

OCCLUDED ARTERY TRIAL (OAT)
Medical History Form

OAT Form 01
Rev 2 (email)
04/14/2003
1 of 2 Pages



14049

Please Use Black Pen To Fill Out Form.

Patient's ID Number:

-

Letter Code:

Correction

Date of OAT Randomization:

- - *fm01dt*

mmm dd yyyy

1. Patient's gender:

Male Female *fm01sex*

2. Patient's date of birth:

- - *dobdt*

mmm dd yyyy

3A. Ethnicity:

Hispanic or Latino Not Hispanic or Latino *hisp*

3B. Race (answer each item). What race do you primarily identify with?

	Yes	No
1. American Indian or Alaskan Native	<input type="radio"/>	<input type="radio"/> <i>native</i>
2. Asian	<input type="radio"/>	<input type="radio"/> <i>asianx</i>
3. Black or African American	<input type="radio"/>	<input type="radio"/> <i>blackx</i>
4. Native Hawaiian or other Pacific Islander	<input type="radio"/>	<input type="radio"/> <i>pacific</i>
5. White	<input type="radio"/>	<input type="radio"/> <i>whitex</i>
6. Australian Aboriginal	<input type="radio"/>	<input type="radio"/> <i>aaborig</i>

4. Prior History of:

	Yes	No	Unknown
A. Angina	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> <i>angina</i>
B. Myocardial Infarction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> <i>mi</i>
C. Cerebrovascular disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> <i>cerevas</i>
1. Stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> <i>stroke</i>
D. Peripheral vessel disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> <i>pvd</i>
E. Renal Insufficiency	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> <i>rnlinf</i>
F. AICD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> <i>aicd</i>
G. CHF	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> <i>chf</i>
H. Percutaneous coronary intervention	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> <i>pci</i>

If Yes, date:

pcidt

mmm dd yyyy

pci_uk

date unknown

Signature: _____

-

OAT Staff Number

OCCLUDED ARTERY TRIAL (OAT)
Medical History Form (continued)

OAT Form 01
Rev 2 (email)
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2 of 2 Pages



36517

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Patient's ID Number:

-

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4. Prior history of (Continued):

Yes No Unknown

I. CABG

cabg

If Yes, date:

cabgdt

mmm dd yyyy

cabg_uk

date unknown

5. Cardiac Risk Factors (see instructions for definitions)

Yes No Unknown

A. Diabetes

diab

A1. Insulin used

insulin

A2. Oral agents used

oralagt

B. Hypercholesterolemia

hych

C. Hypertension

hten

D. Family History

famhx

Current Smoker Former Smoker Never Smoked Unknown

6. Cigarette Smoking History

cigaret

7. Highest New York Heart Association Classification prior to index MI?

Class I Class II Class III Class IV

nyhapri

Signature: _____

-

OAT Staff Number