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(1) FORM NUMBER 30-32 (2) VERSION NUMBER 33

SHEP ANNUAL MEDICAL, MEDICATION AND HABITS HISTORY

40 (5/8) SEQUENCE

This Space for Clinic Use Only

Name: _____

(3) (4) (5) SHEP ID: 22,23 - 24,25,26,27 - 28,29

(6) 41-46 Acrostic: _____

(7) Date of next Clinic Visit: 36,37 Month 38,39 Day 34,35 Year at (8) 47,48 Hour : (9) 49,50 Minute (10) 51 a.m. ☐ 1 p.m. ☐ 2

DEAR PARTICIPANT:

PLEASE FILL OUT THIS FORM AS COMPLETELY AS POSSIBLE AND BRING IT WITH YOU TO THE CLINIC VISIT SCHEDULED ABOVE. IF YOU DO NOT UNDERSTAND SOME OF THE QUESTIONS, LEAVE THEM BLANK UNTIL YOUR CLINIC VISIT. WE WILL REVIEW THE WHOLE FORM WITH YOU AT THAT TIME.

IN THE PAST YEAR, HAS A DOCTOR TOLD YOU THAT YOU HAD ANY OF THE FOLLOWING?

1.	High blood pressure severe enough to lead to hospitalization?	52 (11)	Yes ☐ 1	No ☐ 2	Don't know ☐ 3
2.	Heart attack (myocardial infarction, coronary occlusion or coronary thrombosis)	53 (12)	Yes ☐ 1	No ☐ 2	Don't know ☐ 3
3.	Angina (chest pain)	54 (13)	Yes ☐ 1	No ☐ 2	Don't know ☐ 3
4.	Other heart problems	55 (14)	Yes ☐ 1	No ☐ 2	Don't know ☐ 3
5.	Stroke (cerebrovascular accident, CVA)	56 (15)	Yes ☐ 1	No ☐ 2	Don't know ☐ 3
6.	Memory problems or other problems of the brain	57 (16)	Yes ☐ 1	No ☐ 2	Don't know ☐ 3
7.	Diabetes (high blood or urine sugar)	58 (17)	Yes ☐ 1	No ☐ 2	Don't know ☐ 3
8.	Gout	59 (18)	Yes ☐ 1	No ☐ 2	Don't know ☐ 3
9.	Cancer	60 (19)	Yes ☐ 1	No ☐ 2	Don't know ☐ 3
10.	Other major diseases (specify): _____	61 (20)	Yes ☐ 1	No ☐ 2	Don't know ☐ 3

(PLEASE TURN OVER)

11. a. How many days in the past two weeks have you had to substantially reduce your social activities outside the home (meetings, shopping) because you did not feel well? (21) 62,63

b. How many days in the past two weeks have you had to substantially reduce your major work activities at home (house cleaning, laundry) because you did not feel well? (22) 64,65

c. How many days in the past two weeks have you had to substantially reduce your ordinary activities at home (cooking, dressing) because you did not feel well? (23) 66,67

d. How many days in the past two weeks did you spend most of the day in bed because you did not feel well? (24) 68,69

12. a. In the past year, have you had any pain or discomfort in your chest? (25) 70 Yes ☐ 1 No ☐ 2

↓

Skip to 12c

b. In the past year, have you had any pressure or heaviness in your chest? (26) 71 Yes ☐ 1 No ☐ 2

↓

Skip to 13 (next page)

c. Do you get this pain, discomfort, pressure or heaviness when you walk uphill or hurry? (27) 72 Yes ☐ 1 No ☐ 2

↓

Skip to 13 (next page)

d. Do you get it when you walk at an ordinary pace on the level ground? (28) 73 Yes ☐ 1 No ☐ 2

e. What do you do when you get this pain while you are walking? 74 (29)

Stop or slow down ☐ 1
Continue at same pace ☐ 2

f. Does it go away when you stand still? 75 (30) Yes ☐ 1 No ☐ 2

↓

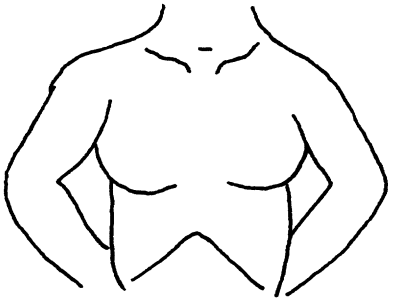
Skip to 12h (next page)

g. How soon? 76 (31)

10 minutes or less ☐ 1
More than 10 minutes ☐ 2

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

RIGHT SIDE



LEFT SIDE

Do not use--clinic use only.

77 (32) (1) Yes ☐ 1 No ☐ 2 78
(2) Yes ☐ 1 No ☐ 2 (33)
79 (34) (3) Yes ☐ 1 No ☐ 2

---

13. In the past year, have you had a severe pain across the front of your chest lasting for half an hour or more?

80 (35) Yes ☐ 1 No ☐ 2

---

14. a. Have you had a heart attack (myocardial infarction, coronary thrombosis) in the past year?

(36) 81 Yes ☐ 1 No ☐ 2 Don't know ☐ 3

↓ ↓

Skip to 15 (next page)

b. Were you hospitalized for any heart attacks in the past year?

(37) 82 Yes ☐ 1 No ☐ 2

c. How many such attacks have you had?

(38) 83,84

d. What were the dates of these heart attacks? (month/year)

_____

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(PLEASE TURN OVER)

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

85 (39) Yes ☐ 1 No ☐ 2 ↓ Skip to 16

b. Does this pain ever begin when you are standing still or sitting?

86 (40) Yes ☐ 1 No ☐ 2

c. Do you get this pain in your calf? (or calves?)

87 (41) Yes ☐ 1 No ☐ 2

d. Do you get it when you walk uphill or hurry?

88 (42) Yes ☐ 1 No ☐ 2 ↓ Skip to 16

e. Do you get it when you walk at an ordinary pace on the level ground?

89 (43) Yes ☐ 1 No ☐ 2

f. Does this pain ever disappear while you are still walking?

90 (44) Yes ☐ 1 No ☐ 2

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

91 (45) Stop or slow down ☐ 1
Continue at same pace ☐ 2

h. Does it go away when you stand still?

92 (46) Yes ☐ 1 No ☐ 2 ↓ Skip to 16

i. How soon?

93 (47) 10 minutes or less ☐ 1
More than 10 minutes ☐ 2

---

16. a. 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.)

94 (48) Yes ☐ 1 No ☐ 2 ↓ Skip to 16c

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

95 (49) Yes ☐ 1 No ☐ 2 ↓ Skip to 17 (next page)

c. Do you cough like this on most days for as much as 3 months each year?

96 (50) Yes ☐ 1 No ☐ 2

d. Do you usually bring up any phlegm (mucus) from your chest first thing in the morning in the winter?

97 (51) Yes ☐ 1 No ☐ 2

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

98 (52) Yes ☐ 1 No ☐ 2

↓

Skip to 17

f. Do you bring up phlegm like this on most days for as much as 3 months each year?

99 (53) Yes ☐ 1 No ☐ 2

g. In the past year, have you had a period of increased cough and phlegm lasting for 3 weeks or more?

100 (54) Yes, once ☐ 1
Yes, more than once ☐ 2
No ☐ 3

---

17. a. Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill?

101 (55) Yes ☐ 1 No ☐ 2

b. Do you get short of breath walking with other people of your own age on level ground?

102 (56) Yes ☐ 1 No ☐ 2

c. Do you ever wake up at night gasping for breath?

103 (57) Yes ☐ 1 No ☐ 2

d. Do you get short of breath at night unless you sleep on two or more pillows?

104 (58) Yes ☐ 1 No ☐ 2

e. Have you ever had asthma?

105 (59) Yes ☐ 1 No ☐ 2

↓

Skip to 18 (next page)

f. Have you had any asthma attacks in the past year?

106 (60) Yes ☐ 1 No ☐ 2

g. Do you take medication to control or treat asthma?

107 (61) Yes ☐ 1 No ☐ 2

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(PLEASE TURN OVER)

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

108 (62) Yes ☐ 1 No ☐ 2 → Skip to 19

b. How many attacks of such numbness or tingling have you had in the past year? (Check one.)

109 (63)
- Only one ☐ 1
- Two ☐ 2
- Three to five ☐ 3
- More than five ☐ 4

c. How long did each of the attack(s) usually last?

110 (64)
- Less than 5 minutes ☐ 1
- From 5 minutes to one hour ☐ 2
- From 1-6 hours ☐ 3
- From 6-24 hours ☐ 4
- More than 24 hours ☐ 5

d. Did you see a doctor for the numbness, tingling, or loss of feeling?

111 (65) Yes ☐ 1 No ☐ 2

---

19. a. In the past year, have you had any sudden attacks of paralysis or loss of use of either arm, hand, leg or foot?

112 (66) Yes ☐ 1 No ☐ 2 → Skip to 20 (next page)

b. How many attacks of such paralysis have you had in the past year? (Check one.)

113 (67)
- Only one ☐ 1
- Two ☐ 2
- Three to five ☐ 3
- More than five ☐ 4

c. How long did the attack(s) usually last?

114 (68)
- Less than 5 minutes ☐ 1
- From 5 minutes to one hour ☐ 2
- From 1-6 hours ☐ 3
- From 6-24 hours ☐ 4
- More than 24 hours ☐ 5

d. Did you see a doctor for this paralysis?

115 (69) Yes ☐ 1 No ☐ 2

---

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

116 (70) Yes ☐ 1 No ☐ 2

↓

Skip to 21

b. What part of your vision was affected?

117 (71)
- Right eye only ☐ 1
- Left eye only ☐ 2
- Both eyes ☐ 3
- Vision to the right side ☐ 4
- Vision to the left side ☐ 5

c. How many attacks of loss of eyesight or blurring of vision have you had in the past year?

118 (72)
- Only one ☐ 1
- Two ☐ 2
- Three-five ☐ 3
- More than five ☐ 4

d. How long did the attack(s) usually last?

119 (73)
- Less than 5 minutes ☐ 1
- From 5 minutes to one hour ☐ 2
- From 1-6 hours ☐ 3
- From 6-24 hours ☐ 4
- More than 24 hours ☐ 5

e. Did you see a doctor for this vision problem?

120 (74) Yes ☐ 1 No ☐ 2

---

21. a. In the past year, have you had any sudden attacks of changes in speech, loss of speech or inability to say words?

121 (75) Yes ☐ 1 No ☐ 2

↓

Skip to 22 (next page)

b. How many attacks of loss of speech have you had in the past year?

122 (76)
- Only one ☐ 1
- Two ☐ 2
- Three-five ☐ 3
- More than five ☐ 4

c. How long did the attack(s) usually last?

123 (77)
- Usually less than 5 minutes ☐ 1
- From 5 minutes to one hour ☐ 2
- From 1-6 hours ☐ 3
- From 6-24 hours ☐ 4
- More than 24 hours ☐ 5

d. Did you see a doctor for your speech problem?

124 (78) Yes ☐ 1 No ☐ 2

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(PLEASE TURN OVER)

22. In the past year, have you had any of the following:

a.	Dizziness	125 (79)	Yes □ 1	No □ 2
b.	Spinning sensation (vertigo)	126 (80)	Yes □ 1	No □ 2
c.	Loss of balance	127 (81)	Yes □ 1	No □ 2
d.	Difficulty walking	128 (82)	Yes □ 1	No □ 2
e.	Blackouts or fainting	129 (83)	Yes □ 1	No □ 2
f.	Frequent falls	130 (84)	Yes □ 1	No □ 2

23. a. Did you answer "yes" to any of the problems in Question 22?

131 (85) Yes □ 1 No □ 2 ↓

Skip to 24

b. About how many total attacks of all conditions checked do you think you had in the past year?

132 (86)
- Only one □ 1
- Two □ 2
- Three-five □ 3
- More than five □ 4

c. How long did the attack(s) usually last?

133 (87)
- Usually less than 5 minutes □ 1
- From 5 minutes to one hour □ 2
- From 1-6 hours □ 3
- From 6-24 hours □ 4
- More than 24 hours □ 5

d. Did you see a doctor for any of these spells?

134 (88) Yes □ 1 No □ 2

---

24. a. In the past year, have you had surgery to improve the blood flow in your arteries or vessels (endarterectomy, by-pass surgery)? (Do not include surgery for varicose veins.)

135 (89) Yes □ 1 No □ 2 ↓

Skip to 25 (next page)

b. Did you have surgery on your neck vessels (carotid artery)?

136 (90) Yes □ 1 No □ 2

Date(s) of surgery _____

c. Did you have surgery on your heart (coronary by-pass)?

137 (91) Yes □ 1 No □ 2

Date(s) of surgery _____

d. Did you have surgery on the aorta or leg arteries?

138 (92) Yes □ 1 No □ 2

Date(s) of surgery _____

---

25. a. Have you been hospitalized for any reason within the past year? 139 (93) Yes ☐ 1 No ☐ 2

Skip to 26

b. List the reason, the name and address of the hospital, and the month and year of the hospitalization.

	Reason	Month/Year	Name of Hospital, City and State
(1)			
(2)			
(3)			
(4)			
(5)			

(If more than 5 hospitalizations, list rest on a blank sheet of paper.)

26. In the past year, have you had a fracture of the:

a. Hip? When? _____ 140 (94) Yes ☐ 1 No ☐ 2

b. Spine? When? _____ 141 (95) Yes ☐ 1 No ☐ 2

c. Forearm? When? _____ 142 (96) Yes ☐ 1 No ☐ 2

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SHEP ID: [ ] - [ ] - [ ] Acrostic: [ ]

(PLEASE TURN OVER)

27. a. About how many times would you say that you have fallen to the floor or ground for no obvious reason in the past three months?

143 (97)

- None □ 1
- Once □ 2
- Twice □ 3
- Three times □ 4
- Four or five times □ 5
- More than five times □ 6
- Don't know □ 7

If "None," skip to 28

b. Did you have any injury from those falls that required a doctor's attention? (98) Yes □ 1 No □ 2 Don't know □ 3

Describe injury: _____ 144

---

28. Has any medicine you may be taking, or have taken in the past year, ever caused you to have a skin rash or other kind of allergic reaction?

145 (99) Yes □ 1 No □ 2

Describe medicine, reaction and circumstances:

_____

_____

_____

PERSONAL INFORMATION:

29. a. Which of the following most closely describes your current employment status?

146 (100)

- Employed full time □ 1
- Employed part time □ 2
- Retired or not employed □ 3

b. If retired, in what month and year did you retire from your last paid employment (20 hours per week or more)?

147-148 149-150

(101) Month ____ Year ____ (102)

30. What is your current marital status?

151 (103)

- Married □ 1
- Widowed □ 2
- Separated □ 3
- Divorced □ 4
- Never married □ 5

31. a. Do you currently smoke cigarettes?

152 (104) Yes □ 1 No □ 2 ↓

Skip to 32 (next page)

b. How many do you now smoke per day?

(105) 153-155 ____

32. a. Which answer best describes how often you drink wine, beer, whiskey or liquor? (Check one.)

156 (106)

- Never drank □ 1
- I used to drink, but don't drink now □ 2
- 1 or 2 times a year or very occasionally □ 3
- Less than one per week or only at parties □ 4
- 1 to 2 times a week □ 5
- 3 to 4 times a week □ 6
- Nearly every day □ 7
- Every day □ 8

b. When you drink alcoholic beverages, how many do you usually drink in a day? (One drink = 1 can of beer, or a glass of wine or 1 shot of whiskey or liquor)

157-158 (107) ____

33. a. Are you taking any medicines that require a prescription from a doctor?

159 (108) Yes □ 1 No □ 2 ↓

Skip to 34 (next page)

Name all of the medicines that are being prescribed for you by a doctor or a clinic.

	Medicine Name	What illness is medicine for?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

160-161 (109) ____

b. Total number of prescription medicines being taken

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SHEP ID: ____ - ____ - ____ Acrostic: ____

(PLEASE TURN OVER)

34. Have you stopped taking any prescription medications in the past two weeks? 162 (110) Yes □ 1 No □ 2

↓

Skip to 35 (next page)

Please list them below

	Medicine Name	What illness is medicine for?
1.	_____	_____
2.	_____	_____
3.	_____	_____

Why did you stop taking the medicines?

Medicine No. 1

		Check if Yes	
1.	The doctor advised me to stop	163 (111) □ 1	(112) 164
2.	The prescription ran out	□ 1	
3.	I felt better	165 (113) □ 1	
4.	I couldn't remember to take them	□ 1	(114) 166
5.	I couldn't be bothered	□ 1	
6.	They made me feel sick	167 (115) □ 1	(116) 168
7.	I didn't think they were working	□ 1	
8.	A friend told me to stop	(117) □ 1	
9.	Don't know	169 □ 1	(118) 170
10.	Other:	171 (119) □ 1	
	_____		(120) 172
	_____		

Medicine No. 2

		Check if Yes	
1.	The doctor advised me to stop	173 (121) □ 1	(122) 174
2.	The prescription ran out	□ 1	
3.	I felt better	175 (123) □ 1	
4.	I couldn't remember to take them	□ 1	(124) 176
5.	I couldn't be bothered	□ 1	
6.	They made me feel sick	177 (125) □ 1	(126) 178
7.	I didn't think they were working	□ 1	
8.	A friend told me to stop	(127) □ 1	
9.	Don't know	179 □ 1	(128) 180
10.	Other:	181 (129) □ 1	
	_____		(130) 182
	_____		

Medicine No. 3

Check if Yes

1. The doctor advised me to stop
2. The prescription ran out
3. I felt better
4. I couldn't remember to take them
5. I couldn't be bothered
6. They made me feel sick
7. I didn't think they were working
8. A friend told me to stop
9. Don't know
10. Other:

183 131 □ 1 — 132 184
185 133 □ 1 — 134 186
187 135 □ 1 — 136 188
137 □ 1 — 138 190
189 □ 1
191 139 □ 1 — 140 192

_____

_____

35. a. Are you presently taking any medicines or diet supplements that you buy in a drugstore, supermarket or health food store without a prescription? For example, aspirin, laxatives, vitamins, antacids.

193 141 Yes □ 1 No □ 2 ↓

Skip to 36 (next page)

What kind?

	Brand Name	What illness do take it for?
1.		
2.		
3.		
4.		
5.		

(If more than 5, list on a blank sheet of paper.)

b. Total number of non-prescription medicines being taken

194-195 142 [ ]

Clinic Use Only

SHEP ID: [ ] - [ ] - [ ] Acrostic: [ ]

(PLEASE TURN OVER)

36. a. In the past year, have you changed where you go for medical care?

196 (143) Yes ☐ 1 No ☐ 2

b. If yes, would you object to us sending your blood pressure results to the person or clinic that usually supplies your health care?

(144)

197

- Yes ☐ 1
- No ☐ 2
- Don't know ☐ 3
- I do not have a personal physician or clinic that supplies health care ☐ 4

New Clinic Name or Doctor: _____

Address: _____

_____

Telephone: _____

Thank you for completing this form. Please remember to bring this form and any prescription medications that you are now taking with you for your clinic visit which is scheduled on the date shown on the front page.

198	(145)	RECORD TYPE
199-204	(146)	DATE RECEIVED
205-207	(147)	UPDATE NUMBER
208-213	(148)	DATE LAST PROCESSED
214	(149)	PAPER COPY
215	(150)	EDIT STATUS CODE
3-8	(514)	BATCH DATE
11-16	(515)	DATE MODIFIED
17-20	(516)	TIME MODIFIED
21	(517)	EDIT STATUS

30-32 (1) FORM NUMBER

40 (518) SEQUENCE NUMBER

SHEP ANNUAL MEDICAL, MEDICATION AND HABITS HISTORY

33 (2) VERSION NUMBER

This Space for Clinic Use Only

Name: _____

SHEP ID: (3) 22 23 - (4) 24 25 26 27 - (5) 28 29

Acrostic: (6) 41-46 51

Date of next Clinic Visit: (7) 36 37 Month / 38 39 Day / 34 35 Year at (8) 47 48 Hour : (9) 49 50 Minute (10) a.m. ☐ 1 p.m. ☐ 2

DEAR PARTICIPANT:

PLEASE FILL OUT THIS FORM AS COMPLETELY AS POSSIBLE AND BRING IT WITH YOU TO THE CLINIC VISIT SCHEDULED ABOVE. IF YOU DO NOT UNDERSTAND SOME OF THE QUESTIONS, LEAVE THEM BLANK UNTIL YOUR CLINIC VISIT. WE WILL REVIEW THE WHOLE FORM WITH YOU AT THAT TIME.

IN THE PAST YEAR, HAS A DOCTOR TOLD YOU THAT YOU HAD ANY OF THE FOLLOWING?

52 (11)	1.	High blood pressure severe enough to lead to hospitalization?	Yes ☐ 1	No ☐ 2	Don't know ☐ 3
53 (12)	2.	Heart attack (myocardial infarction, coronary occlusion or coronary thrombosis)	Yes ☐ 1	No ☐ 2	Don't know ☐ 3
54 (13)	3.	Angina (chest pain)	Yes ☐ 1	No ☐ 2	Don't know ☐ 3
55 (14)	4.	Other heart problems	Yes ☐ 1	No ☐ 2	Don't know ☐ 3
56 (15)	5.	Stroke (cerebrovascular accident, CVA)	Yes ☐ 1	No ☐ 2	Don't know ☐ 3
57 (16)	6.	Memory problems or other problems of the brain	Yes ☐ 1	No ☐ 2	Don't know ☐ 3
58 (17)	7.	Diabetes (high blood or urine sugar)	Yes ☐ 1	No ☐ 2	Don't know ☐ 3
59 (18)	8.	Gout	Yes ☐ 1	No ☐ 2	Don't know ☐ 3
60 (19)	9.	Cancer	Yes ☐ 1	No ☐ 2	Don't know ☐ 3
61 (20)	10.	Other major diseases (specify):	Yes ☐ 1	No ☐ 2	Don't know ☐ 3

_____

(PLEASE TURN OVER)

11. a. How many days in the past two weeks have you had to substantially reduce your social activities outside the home (meetings, shopping) because you did not feel well? (21) 62,63

b. How many days in the past two weeks have you had to substantially reduce your major work activities at home (house cleaning, laundry) because you did not feel well? (22) 64,65

c. How many days in the past two weeks have you had to substantially reduce your ordinary activities at home (cooking, dressing) because you did not feel well? (23) 66,67

d. How many days in the past two weeks did you spend most of the day in bed because you did not feel well? (24) 68,69

12. a. (25) In the past year, have you had any pain or discomfort in your chest? 70
Yes ☐ 1 No ☐ 2
↓
Skip to 12c

b. (26) In the past year, have you had any pressure or heaviness in your chest? 71
Yes ☐ 1 No ☐ 2
↓
Skip to 13 (next page)

c. (27) Do you get this pain, discomfort, pressure or heaviness when you walk uphill or hurry? 72
Yes ☐ 1 No ☐ 2
↓
Skip to 13 (next page)

d. (28) Do you get it when you walk at an ordinary pace on the level ground? 73
Yes ☐ 1 No ☐ 2

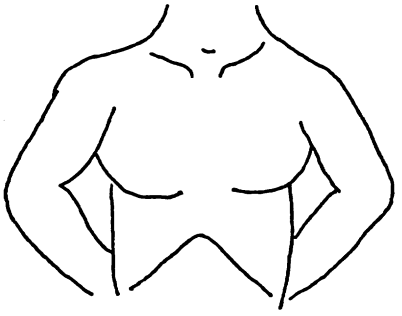
e. (29) What do you do when you get this pain while you are walking? 74
Stop or slow down ☐ 1
Continue at same pace ☐ 2

f. (30) Does it go away when you stand still? 75
Yes ☐ 1 No ☐ 2
↓
Skip to 12h (next page)

g. (31) How soon? 76
10 minutes or less ☐ 1
More than 10 minutes ☐ 2

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

RIGHT SIDE



LEFT SIDE

77 (32) Do not use--clinic use only.

78 (33) (1) Yes □ 1 No □ 2

(2) Yes □ 1 No □ 2

79 (34) (3) Yes □ 1 No □ 2

---

13. In the past year, have you had a severe pain across the front of your chest lasting for half an hour or more?

80 (35) Yes □ 1 No □ 2

---

14. a. Have you had a heart attack (myocardial infarction, coronary thrombosis) in the past year?

81 (36) Yes □ 1 No □ 2 Don't know □ 3

↓ ↓

Skip to 15 (next page)

b. Were you hospitalized for any heart attacks in the past year?

82 (37) Yes □ 1 No □ 2

c How many such attacks have you had?

(38) 83 84

d What were the dates of these heart attacks? (month/year) _____

Clinic Use Only

SHEP ID: [ ] - [ ] - [ ] Acrostic: [ ]

(PLEASE TURN OVER)

15. a (39) Do you get a pain in either leg on walking? — Yes ☐ 1 No ☐ 2 → Skip to 16

b (40) Does this pain ever begin when you are standing still or sitting? — Yes ☐ 1 No ☐ 2

c (41) Do you get this pain in your calf? (or calves?) — Yes ☐ 1 No ☐ 2

d (42) Do you get it when you walk uphill or hurry? — Yes ☐ 1 No ☐ 2 → Skip to 16

e (43) Do you get it when you walk at an ordinary pace on the level ground? — Yes ☐ 1 No ☐ 2

f (44) Does this pain ever disappear while you are still walking? — Yes ☐ 1 No ☐ 2

g (45) What do you do if you get it when you are walking? — Stop or slow down ☐ 1; Continue at same pace ☐ 2

h (46) Does it go away when you stand still? — Yes ☐ 1 No ☐ 2 → Skip to 16

i (47) How soon? — 10 minutes or less ☐ 1; More than 10 minutes ☐ 2

---

16. a (48) 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.) — Yes ☐ 1 No ☐ 2 → Skip to 16c

b (49) Do you usually cough during the day or at night in the winter? (Do not respond "yes" for a single cough.) — Yes ☐ 1 No ☐ 2 → Skip to 17 (next page)

c (50) Do you cough like this on most days for as much as 3 months each year? — Yes ☐ 1 No ☐ 2

d (51) Do you usually bring up any phlegm (mucus) from your chest first thing in the morning in the winter? — Yes ☐ 1 No ☐ 2

e. Do you usually bring up any phlegm from your chest during the day or at night in the winter? (52) 98 — Yes ☐ 1 No ☐ 2 → Skip to 17

f. (53) Do you bring up phlegm like this on most days for as much as 3 months each year? 99 — Yes ☐ 1 No ☐ 2

g. (54) In the past year, have you had a period of increased cough and phlegm lasting for 3 weeks or more? 100 — Yes, once ☐ 1; Yes, more than once ☐ 2; No ☐ 3

---

17. a. (55) Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill? 101 — Yes ☐ 1 No ☐ 2

b. (56) Do you get short of breath walking with other people of your own age on level ground? 102 — Yes ☐ 1 No ☐ 2

c. (57) Do you ever wake up at night gasping for breath? 103 — Yes ☐ 1 No ☐ 2

d. (58) Do you get short of breath at night unless you sleep on two or more pillows? 104 — Yes ☐ 1 No ☐ 2

e. (59) Have you ever had asthma? 105 — Yes ☐ 1 No ☐ 2 → Skip to 18 (next page)

f. (60) Have you had any asthma attacks in the past year? 106 — Yes ☐ 1 No ☐ 2

g. (61) Do you take medication to control or treat asthma? 107 — Yes ☐ 1 No ☐ 2

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18. a. (62) In the past year, have you had any sudden feeling of numbness, tingling or loss of feeling in either arm, hand, leg, foot or face?

108

Yes ☐ 1 No ☐ 2 ↓

Skip to 19

b. (63) How many attacks of such numbness or tingling have you had in the past year? (Check one.)

109

Only one ☐ 1
Two ☐ 2
Three to five ☐ 3
More than five ☐ 4

c. (64) How long did each of the attack(s) usually last?

110

Less than 5 minutes ☐ 1
From 5 minutes to one hour ☐ 2
From 1-6 hours ☐ 3
From 6-24 hours ☐ 4
More than 24 hours ☐ 5

d. (65) Did you see a doctor for the numbness, tingling, or loss of feeling?

111

Yes ☐ 1 No ☐ 2

---

19. a. (66) In the past year, have you had any sudden attacks of paralysis or loss of use of either arm, hand, leg or foot?

112

Yes ☐ 1 No ☐ 2 ↓

Skip to 20 (next page)

b. (67) How many attacks of such paralysis have you had in the past year? (Check one.)

113

Only one ☐ 1
Two ☐ 2
Three to five ☐ 3
More than five ☐ 4

c. (68) How long did the attack(s) usually last?

114

Less than 5 minutes ☐ 1
From 5 minutes to one hour ☐ 2
From 1-6 hours ☐ 3
From 6-24 hours ☐ 4
More than 24 hours ☐ 5

115

d. (69) Did you see a doctor for this paralysis?

Yes ☐ 1 No ☐ 2

---

20. a. (70) In the past year, have you had any sudden loss of eyesight or blurring of vision for a short period of time? 116

Yes ☐ 1 No ☐ 2 ↓

Skip to 21

b. (71) What part of your vision was affected? 117

Right eye only	☐ 1
Left eye only	☐ 2
Both eyes	☐ 3
Vision to the right side	☐ 4
Vision to the left side	☐ 5

c. (72) How many attacks of loss of eyesight or blurring of vision have you had in the past year? 118

Only one	☐ 1
Two	☐ 2
Three-five	☐ 3
More than five	☐ 4

d. (73) How long did the attack(s) usually last? 119

Less than 5 minutes	☐ 1
From 5 minutes to one hour	☐ 2
From 1-6 hours	☐ 3
From 6-24 hours	☐ 4
More than 24 hours	☐ 5

120

e. (74) Did you see a doctor for this vision problem? Yes ☐ 1 No ☐ 2

---

21. a. (75) In the past year, have you had any sudden attacks of changes in speech, loss of speech or inability to say words? 121

Yes ☐ 1 No ☐ 2 ↓

Skip to 22 (next page)

b. (76) How many attacks of loss of speech have you had in the past year? 122

Only one	☐ 1
Two	☐ 2
Three-five	☐ 3
More than five	☐ 4

c. (77) How long did the attack(s) usually last? 123

Usually less than 5 minutes	☐ 1
From 5 minutes to one hour	☐ 2
From 1-6 hours	☐ 3
From 6-24 hours	☐ 4
More than 24 hours	☐ 5

124

d. (78) Did you see a doctor for your speech problem? Yes ☐ 1 No ☐ 2

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22. In the past year, have you had any of the following:

a.	Dizziness	125	Yes ☐ 1 No ☐ 2
b.	Spinning sensation (vertigo)	127	Yes ☐ 1 No ☐ 2
c.	Loss of balance		Yes ☐ 1 No ☐ 2
d.	Difficulty walking	129	Yes ☐ 1 No ☐ 2
e.	Blackouts or fainting		Yes ☐ 1 No ☐ 2
f.	Frequent falls	130	Yes ☐ 1 No ☐ 2

126 (80) (79) 81 128 (82) 83 84

23. a. Did you answer "yes" to any of the problems in Question 22? (85) 131 Yes ☐ 1 No ☐ 2 ↓

Skip to 24

b. (86) About how many total attacks of all conditions checked do you think you had in the past year? 132

- Only one ☐ 1
- Two ☐ 2
- Three-five ☐ 3
- More than five ☐ 4

c. (87) How long did the attack(s) usually last? 133

- Usually less than 5 minutes ☐ 1
- From 5 minutes to one hour ☐ 2
- From 1-6 hours ☐ 3
- From 6-24 hours ☐ 4
- More than 24 hours ☐ 5

134

d. (88) Did you see a doctor for any of these spells? Yes ☐ 1 No ☐ 2

---

24. a. (89) In the past year, have you had surgery to improve the blood flow in your arteries or vessels (endarterectomy, by-pass surgery)? (Do not include surgery for varicose veins.) 135 Yes ☐ 1 No ☐ 2 ↓

Skip to 25 (next page)

b. (90) Did you have surgery on your neck vessels (carotid artery)? Yes ☐ 1 No ☐ 2

136 Date(s) of surgery _____

c. (91) Did you have surgery on your heart (coronary by-pass)? Yes ☐ 1 No ☐ 2

137 Date(s) of surgery _____

d. (92) Did you have surgery on the aorta or leg arteries? Yes ☐ 1 No ☐ 2

138 Date(s) of surgery _____

---

25. a (93) Have you been hospitalized for any reason within the past year? Yes ☐ 1 No ☐ 2

139

↓ Skip to 26

b. List the reason, the name and address of the hospital, and the month and year of the hospitalization.

	Reason	Month/Year	Name of Hospital, City and State
(1)			
(2)			
(3)			
(4)			
(5)			

(If more than 5 hospitalizations, list rest on a blank sheet of paper.)

26. In the past year, have you had a fracture of the:

a (94) Hip? Yes ☐ 1 No ☐ 2
140 When? _____

b (95) Spine? Yes ☐ 1 No ☐ 2
141 When? _____

c (96) Forearm? Yes ☐ 1 No ☐ 2
142 When? _____

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27. a. (97) About how many times would you say that you have fallen to the floor or ground for no obvious reason in the past three months? 143

None	☐ 1
Once	☐ 2
Twice	☐ 3
Three times	☐ 4
Four or five times	☐ 5
More than five times	☐ 6
Don't know	☐ 7

If "None," skip to 28

b. (98) Did you have any injury from those falls that required a doctor's attention? Yes ☐ 1 No ☐ 2 Don't know ☐ 3

144 Describe injury: _____

---

28. (99) Has any medicine you may be taking, or have taken in the past year, ever caused you to have a skin rash or other kind of allergic reaction? 145 Yes ☐ 1 No ☐ 2

Describe medicine, reaction and circumstances:

_____

_____

_____

PERSONAL INFORMATION:

29. a. (100) Which of the following most closely describes your current employment status? 146

Employed full time	☐ 1
Employed part time	☐ 2
Retired or not employed	☐ 3

b If retired, in what month and year did you retire from your last paid employment (20 hours per week or more)?

(101) 147-148 Month (102) 149-150 Year

30. (103) What is your current marital status? 151

Married	☐ 1
Widowed	☐ 2
Separated	☐ 3
Divorced	☐ 4
Never married	☐ 5

31. a. (104) Do you currently smoke cigarettes? 152 Yes ☐ 1 No ☐ 2 ↓

Skip to 32 (next page)

b How many do you now smoke per day? (105) 153-155

32. a. (106) Which answer best describes how often you drink wine, beer, whiskey or liquor? (Check one.)

156

Never drank	☐ 1
I used to drink, but don't drink now	☐ 2
1 or 2 times a year or very occasionally	☐ 3
Less than one **per** week or only at parties	☐ 4
1 to 2 times a week	☐ 5
3 to 4 times a week	☐ 6
Nearly every day	☐ 7
Every day	☐ 8

b. When you drink alcoholic beverages, how many do you usually drink in a day? (One drink = 1 can of beer, or a glass of wine or 1 shot of whiskey or liquor)

157-158

(107) ☐☐

33. a. (108) Are you taking any medicines that require a prescription from a doctor?

159

Yes ☐ 1 No ☐ 2

↓

Skip to 34 (next page)

Name all of the medicines that are being prescribed for you by a doctor or a clinic.

	Medicine Name	What illness is medicine for?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

160-161

b. Total number of prescription medicines being taken (109) ☐☐

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34 (110) Have you stopped taking any prescription medications in the past two weeks? Yes ☐ 1 No ☐ 2 ↓

162 _____

Skip to 35 (next page)

Please list them below

Medicine Name What illness is medicine for?

1. _____

2. _____

3. _____

163 (111) Why did you stop taking the medicines?

Medicine No. 1	Check if Yes
1. The doctor advised me to stop	☐ 1
2. The prescription ran out	☐ 1
3. I felt better	☐ 1
4. I couldn't remember to take them	☐ 1
5. I couldn't be bothered	☐ 1
6. They made me feel sick	☐ 1
7. I didn't think they were working	☐ 1
8. A friend told me to stop	☐ 1
9. Don't know	☐ 1
10. Other:	☐ 1

(112) (113) (114) (115) (116) (117) (118) (119) (120)

_____

_____

Medicine No. 2	Check if Yes
1. The doctor advised me to stop	☐ 1
2. The prescription ran out	☐ 1
3. I felt better	☐ 1
4. I couldn't remember to take them	☐ 1
5. I couldn't be bothered	☐ 1
6. They made me feel sick	☐ 1
7. I didn't think they were working	☐ 1
8. A friend told me to stop	☐ 1
9. Don't know	☐ 1
10. Other:	☐ 1

(121) (122) (123) (124) (125) (126) (127) (128) (129) (130)

_____

_____

183

131 Medicine No. 3 — Check if Yes

1.	The doctor advised me to stop	☐ 1
2.	The prescription ran out	☐ 1
3.	I felt better	☐ 1
4.	I couldn't remember to take them	☐ 1
5.	I couldn't be bothered	☐ 1
6.	They made me feel sick	☐ 1
7.	I didn't think they were working	☐ 1
8.	A friend told me to stop	☐ 1
9.	Don't know	☐ 1
10.	Other:	☐ 1

185 133 132 184 186 187 135 134 136 188 137 189 138 190 139 140 191 192

_____

_____

35. a. Are you presently taking any medicines or diet supplements that you buy in a drugstore, supermarket or health food store without a prescription? For example, aspirin, laxatives, vitamins, antacids.

141 193

Yes ☐ 1 No ☐ 2 ↓

Skip to 36 (next page)

What kind?

	Brand Name	What illness do take it for?
1.		
2.		
3.		
4.		
5.		

(If more than 5, list on a blank sheet of paper.)

194-195

b. Total number of non-prescription medicines being taken 142 ☐☐

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36. What are your current living arrangements? (Check all that apply.)

216 (151) (152) 217 218 (153) 219 (154) (155) 220

a.	Living alone (skip to 37)	☐ 1
b.	Living with spouse	☐ 1
c.	Living with other related individuals	☐ 1
d.	Living with non-related friends	☐ 1
e.	Living with non-related paid help	☐ 1

37. a. (143) 196 In the past year, have you changed where you go for medical care? Yes ☐ 1 No ☐ 2

b. (144) 197 If yes, would you object to us sending your blood pressure results to the person or clinic that usually supplies your health care?

Yes	☐ 1
No	☐ 2
Don't know	☐ 3
I do not have a personal physician or clinic that supplies health care	☐ 4

New Clinic Name or Doctor: _____

Address: _____

_____

Telephone: _____

Thank you for completing this form. Please remember to bring this form and any prescription medications that you are now taking with you for your clinic visit which is scheduled on the date shown on the front page.

3-8 (514) BATCH DATE

11-16 (515) DATE MODIFIED

17-20 (516) TIME MODIFIED

21 (517) **Edit Status**

198 (145) RECORD TYPE

199-204 (146) DATE RECEIVED

205-207 (147) UPDATE NUMBER

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214 (149) PAPER COPY

215 (150) **Cross Forms Edit**