL A POSITIVE RESPONSE IS GIVEN]		
	Double vision	01
	Vision loss in right eye only	02
	Vision loss in left eye only	03
	Total loss of vision in both eyes	04
	Trouble in both eyes seeing to the right	05
	Trouble in both eyes seeing to the left	06
	Trouble in both eyes seeing to both sides or straight ahead	07
	Don't know	77
	Refused	88
	Missing	99

G. SUDDEN SPELLS OF DIZZINESS OR LOSS OF BALANCE

25. In the past 5 years, since your last Jackson Heart Study exam, have you had any sudden spells of dizziness, loss of balance, or sensation of spinning which lasted 24 hours or longer? Yes		1
	No	2
	Don't know	7
	Refused	8
	Missing	9

Go to Item 29

26. Did the dizziness, loss of balance or spinning sensation occur only when changing the position of your head or body?

- Yes 1
- No 2
- Don't know 7
- Refused 8
- Missing 9

Go to Item 29

27. While you were having your episode of dizziness, loss of balance or spinning sensation, did any of the following occur? [INCLUDE ALL THAT APPLY]

- 27a. Speech disturbances?
- Yes 1
 - No 2
 - Don't know 7
 - Refused 8
 - Missing 9

- 27b. Paralysis or weakness?
- Yes 1
 - No 2
 - Don't know 7
 - Refused 8
 - Missing 9

Go to Item 27d

- 27c. Did you have difficulty on: [READ ALL CHOICES]
- The right side only 1
 - The left side only 2
 - Both sides 3
 - Don't know 7

	Refused	8
	Missing	9
27d. Numbness or tingling?	Yes	1
	Go to Item 27f — No	2
	Don't know	7
	Refused	8
	Missing	9
27e. Did you have difficulty on:	The right side only	1
[READ ALL CHOICES]	The left side only	2
	Both sides	3
	Don't know	7
	Refused	8
	Missing	9
27f. Blackouts or fainting?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9
27g. Seizures or convulsions?	Yes	1
	No	2
	Don't know	7
	Refused	8

	Missing	9
27h. Headache?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

27i. Visual disturbances?	Yes	1
	<div style="border: 1px solid black; display: inline-block; padding: 2px;">Go to Item 28</div> — No	2
	Don't know	7
	Refused	8
	Missing	9

27j. Did you have:

[READ ALL CHOICES UNTIL A POSITIVE RESPONSE IS GIVEN]

Double vision	01
Vision loss in right eye only	02
Vision loss in left eye only	03
Total loss of vision in both eyes	04
Trouble in both eyes seeing to the right	05
Trouble in both eyes seeing to the left	06
Trouble in both eyes seeing to both sides or straight ahead	07
Don't know	77

Refused	88
Missing	99

28. Did the episode of dizziness, loss of balance, or spinning sensation come on suddenly?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

H. ADMINISTRATIVE INFORMATION

29. Date of data collection:

		/			/				
m	m		d	d		y	y	y	y

30. Method of data collection:	Computer	1
	Paper form	2
31. Data Collected:	In clinic	1
	Off site	2

32. Code number of person completing this interview: