DATE ☐☐-☐☐-☐☐ (17) CLINIC ☐ (23)

09471
1 5

MULTIPLE RISK FACTOR INTERVENTION TRIAL

SEVENTH ANNUAL MEDICAL HISTORY QUESTIONNAIRE

ID (6–16)

NAME

ADDRESSOGRAPH PLATE

Year of Follow-up ☐7 (24)

Attach ID Label Here

The following set of questions includes a Medical History Questionnaire and some questions regarding diet changes over the past six years. Please follow these directions when completing this questionnaire.

1. Read every question carefully and answer every one. Unless otherwise indicated, only one response should be selected for each question. PLEASE USE BALLPOINT PEN AND PRESS FIRMLY.
2. It is essential that you bring this completed questionnaire with you to your scheduled appointment. A protective envelope is enclosed for your convenience. PLEASE DO NOT FOLD THE QUESTIONNAIRE.

The answers you give are treated completely confidentially and will become part of your study record.

PLEASE BRING ALL MEDICINES THAT YOU ARE CURRENTLY TAKING, OR HAVE TAKEN DURING THE PAST TWO WEEKS, TO THE NEXT VISIT SO THAT THE DOCTOR CAN IDENTIFY THEM.

Your present address and telephone number:

CC USE 1☐ (25)

ADDRESS: _____
Street Apartment No.

_____
City State Zip Code

_____ _____
Home Telephone Number Work Telephone Number

If you wish the results of the tests, the ECG and physical examination sent to your physician, please give his name and address below and check the box. ☐

CC USE 1☐ (26)

NAME: _____

ADDRESS: _____
Street Apartment No.

_____
City State Zip Code

Please give the name and address of someone who is not living in your household but who will know where you are if we should need to contact you. If this person is a married woman, please give her husband's name also in the space provided.

CC USE 1☐ (27)

_____ _____
Name: First Last Husband

_____
Street No. and Name

_____
City State Zip Code

PART I – MEDICAL HISTORY QUESTIONNAIRE

A complete and accurate medical history is essential in evaluating your health status. This questionnaire is intended to help you become more aware of your physical well-being and to help our staff with your examination at the next visit.

DURING THE PAST 12 MONTHS HAS A DOCTOR TOLD YOU THAT YOU HAD ANY OF THE FOLLOWING?
(Check either yes, no, or not sure for each item.)

MHQ01V84	1. High blood pressure (hypertension)	28	1 ☐ yes 2 ☐ no 3 ☐ not sure
MHQ02V84	2. Heart attack (myocardial infarction, coronary occlusion or coronary thrombosis)	29	1 ☐ yes 2 ☐ no 3 ☐ not sure
MHQ03V84	3. Angina	30	1 ☐ yes 2 ☐ no 3 ☐ not sure
MHQ04V84	4. Congenital heart disease (born with heart defect)	31	1 ☐ yes 2 ☐ no 3 ☐ not sure
MHQ05V84	5. Rheumatic fever, chorea (St. Vitus Dance)	32	1 ☐ yes 2 ☐ no 3 ☐ not sure
MHQ06V84	6. Rheumatic heart disease	33	1 ☐ yes 2 ☐ no 3 ☐ not sure
MHQ07V84	7. Stroke	34	1 ☐ yes 2 ☐ no 3 ☐ not sure
MHQ08V84	8. Diabetes (sugar in the blood or urine)	35	1 ☐ yes 2 ☐ no 3 ☐ not sure
MHQ09V84	9. Gout	36	1 ☐ yes 2 ☐ no 3 ☐ not sure
MHQ10V84	10. Kidney disease (nephritis, pyelonephritis, glomerulonephritis, kidney infection)	37	1 ☐ yes 2 ☐ no 3 ☐ not sure
MHQ11V84	11. Kidney stones	38	1 ☐ yes 2 ☐ no 3 ☐ not sure
MHQ12V84	12. Prostate infection, enlargement or other prostate disease	39	1 ☐ yes 2 ☐ no 3 ☐ not sure
MHQ13V84	13. Urinary tract infection, bladder infection, other bladder disease	40	1 ☐ yes 2 ☐ no 3 ☐ not sure
MHQ14V84	14. Bronchitis	41	1 ☐ yes 2 ☐ no 3 ☐ not sure
MHQ15V84	15. Pneumonia	42	1 ☐ yes 2 ☐ no 3 ☐ not sure
MHQ16V84	16. Pleurisy	43	1 ☐ yes 2 ☐ no 3 ☐ not sure
MHQ17V84	17. Emphysema	44	1 ☐ yes 2 ☐ no 3 ☐ not sure
MHQ18V84	18. Tuberculosis	45	1 ☐ yes 2 ☐ no 3 ☐ not sure
MHQ19V84	19. Thyroid problem or disease	46	1 ☐ yes 2 ☐ no 3 ☐ not sure
MHQ20V84	20. Colitis or inflammation of the colon	47	1 ☐ yes 2 ☐ no 3 ☐ not sure
MHQ21V84	21. Ulcer (stomach or duodenal), or intestinal bleeding	48	1 ☐ yes 2 ☐ no 3 ☐ not sure
MHQ22V84	22. Hepatitis	49	1 ☐ yes 2 ☐ no 3 ☐ not sure
MHQ23V84	23. Cirrhosis or other liver disease	50	1 ☐ yes 2 ☐ no 3 ☐ not sure
MHQ24V84	24. Anemia	51	1 ☐ yes 2 ☐ no 3 ☐ not sure
MHQ25V84	25. Cancer	52	1 ☐ yes 2 ☐ no 3 ☐ not sure
MHQ26V84	26. Nervous, emotional or mental disorder	53	1 ☐ yes 2 ☐ no 3 ☐ not sure
MHQ27V84	27. Rheumatoid arthritis	54	1 ☐ yes 2 ☐ no 3 ☐ not sure
MHQ28V84	28. Other arthritis	55	1 ☐ yes 2 ☐ no 3 ☐ not sure
☐	29. Epilepsy or seizures or fits	56	1 ☐ yes 2 ☐ no 3 ☐ not sure
MHQ30V84	30. Allergies	57	1 ☐ yes 2 ☐ no 3 ☐ not sure
MHQ31V84	31. Asthma	58	1 ☐ yes 2 ☐ no 3 ☐ not sure
MHQ32V84	32. Hives or hay fever	59	1 ☐ yes 2 ☐ no 3 ☐ not sure
	33. Other major diseases (specify) _____	60	1 ☐ yes 2 ☐ no 3 ☐ not sure
	34. During the past 12 months have you been told by a doctor that you have gallstones or gall bladder disease?	61	1 ☐ yes 2 ☐ no 3 ☐ not sure
	35. During the past 12 months have you had x-rays taken of your gall bladder?	62	1 ☐ yes 2 ☐ no 3 ☐ not sure
	36. During the past 12 months have you had surgery for gall bladder disease?	63	1 ☐ yes 2 ☐ no 3 ☐ not sure
37	During the past 12 months have you had surgery on your heart or arteries?	64	1 ☐ yes 2 ☐ no 3 ☐ not sure

CASURG84

DURING THE PAST 12 MONTHS HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?

	38. Skin rash or unusual bruises?	65	1 ☐ yes 2 ☐ no 3 ☐ not sure
	39. Headaches that were so bad you had to stop what you were doing?	66	1 ☐ yes 2 ☐ no 3 ☐ not sure
	40. Headache attack, racing heart and sweating, all at the same time?	67	1 ☐ yes 2 ☐ no 3 ☐ not sure
	41. Faintness or light-headedness when you stand up quickly?	68	1 ☐ yes 2 ☐ no 3 ☐ not sure
	42. Your heart beating unusually fast or skipping beats?	69	1 ☐ yes 2 ☐ no 3 ☐ not sure
	43. Blacking out or losing consciousness?	70	1 ☐ yes 2 ☐ no 3 ☐ not sure
	44. Frequent stomach pains?	71	1 ☐ yes 2 ☐ no 3 ☐ not sure
	45. Waking up early, having trouble getting back to sleep?	72	1 ☐ yes 2 ☐ no 3 ☐ not sure
	46. Black or tarry stools?	73	1 ☐ yes 2 ☐ no 3 ☐ not sure
	47. Bright red blood in your stools?	74	1 ☐ yes 2 ☐ no 3 ☐ not sure
	48. Allergies to medicines?	75	1 ☐ yes 2 ☐ no 3 ☐ not sure
	49. Unexplained weight loss?	76	1 ☐ yes 2 ☐ no 3 ☐ not sure

50. Were you hospitalized for any reason in the past 12 months?

HOSP84

77 1 ☐ yes → Please give the name and address of the hospital you visited.

2 ☐ no

A. _____ Hospital

_____ Street

_____ City - State

B. _____ Hospital

_____ Street

_____ City - State

C. _____ Hospital

_____ Street

_____ City - State

51. During the past 12 months have you had a chest x-ray? 78 1 ☐ yes 2 ☐ no

52. During the past 12 months, about how many times have you seen or talked to a medical doctor for health reasons? Do not count the MRFIT physicians. (check one)

79 1 ☐ zero times during past year 2 ☐ one - two times during past year 3 ☐ three - five times during past year 4 ☐ six or more times during past year

53. During the past 12 months, about how many visits have you made to the dentist? (check one)

80 1 ☐ zero times during past year 2 ☐ one time during past year 3 ☐ two times during past year 4 ☐ three or more times during past year

54. About how many days during the past 12 months were you kept in bed for all or most of the day because of illness, disability or injury? (check one)

81 1 ☐ zero - three days during past year 2 ☐ four - six days during past year 3 ☐ seven - nine days during past year 4 ☐ ten or more days during past year

RATACT84

55. Considering all the things you do, how would you rate yourself as to the amount of physical activity you get compared with other men your age? (check one)

82 1 ☐ I am much less active than others 2 ☐ I am somewhat less active than others 3 ☐ I am about the same 4 ☐ I am somewhat more active 5 ☐ I am much more active

ASPIR84

56. During the past four weeks, how often did you take aspirin or similar drugs containing aspirin such as Alka-Seltzer, Anacin, APC, Bufferin, Darvon Compound, Dristan, Empirin, or Excedrin? (check one)

83 1 ☐ daily 2 ☐ four, five, six days per week 3 ☐ one, two, three days per week 4 ☐ occasionally - less often than one day per week 5 ☐ not at all

THINKING ABOUT THE LAST 12 MONTHS PLEASE ANSWER THE FOLLOWING QUESTIONS:

CHF84

57. Have you ever awakened at night gasping for breath? 84 1 ☐ yes 2 ☐ no

58. Do you usually cough first thing in the morning in the winter? (If you cough with your first smoke or when first going outside, you should mark "yes". Do not respond "yes" for clearing of throat or a single cough.) 85 1 ☐ yes 2 ☐ no

COUGH84

59. Do you usually cough during the day or at night in the winter? (Do not respond "yes" for a single cough.)

86 1 ☐ yes → 60. Do you cough like this on most days for as much as 3 months each year? 87 1 ☐ yes 2 ☐ no

2 ☐ no

Continue with question 61.

61. Do you usually bring up any phlegm (mucus) from your chest first thing in the morning in the winter? 88 1 ☐ yes 2 ☐ no

PHLEGM84

62. Do you usually bring up any phlegm from your chest during the day—or at night—in the winter?

89 1 ☐ yes → 63. Do you bring up phlegm like this on most days for as much as 3 months each year? 90 1 ☐ yes 2 ☐ no

89 2 ☐ no

64. In the past 3 years, have you had a period of increased cough and phlegm lasting for 3 weeks or more? 91 1 ☐ yes, once 2 ☐ yes, more than once 3 ☐ no

DYSPNE84

65. Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill? 92 1 ☐ yes 2 ☐ no

66. Do you get short of breath walking with other people of your own age on level ground? 93 1 ☐ yes 2 ☐ no

67. Have you ever had asthma? 94 1 ☐ yes 2 ☐ no

68. Have you ever had any pain or discomfort in your chest?

95 1 ☐ yes → 70. Do you get it when you walk uphill or hurry? 97 1 ☐ yes 2 ☐ no

95 2 ☐ no

71. Do you get it when you walk at an ordinary pace on the level? 98 1 ☐ yes 2 ☐ no

ROSEAN84
ROSEMI84

72. When you get it in your chest what do you do?

99 1 ☐ stop 2 ☐ slow down 3 ☐ continue at same pace

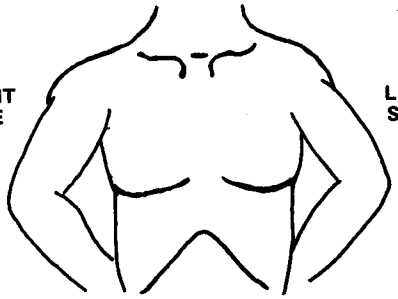
73. Does it go away when you stand still?

100 1 ☐ yes → 74. How soon? 101 1 ☐ 10 min. or less 2 ☐ more than 10 min.

Continue with question 75.

100 2 ☐ no

75. Where do you get this pain or discomfort? (Mark the place or places with an "X" on the diagram.)



DO NOT USE

102 1 ☐ yes 2 ☐ no

103 1 ☐ yes 2 ☐ no

104 1 ☐ yes 2 ☐ no

76. Have you ever had a severe pain across the front of your chest lasting for half an hour or more? 105 1 ☐ yes 2 ☐ no

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

96 1 ☐ yes

96 2 ☐ no

77. Do you get a pain in either leg on walking?

106 1 ☐ yes → 78. Does this pain ever begin when you are standing still or sitting? 107 1 ☐ yes 2 ☐ no

106 2 ☐ no

79. Do you get this pain in your calf? (or calves?) 108 1 ☐ yes 2 ☐ no

ROSEIC84

80. Do you get it when you walk uphill or hurry? 109 1 ☐ yes 2 ☐ no

81. Do you get it when you walk at an ordinary pace on the level? 110 1 ☐ yes 2 ☐ no

82. Does the pain ever disappear while you are still walking? 111 1 ☐ yes 2 ☐ no

83. What do you do if you get it when you are walking?

112 1 ☐ stop 2 ☐ slow down 3 ☐ continue at same pace

84. What happens to it if you stand still?

113 1 ☐ usually continues more than 10 min. 2 ☐ usually disappears in 10 min. or less

Continue with question 85.

PLEASE ANSWER THE FOLLOWING QUESTIONS AS DIRECTED

85. In the past 12 months, have you had any sudden feeling of numbness, tingling or loss of feeling in either arm, hand, leg, foot or face?

114 1 ☐ yes → 2 ☐ no

NDNUMB84

86. How many attacks of such numbness or tingling have you had? (Check one)

115 1 ☐ only one 2 ☐ two 3 ☐ three - five 4 ☐ more than five

87. How long did the attack(s) usually last? (Check one)

116 1 ☐ usually less than 5 minutes 2 ☐ from 5 minutes to an hour 3 ☐ from 1 to 6 hours
4 ☐ from 6 to 24 hours 5 ☐ more than a day

88. Did you see a doctor for the numbness or tingling? 117 1 ☐ yes 2 ☐ no

89. During the past 12 months, have you had any sudden attacks of paralysis or loss of use of either arm, hand, leg or foot?

118 1 ☐ yes → 2 ☐ no

NDPARL84

90. How many attacks of such paralysis have you had? (Check one)

119 1 ☐ only one 2 ☐ two 3 ☐ three - five 4 ☐ more than five

91. How long did the attack(s) usually last? (Check one)

120 1 ☐ usually less than 5 minutes 2 ☐ from 5 minutes to an hour 3 ☐ from 1 to 6 hours
4 ☐ from 6 to 24 hours 5 ☐ more than a day

92. Did you see a doctor for this paralysis? 121 1 ☐ yes 2 ☐ no

93. In the past 12 months, have you had any sudden loss of eyesight or blurring of vision for a short period of time?

122 1 ☐ yes → 2 ☐ no

NDANOP84

94. What part of your vision was affected? (Check one)

123 1 ☐ right eye 2 ☐ left eye 3 ☐ both eyes
4 ☐ vision to the right side 5 ☐ vision to the left side

95. How many attacks of loss of eyesight or blurring of vision have you had? (Check one)

124 1 ☐ only one 2 ☐ two 3 ☐ three - five 4 ☐ more than five

96. How long did the attack(s) usually last? (Check one)

125 1 ☐ usually less than 5 minutes 2 ☐ from 5 minutes to an hour 3 ☐ from 1 to 6 hours
4 ☐ from 6 to 24 hours 5 ☐ more than a day

97. Did you see a doctor for this vision problem? 126 1 ☐ yes 2 ☐ no

98. In the past 12 months, have you had any sudden attacks of changes in speech, loss of speech or inability to say words for more than two minutes?

127 1 ☐ yes → 2 ☐ no

NDDYSP84

99. How many attacks of loss of speech have you had? (Check one)

128 1 ☐ only one 2 ☐ two 3 ☐ three - five 4 ☐ more than five

100. How long did the attack(s) usually last? (Check one)

129 1 ☐ usually less than 5 minutes 2 ☐ from 5 minutes to an hour 3 ☐ from 1 to 6 hours
4 ☐ from 6 to 24 hours 5 ☐ more than a day

101. Did you see a doctor for your speech problem? 130 1 ☐ yes 2 ☐ no

Continue with question 102.

102. During the past 12 months, have you had any spells of dizziness, difficulty in walking, lightheadedness or loss of balance? Check yes or no for each condition to indicate whether an attack occurred or not.

Dizziness	131	1☐ yes 2☐ no
Spinning sensation (vertigo)	132	1☐ yes 2☐ no
Loss of balance	133	1☐ yes 2☐ no
Difficulty walking	134	1☐ yes 2☐ no
Blackouts or fainting	135	1☐ yes 2☐ no

103. Is "yes" checked one or more times in question 102?

136 1☐ yes → 104. About how many total attacks of all conditions checked do you think you have had in the past 12 months? (Check one)

137 1☐ only one 2☐ two 3☐ three - five 4☐ more than five

105. How long did attack(s) usually last? (Check one)

138 1☐ usually less than 5 minutes 2☐ from 5 minutes to an hour 3☐ from 1 to 6 hours 4☐ from 6 to 24 hours 5☐ more than a day

106. Did you see a doctor for any of these spells? 139 1☐ yes 2☐ no

2☐ no

NDATAX84

NDALL84

THE FOLLOWING QUESTIONS REFER TO HOSPITALIZATIONS OCCURRING SINCE YOUR SIXTH ANNUAL EXAMINATION, APPROXIMATELY ONE YEAR AGO.

107. Have you been hospitalized for heart trouble in the past year?

140 1☐ yes →

MONTH YEAR

108. What was the date of your most recent hospitalization for heart trouble? 141 ☐☐ ☐☐

109. How many days were you hospitalized?

145 1☐ 1 - 2 days 2☐ 3 - 7 days 3☐ 8 - 30 days 4☐ more than 30 days

110. Where were you hospitalized?

Name of Hospital _____

Street _____

City — State _____

2☐ no

111. Have you been hospitalized for stroke in the past year?

146 1☐ yes →

MONTH YEAR

112. What was the date of your most recent hospitalization for stroke? 147 ☐☐ ☐☐

113. How many days were you hospitalized?

151 1☐ 1 - 2 days 2☐ 3 - 7 days 3☐ 8 - 30 days 4☐ more than 30 days

114. Where were you hospitalized?

Name of Hospital _____

Street _____

City — State _____

2☐ no

115. Have you been hospitalized for cancer in the past year?

152 1☐ yes →

MONTH YEAR

116. What was the date of your most recent hospitalization for cancer? 153 ☐☐ ☐☐

117. How many days were you hospitalized?

157 1☐ 1 - 2 days 2☐ 3 - 7 days 3☐ 8 - 30 days 4☐ more than 30 days

118. What was the site (location) of the cancer?

158 1☐ lung 2☐ colon 3☐ other, specify _____

119. Where were you hospitalized?

Name of Hospital _____

Street _____

City — State _____

2☐ no

Continue with Part II.

SKIP 159-END

09472
Dup 6-24

PART II – NUTRITION

1. Since the beginning of the program has your personal physician (other than MRFIT physician) advised you to follow any special diet or to make any changes in the food you eat?

25 1 ☐ yes → 2. Did you personally request the diet information from your physician? 26 1 ☐ yes 2 ☐ no

25 2 ☐ no

3. Please summarize the food changes your physician advised you to make.

_____

_____

_____

CC USE 1 ☐ 27

4. For each item below indicate whether it was for that reason that the physician asked you to follow the special diet.

a. Diabetes	28 1 ☐ yes	2 ☐ no
b. Overweight	29 1 ☐ yes	2 ☐ no
c. High Blood Pressure	30 1 ☐ yes	2 ☐ no
d. High Blood Fat or Cholesterol	31 1 ☐ yes	2 ☐ no
e. Food Allergy	32 1 ☐ yes	2 ☐ no
f. Ulcer	33 1 ☐ yes	2 ☐ no
g. Other	34 1 ☐ yes	2 ☐ no

Specify _____

5. Were you given printed instructions describing the special diet? 35 1 ☐ yes 2 ☐ no

6. Was the special diet explained to you by the physician or his staff?

36 1 ☐ yes → 7. Check the following people who explained the diet to you.

a. Physician	37 1 ☐ yes	2 ☐ no
b. Nurse	38 1 ☐ yes	2 ☐ no
c. Dietitian or Nutritionist	39 1 ☐ yes	2 ☐ no
d. Other Staff	40 1 ☐ yes	2 ☐ no

Specify _____

36 2 ☐ no

8. How well did you understand the diet changes the physician advised you to make? (Check one)

41 1 ☐ Very well. I understood what changes to make. 2 ☐ Fairly well. I understood some of the changes required but had further questions. 3 ☐ Not very well. I didn't know what changes to make.

9. Have you started making the diet changes the physician advised you to follow?

42 1 ☐ yes → 10. Approximately how long has it been since you started making these diet changes?

43 1 ☐ less than six months 2 ☐ six-twelve months 3 ☐ one-two years
4 ☐ two-three years 5 ☐ three-four years 6 ☐ more than four years

11. In general, how closely have you been following this diet during the past year?

44 1 ☐ have changed eating habits consistent with diet and very rarely go off diet 2 ☐ follow diet most of the time 3 ☐ have not been able to stick to the diet consistently

42 2 ☐ no

Continue with question 12.

12. Since the beginning of the program have you made any changes in the food you eat other than diet changes recommended by your personal physician?

45 1 ☐ yes → 13. What was the major reason that motivated you to make these changes in the food you eat? (Check one)

46 1 ☐ Written information media – such as newspapers, magazines, books and ads
2 ☐ Audio-visual information media – such as radio, television
3 ☐ Advice from MRFIT staff
4 ☐ Family influence
5 ☐ Joined a nutrition education group (other than 3 above) such as Weight Watchers
Specify Group _____
6 ☐ Advice from acquaintances or friends
7 ☐ Personal concern over own health
8 ☐ Other, Specify _____

14. Approximately how long has it been since you started making these diet changes?

47 1 ☐ less than six months 2 ☐ six-twelve months 3 ☐ one-two years
4 ☐ two-three years 5 ☐ three-four years 6 ☐ more than four years

45 2 ☐ no → **FINISHED**

SKIP 48-END