HEART ATTACK PREVENTION PROGRAM

PLEASE READ AND SIGN CONSENT

CONSENT: I volunteer for the first screening examination of the Heart Attack Prevention Program. I understand that this screening procedure will involve measurements of my blood cholesterol and other substances related to heart attacks. There will also be some questions concerning my health and smoking habits. There are no known significant complications from these procedures.

I understand that the screening procedure is to estimate my degree of risk for heart attacks, and that the results will be reported to me and my physician (If I so indicate).

The information which is obtained will be treated as a confidential medical record and will be seen only by myself, members of the Heart Attack Prevention Program staff and my doctor, if I so indicate. The information obtained may be used by the Heart Attack Prevention Program for scientific purposes only.

I have read the orientation material and the foregoing statement, understand them, and any questions which have occurred to me have been answered to my satisfaction. I understand that I may ask additional questions at any time, and that I am free to discontinue my participation in the Program at any time.

DATE SIGNED _____ SIGNATURE OF PARTICIPANT _____

The above participant has been given the opportunity to have his questions about these screening procedures answered. _____ SIGNATURE OF AUDITOR/WITNESS

MONTH CONVERSION TABLE

01 - JANUARY
02 - FEBRUARY
03 - MARCH
04 - APRIL
05 - MAY
06 - JUNE
07 - JULY
08 - AUGUST
09 - SEPTEMBER
10 - OCTOBER
11 - NOVEMBER
12 - DECEMBER

1. PARTICIPANT'S NAME AND ADDRESS

FIRST NAME	MIDDLE NAME	LAST NAME
HOUSE AND STREET ADDRESS		APARTMENT NO.
CITY OR TOWN	STATE	ZIP CODE

IDENTIFICATION LABEL

DAYS1S□
AGE1S

2. HOME PHONE

AREA CODE	NUMBER

☐ forward ☐ do not forward test results to my physician.

NAME AND ADDRESS OF YOUR PHYSICIAN

old_

FIRST NAME	LAST NAME
STREET/CLINIC ADDRESS	
CITY OR TOWN	STATE ZIP CODE

3. DATE OF EXAMINATION MONTH DAY YEAR — enter date as follows: Jan 22, 1974 = 01-22-74

4. SOCIAL SECURITY NUMBER ___-__-____

5. DATE OF BIRTH MONTH DAY YEAR — enter date of birth as follows: June 8, 1950 = 06-08-50

REFGRP1S

6. WHICH OF THE FOLLOWING BEST DESCRIBES THE GROUP TO WHICH YOU BELONG.

WHITE 1 ☐ BLACK 2 ☐ ORIENTAL 3 ☐ SPANISH AMERICAN 4 ☐ AMERICAN INDIAN 5 ☐ OTHER 6 ☐

7. DO YOU DEFINITELY PLAN TO CHANGE YOUR PERMANENT RESIDENCE MORE THAN 50 MILES AWAY FROM THIS AREA DURING THE NEXT YEAR? ☐ Yes 1 ☐ No/Uncertain 2

8. ARE YOU PRESENTLY TAKING MEDICINE PRESCRIBED BY A DOCTOR FOR DIABETES? ☐ Yes 1 ☐ No/Uncertain 2

9. HAVE YOU EVER BEEN HOSPITALIZED FOR A HEART ATTACK FOR TWO WEEKS OR MORE? ☐ Yes 1 ☐ No/Uncertain 2

CIGS1S

10. ON THE AVERAGE, HOW MANY CIGARETTES DO YOU NOW SMOKE A DAY?
Enter number of cigarettes not packs (20 cigarettes = 1 pack).
ENTER 00 IF YOU DO NOT NOW SMOKE CIGARETTES.
▶ ☐☐ NUMBER OF CIGARETTES PER DAY

11. THESE ITEMS (11, 12, and 13) FOR USE BY CLINIC PERSONNEL ONLY

BLOOD PRESSURE: Readings to be taken at 2-minute intervals with participant seated. Leading zeroes must be entered in appropriate box. For example, a pressure of 82 mm Hg must be entered as 082, not 82.

READING	SYSTOLIC (mmHg)	DIASTOLIC (Phase V) (mmHg)
1st	mm Hg	mm Hg
2nd	mm Hg	☐☐☐ mm Hg
3rd	mm Hg	☐☐☐ mm Hg
	BLOOD PRESSURE OBSERVER'S CODE ▶	☐☐

STDDBP1S□
STDSBP1S

fold_to

12. SERUM CHOLESTEROL Attach packing list label ☐☐☐ mg/dl

13. ○ INELIGIBLE ○ ELIGIBLE