

SH04: Baseline Medical History Form**Purpose**

The *Baseline Medical History Form (SH04)*, along with the SH02 and SH03 forms, was given to a screenee who was eligible for the Baseline Visit 1 (BV1) or Drug Evaluation Visit 1 (DEV1). It was completed at home by the screenee before coming to the BV1 or DEV1 clinic visit. The form recorded medical history information about the potential participant to aid in determining eligibility for randomization into the SHEP trial.

13. Kidney problems (nephritis, kidney infection, kidney stones) 64 (23) Yes 1 No 2 Don't know 3
14. (Men only) Problems of the prostate (infection, enlargement) 65 (24) Yes 1 No 2 Don't know 3
15. (Women only) Problems of the female organs 66 (25) Yes 1 No 2 Don't know 3
16. Urinary tract infection or bladder problem 67 (26) Yes 1 No 2 Don't know 3
17. Pneumonia 68 (27) Yes 1 No 2 Don't know 3
18. Lung problems (TB, emphysema pleurisy, bronchitis, or other problems) 69 (28) Yes 1 No 2 Don't know 3
19. Thyroid problem 70 (29) Yes 1 No 2 Don't know 3
20. Ulcer of the stomach or duodenum 71 (30) Yes 1 No 2 Don't know 3
21. Colitis or intestinal problems 72 (31) Yes 1 No 2 Don't know 3
22. Liver problems (hepatitis, cirrhosis or other problems) 73 (32) Yes 1 No 2 Don't know 3
23. Gallstones or gall bladder disease 74 (33) Yes 1 No 2 Don't know 3
24. Anemia 75 (34) Yes 1 No 2 Don't know 3
25. Cancer 76 (35) Yes 1 No 2 Don't know 3
26. Nervous or emotional disorder 77 (36) Yes 1 No 2 Don't know 3
27. Arthritis 78 (37) Yes 1 No 2 Don't know 3
28. Hives or hay fever, or other allergies 79 (38) Yes 1 No 2 Don't know 3
29. Other major diseases (specify): 80 (39) Yes 1 No 2 Don't know 3
-

DURING THE PAST YEAR, HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?

30. Skin rash or unusual bruises 81 (40) Yes 1 No 2 Don't know 3
31. Headaches that were so bad you had to stop what you were doing 82 (41) Yes 1 No 2 Don't know 3
32. Headache attack, racing heart and sweating all at the same time 83 (42) Yes 1 No 2 Don't know 3
33. Faintness or light-headedness when you stood up quickly 84 (43) Yes 1 No 2 Don't know 3
34. Your heart beating unusually fast or skipping beats 84 (44) Yes 1 No 2 Don't know 3
35. Blacking out or losing consciousness 86 (45) Yes 1 No 2 Don't know 3
36. Frequent stomach pains 87 (46) Yes 1 No 2 Don't know 3
37. Waking up early, having trouble getting back to sleep 88 (47) Yes 1 No 2 Don't know 3
38. Black or tarry stools 89 (48) Yes 1 No 2 Don't know 3
39. Bright red blood in your stools 90 (49) Yes 1 No 2 Don't know 3
40. Weight loss without dieting 91 (50) Yes 1 No 2 Don't know 3
41. About how many days during the past year were you kept in bed for all or most of the day because of illness, disability or injury? 92 (51) { Zero to three days 1
Four to six days 2
Seven to nine days 3
Ten or more days 4

Clinic Use Only

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(PLEASE TURN OVER)

42. a. Have you ever had any pain or discomfort in your chest? 93 (52) Yes 1 No 2

SKIP to 42c.

b. Have you ever had any pressure or heaviness in your chest? 94 (53) Yes 1 No 2

SKIP TO 43.

c. Do you get this pain, discomfort, pressure or heaviness when you walk uphill or hurry? 95 (54) Yes 1 No 2

d. Do you get it when you walk at an ordinary pace on the level ground? 96 (55) Yes 1 No 2

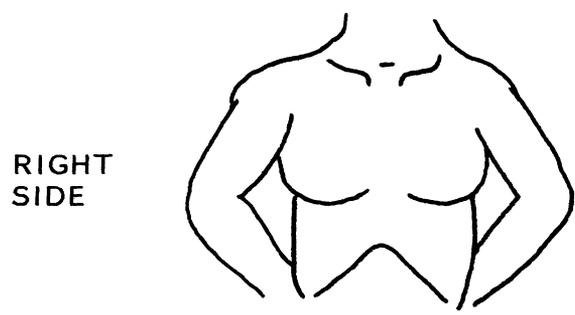
e. What do you do when you get this pain while you are walking? 97 (56) Stop or slow down 1
Continue at same pace 2

f. Does it go away when you stand still? 98 (57) Yes 1 No 2

SKIP to 42h.

g. How soon? 99 (58) 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.)



Do not use--clinic use only.

100 (59) (1) Yes 1 No 2

101 (60) (2) Yes 1 No 2

102 (61) (3) Yes 1 No 2

43. Have you ever had a severe pain across the front of your chest lasting for half an hour or more? 103 (62) Yes 1 No 2

44. a. Have you ever had a heart attack (myocardial infarction, coronary thrombosis)? **104** **(63)** Yes 1 No 2 Don't know 3
 ↓ ↓
 SKIP TO 45.
- b. Were you ever hospitalized for any heart attacks? **105** **(64)** Yes 1 No 2
- c. How many such attacks have you had? **(65)**
106-107
- d. What were the dates of these heart attacks? (month/year) _____

45. a. Do you get a pain in either leg on walking? **(66)** Yes 1 No 2
 ↓
108 SKIP TO 46.
- b. Does this pain ever begin when you are standing still or sitting? **109** **(67)** Yes 1 No 2
- c. Do you get this pain in your calf? (or calves?) Yes 1 No 2 **(68)** **110**
- d. Do you get it when you walk uphill or hurry? **(69)** Yes 1 No 2
111
- e. Do you get it when you walk at an ordinary pace on the level ground? **(70)** Yes 1 No 2
112
- f. Does this pain ever disappear while you are still walking? **113** **(71)** Yes 1 No 2
- g. What do you do if you get it when you are walking? **114** **(72)** { Stop or slow down 1
 Continue at same pace 2
- h. Does it go away when you stand still? **115** **(73)** Yes 1 No 2
 ↓
 SKIP to 46.
- i. How soon? **116** **(74)** { 10 minutes or less 1
 More than 10 minutes 2

Clinic Use Only

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(PLEASE TURN OVER)

46. 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.) (75) Yes 1 No 2
↓
117 Skip to 46c.
- b. Do you usually cough during the day or at night in the winter? (Do not respond "yes" for a single cough.) (76) Yes 1 No 2
↓
118 Skip to 47.
- c. Do you cough like this on most days for as much as 3 months each Year? (77) Yes 1 No 2
119
- d. Do you usually bring up any phlegm (mucus) from your chest first thing in the morning in the winter? (78) Yes 1 No 2
120
- e. Do you usually bring up any phlegm from your chest during the day or at night in the winter? (79) Yes 1 No 2
↓
121 SKIP to 47.
- f. Do you bring up phlegm like this on most days for as much as 3 months each year? (80) Yes 1 No 2
122
- g. In the past 3 years, have you had a period of increased cough and phlegm lasting for 3 weeks or more? (81) Yes, once 1
123 Yes, more than once 2
No 3
-

47. a. Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill? (82) Yes 1 No 2
124
- b. Do you get short of breath walking with other people of your own age on level ground? (83) Yes 1 No 2
125
- c. Do you ever wake up at night gasping for breath? (84) Yes 1 No 2
126
- d. Do you get short of breath at night unless you sleep on two or more pillows? (85) Yes 1 No 2
127
- e. Have you ever had asthma? (86) Yes 1 No 2
↓
128 SKIP to 48.
- f. Have you had any asthma attacks in the past three years? (87) Yes 1 No 2
129
- g. Do you take medication to control or treat asthma? (88) Yes 1 No 2
130
-

48. a. Have you ever had any sudden feeling of numbness, tingling or loss of feeling in either arm, hand, leg, foot or face?

131
89 Yes 1 No 2
↓

SKIP to 49.

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

132 90 {
Only one 1
Two 2
Three to five 3
More than five 4

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

133 91 {
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 or tingling?

134 92 Yes 1 No 2

49. a. Have you ever had any sudden attacks of paralysis or loss of use of either arm, hand, leg or foot?

135 93 Yes 1 No 2
↓

SKIP to 50.

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

136 94 {
Only one 1
Two 2
Three to five 3
More than five 4

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

137 95 {
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?

96 Yes 1 No 2
138

Clinic Use Only

SHEP ID: - -

Acrostic:

(PLEASE TURN OVER)

50. a. Have you ever had any sudden loss of eyesight or blurring of vision for a short period of time? **97** 139 Yes 1 No 2

↓
SKIP to 51.

b. What part of your vision was affected? **140** **98** { 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? **141** **99** { Only one 1
Two 2
Three-five 3
More than five 4

d. How long did the attack(s) usually last? **142** **100** { 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? **101** Yes 1 No 2
143

51. a. Have you ever had any sudden attacks of changes in speech, loss of speech or inability to say words? **144** **102** Yes 1 No 2

↓
SKIP to 52.

b. How many attacks of loss of speech have you had? **145** **103** { Only one 1
Two 2
Three-five 3
More than five 4

c. How long did the attack(s) usually last? **146** **104** { 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? **105** Yes 1 No 2
147

52. Have you ever had any of the following:

- a. Dizziness
- b. Spinning sensation (vertigo)
- c. Loss of balance
- d. Difficulty walking
- e. Blackouts or fainting
- f. Frequent falls

148 (106) Yes 1 No 2
 149 (107) Yes 1 No 2
 151 (109) Yes 1 No 2 (108) 150
 153 (111) Yes 1 No 2 (110) 152

53. a. Did you answer "yes" to any of the problems in Question 52?

(112) Yes 1 No 2

154

SKIP to 54.

b. About how many total attacks of all conditions checked do you think you ever had?

155 (113) { Only one 1
 Two 2
 Three-five 3
 More than five 4

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

156 (114) { 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?

(115) Yes 1 No 2

157

Clinic Use Only

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(PLEASE TURN OVER)

54. a. Have you ever had surgery to improve the blood flow in your arteries or vessels (endarterectomy, by-pass surgery)? (Do not include surgery for varicose veins.) Yes 1 No 2

158

↓
SKIP to 55.

b. Did you have surgery on your neck vessels (carotid artery)? 159 Yes 1 No 2

Date(s) of surgery _____

c. Did you have surgery on your heart (coronary by-pass)? 160 Yes 1 No 2

Date(s) of surgery _____

d. Did you have surgery on the aorta or leg arteries? 161 Yes 1 No 2

Date(s) of surgery _____

55. a. Have you been hospitalized for any reason within the past 5 years? 162 Yes 1 No 2

↓
SKIP to 56.

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

Reason	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.)

ADDENDUM TO SH04 -- BASELINE MEDICAL HISTORY

59. Living arrangements at baseline:

(BLANK/1)

- 187 (137) 59a. Living alone
- 188 (138) 59b. Living with spouse
- 189 (139) 59c. Living with related individuals
- 190 (140) 59d. Living with non-related friends
- 191 (141) 59e. Living with non-related paid help
- 192 (142) 59f. Don't know

1 FORM NUMBER

SHEP BASELINE MEDICAL HISTORY

2 VERSION

33

This Space for Clinic Use Only

Name: _____

SHEP ID: **3** - **4** - **5**

Acrostic: **6** 41-46

Date of Clinic Visit: **7** at **8** : a.m. p.m. **9** **10**
 Month Day Year Hour Minute 51

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.

HAS A DOCTOR EVER TOLD YOU THAT YOU HAD ANY OF THE FOLLOWING?

- 1. High blood pressure **52** **11** Yes 1 No 2 Don't know 3
- 2. High blood pressure severe enough to lead to hospitalization? **53** **12** Yes 1 No 2 Don't know 3
- 3. Heart attack (myocardial infarction, coronary occlusion or coronary thrombosis) **54** **13** Yes 1 No 2 Don't know 3
- 4. Angina (chest pain) **55** **14** Yes 1 No 2 Don't know 3
- 5. Congenital heart problems (born with a heart defect) **56** **15** Yes 1 No 2 Don't know 3
- 6. Rheumatic heart problems **57** **16** Yes 1 No 2 Don't know 3
- 7. Other heart problems **58** **17** Yes 1 No 2 Don't know 3
- 8. Stroke (cerebrovascular accident, CVA) **59** **18** Yes 1 No 2 Don't know 3
- 9. Epilepsy (spells, fits or seizures) **60** **19** Yes 1 No 2 Don't know 3
- 10. Memory problems or other problems of the brain **61** **20** Yes 1 No 2 Don't know 3
- 11. Diabetes (high blood or urine sugar) **62** **21** Yes 1 No 2 Don't know 3
- 12. Gout **63** **22** Yes 1 No 2 Don't know 3

(PLEASE TURN OVER)

13. Kidney problems (nephritis, kidney infection, kidney stones) 64 (23) Yes 1 No 2 Don't know 3
14. (Men only) Problems of the prostate (infection, enlargement) 65 (24) Yes 1 No 2 Don't know 3
15. (Women only) Problems of the female organs 66 (25) Yes 1 No 2 Don't know 3
16. Urinary tract infection or bladder problem 67 (26) Yes 1 No 2 Don't know 3
17. Pneumonia 68 (27) Yes 1 No 2 Don't know 3
18. Lung problems (TB, emphysema pleurisy, bronchitis, or other problems) 69 (28) Yes 1 No 2 Don't know 3
19. Thyroid problem 70 (29) Yes 1 No 2 Don't know 3
20. Ulcer of the stomach or duodenum 71 (30) Yes 1 No 2 Don't know 3
21. Colitis or intestinal problems 72 (31) Yes 1 No 2 Don't know 3
22. Liver problems (hepatitis, cirrhosis or other problems) 73 (32) Yes 1 No 2 Don't know 3
23. Gallstones or gall bladder disease 74 (33) Yes 1 No 2 Don't know 3
24. Anemia 75 (34) Yes 1 No 2 Don't know 3
25. Cancer 76 (35) Yes 1 No 2 Don't know 3
26. Nervous or emotional disorder 77 (36) Yes 1 No 2 Don't know 3
27. Arthritis 78 (37) Yes 1 No 2 Don't know 3
28. Hives or hay fever, or other allergies 79 (38) Yes 1 No 2 Don't know 3
29. Other major diseases (specify): 80 (39) Yes 1 No 2 Don't know 3
-

DURING THE PAST YEAR, HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?

- 30. Skin rash or unusual bruises 81 (40) Yes 1 No 2 Don't know 3
- 31. Headaches that were so bad you had to stop what you were doing 82 (41) Yes 1 No 2 Don't know 3
- 32. Headache attack, racing heart and sweating all at the same time 83 (42) Yes 1 No 2 Don't know 3
- 33. Faintness or light-headedness when you stood up quickly 84 (43) Yes 1 No 2 Don't know 3
- 34. Your heart beating unusually fast or skipping beats 85 (44) Yes 1 No 2 Don't know 3
- 35. Blacking out or losing consciousness 86 (45) Yes 1 No 2 Don't know 3
- 36. Frequent stomach pains 87 (46) Yes 1 No 2 Don't know 3
- 37. Waking up early, having trouble getting back to sleep 88 (47) Yes 1 No 2 Don't know 3
- 38. Black or tarry stools 89 (48) Yes 1 No 2 Don't know 3
- 39. Bright red blood in your stools 90 (49) Yes 1 No 2 Don't know 3
- 40. Weight loss without dieting 91 (50) Yes 1 No 2 Don't know 3

- 41. 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? (133) 187-188
- 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? (134) 189-190
- 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? (135) 191-192
- d. How many days in the past two weeks did you spend most of the day in bed because you did not feel well? (136) 193-194

Clinic Use Only

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(PLEASE TURN OVER)

42. a. Have you ever had any pain or discomfort in your chest? ⁹³ (52) Yes 1 No 2

Skip to 42c

b. Have you ever had any pressure or heaviness in your chest? 94 (53) Yes 1 No 2

Skip to 43

c. Do you get this pain, discomfort, pressure or heaviness when you walk uphill or hurry? ⁹⁵ (54) Yes 1 No 2

Skip to 43

d. Do you get it when you walk at an ordinary pace on the level ground? 96 (55) Yes 1 No 2

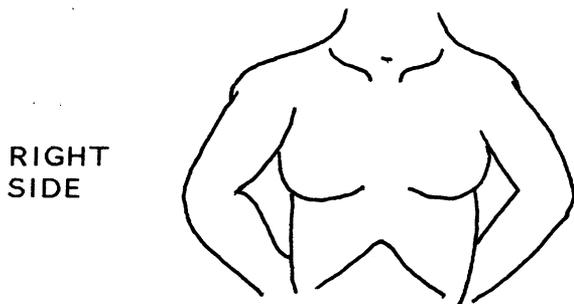
e. What do you do when you get this pain while you are walking? 97 (56) { Stop or slow down 1
Continue at same pace 2

f. Does it go away when you stand still? 98 (57) Yes 1 No 2

Skip to 42h

g. How soon? 99 (58) { 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.)



100 Do not use--clinic use only.
 LEFT SIDE (59)
 101 (60)
 102 (61)
 (1) Yes 1 No 2
 (2) Yes 1 No 2
 (3) Yes 1 No 2

43. Have you ever had a severe pain across the front of your chest lasting for half an hour or more? ¹⁰³ (62) Yes 1 No 2

44. a. Have you ever had a heart attack (myocardial infarction, coronary thrombosis)? 63 Yes 1 No 2 Don't know 3
 104 Skip to 45
- b. Were you ever hospitalized for any heart attacks? 105 64 Yes 1 No 2
- c. How many such attacks have you had? 65
 106-107
- d. What were the dates of these heart attacks? (month/year)
-

45. a. Do you get a pain in either leg on walking? 66 Yes 1 No 2
 108 Skip to 46
- b. Does this pain ever begin when you are standing still or sitting? 109 67 Yes 1 No 2
- c. Do you get this pain in your calf? (or calves?) Yes 1 No 2 68 110
- d. Do you get it when you walk uphill or hurry? 69 Yes 1 No 2
 111 Skip to 46
- e. Do you get it when you walk at an ordinary pace on the level ground? 70 112 Yes 1 No 2
- f. Does this pain ever disappear while you are still walking? 113 71 Yes 1 No 2
- g. What do you do if you get it when you are walking? 114 72 { Stop or slow down 1
 Continue at same pace 2
- h. Does it go away when you stand still? 115 73 Yes 1 No 2
Skip to 46
- i. How soon? 116 74 { 10 minutes or less 1
 More than 10 minutes 2
-

Clinic Use Only

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(PLEASE TURN OVER)

46. 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.) 117 (75) Yes 1 No 2
↓
Skip to 46c
- b. Do you usually cough during the day or at night in the winter? (Do not respond "yes" for a single cough.) 118 (76) Yes 1 No 2
↓
Skip to 47
- c. Do you cough like this on most days for as much as 3 months each Year? 119 (77) Yes 1 No 2
- d. Do you usually bring up any phlegm (mucus) from your chest first thing in the morning in the winter? 120 (78) Yes 1 No 2
- e. Do you usually bring up any phlegm from your chest during the day or at night in the winter? 121 (79) Yes 1 No 2
↓
Skip to 47
- f. Do you bring up phlegm like this on most days for as much as 3 months each year? 122 (80) Yes 1 No 2
- g. In the past 3 years, have you had a period of increased cough and phlegm lasting for 3 weeks or more? 123 (81) Yes, once 1
Yes, more than once 2
No 3
-
47. a. Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill? 124 (82) Yes 1 No 2
- b. Do you get short of breath walking with other people of your own age on level ground? 125 (83) Yes 1 No 2
- c. Do you ever wake up at night gasping for breath? 126 (84) Yes 1 No 2
- d. Do you get short of breath at night unless you sleep on two or more pillows? 127 (85) Yes 1 No 2
- e. Have you ever had asthma? 128 (86) Yes 1 No 2
↓
Skip to 48
- f. Have you had any asthma attacks in the past three years? 129 (87) Yes 1 No 2
- g. Do you take medication to control or treat asthma? 130 (88) Yes 1 No 2

48. a. Have you ever had any sudden feeling of numbness, tingling or loss of feeling in either arm, hand, leg, foot or face? (89) Yes 1 No 2
↓
131 Skip to 49
- b. How many attacks of such numbness or tingling have you had? (Check one.) 132 (90) {
Only one 1
Two 2
Three to five 3
More than five 4
- c. How long did each of the attack(s) usually last? 133 (91) {
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? 134 (92) Yes 1 No 2
-

49. a. Have you ever had any sudden attacks of paralysis or loss of use of either arm, hand, leg or foot? (93) Yes 1 No 2
↓
135 Skip to 50
- b. How many attacks of such paralysis have you had? (Check one.) 136 (94) {
Only one 1
Two 2
Three to five 3
More than five 4
- c. How long did the attack(s) usually last? 137 (95) {
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? 138 (96) Yes 1 No 2
-

Clinic Use Only

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(PLEASE TURN OVER)

50. a. Have you ever had any sudden loss of eyesight or blurring of vision for a short period of time? **97** 139 Yes 1 No 2

↓

Skip to 51

- b. What part of your vision was affected?

- 140 **98** { 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?

- 141 **99** { Only one 1
Two 2
Three-five 3
More than five 4

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

- 142 **100** { 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? **101** Yes 1 No 2

143

51. a. Have you ever had any sudden attacks of changes in speech, loss of speech or inability to say words?

- 144 **102** Yes 1 No 2

↓

Skip to 52

- b. How many attacks of loss of speech have you had?

- 145 **103** { Only one 1
Two 2
Three-five 3
More than five 4

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

- 146 **104** { 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? Yes 1 No 2 **105** 147
-

52. Have you ever had any of the following:

- a. Dizziness
- b. Spinning sensation (vertigo)
- c. Loss of balance
- d. Difficulty walking
- e. Blackouts or fainting
- f. Frequent falls

148 (106) Yes 1 No 2
 149 (107) Yes 1 No 2
 151 (109) Yes 1 No 2 (108) 150
 153 (111) Yes 1 No 2 (110) 152

53. a. Did you answer "yes" to any of the problems in Question 52?

(112) Yes 1 No 2

154

Skip to 54

b. About how many total attacks of all conditions checked do you think you ever had?

155 (113) { Only one 1
 Two 2
 Three-five 3
 More than five 4

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

156 (114) { 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? (115) Yes 1 No 2

157

Clinic Use Only

SHEP ID: <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 30px; height: 20px;" type="text"/> - <input style="width: 20px; height: 20px;" type="text"/>	Acrostic: <input style="width: 20px; height: 20px;" type="text"/>
--	---

(PLEASE TURN OVER)

54. a. Have you ever had surgery to improve the blood flow in your arteries or vessels (endarterectomy, by-pass surgery)? (Do not include surgery for varicose veins.) **158** 116 Yes 1 No 2

↓

Skip to 55

b. Did you have surgery on your neck vessels (carotid artery)? **159** 117 Yes 1 No 2

Date(s) of surgery _____

c. Did you have surgery on your heart (coronary by-pass)? **160** 118 Yes 1 No 2

Date(s) of surgery _____

d. Did you have surgery on the aorta or leg arteries? **161** 119 Yes 1 No 2

Date(s) of surgery _____

55. a. Have you been hospitalized for any reason within the past 5 years? **162** 120 Yes 1 No 2

↓

Skip to 56

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

Reason	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.)

ADDENDUM TO SH04 -- BASELINE MEDICAL HISTORY

59. Living arrangements at baseline:

(BLANK/1)

- 195 (137) 59a. Living alone
- 196 (138) 59b. Living with spouse
- 197 (139) 59c. Living with related individuals
- 198 (140) 59d. Living with non-related friends
- 199 (141) 59e. Living with non-related paid help
- 200 (142) 59f. Don't know

ENTRY INSTRUCTIONS FOR SH04 LIVING ARRANGEMENTS LIST

A listing of all randomized participants was sent out to the SHEP clinics for them to fill in living arrangements at Baseline. The choices were such things as "Living Alone," "With Spouse," etc. These listings have now been returned, all filled in, and we must enter the data so it can be put on the SHEP masterfile.

An entry program has been created for entry of this data, and then other programs will actually put the new data onto the old SH04 forms on the SHEP masterfile. These other programs will match the ID and Acrostic as entered with the data currently on the masterfile.

To access the data entry program, sign on to account SHEP001, then type:

@LIVARNG

The computer will respond with the standard Viking menu as shown below in Figure 1.

THE VDE MAIN SELECTION MENU
A. CREATE a new file
B. UPDATE an existing file
C. VERIFY an existing file
D. EXAMINE an existing file
E. EXIT with no work done

YOUR SELECTION: _

Figure 1: Viking Main Selection Menu

FILE NAME: _____

Figure 2: Viking File Name Request Menu

After you make your selection, another menu (Figure 2, above) will appear at the bottom of the screen and ask for the name of the file. After you supply the file name, the computer will show you the data screen. If you are creating a file, the data fields on the screen will be empty and you can immediately begin to enter data. If you are updating an existing file, the computer will show you the last page of data previously entered. To get to an empty screen so you can enter more data, push the "Next Screen" button.

The empty screen, ready for new data, will look like Figure 3.

		SHEP Baseline Living Arrangements						
To SKIP to the end of the page, ENTER "1" here: -		In the columns below, ENTER "1" instead of "X"						
SHEP ID	Acrostic	Living Alone	With Spouse	Related Individuals	Non-Related Friends	Non-Related Paid Help	Don't Know	
-	-	-	-	-	-	-	-	
-	-	-	-	-	-	-	-	
-	-	-	-	-	-	-	-	
-	-	-	-	-	-	-	-	
-	-	-	-	-	-	-	-	
-	-	-	-	-	-	-	-	
-	-	-	-	-	-	-	-	
-	-	-	-	-	-	-	-	

Figure 3. Screen Page for Data Entry

When the empty page is displayed waiting for data entry to begin, the cursor will be sitting on the line following the note at the top of the page which says, 'To SKIP to the end of the page, ENTER "1" here:'. To begin data entry in the first ID number, just skip this field by hitting the RETURN key. The cursor will jump down to the first ID number, and data entry can begin.

All the fields of the ID number and the Acrostic field on each line are "must enter" fields. They cannot be skipped. But most of the data fields under the columns will be blank, and can be skipped by hitting the RETURN key.

Start entering data on the first line, and when you finish it the cursor will automatically go to the next line. When the page is filled up, a new empty page will appear.

Note that the listing that came back from the clinics has "X" or check marks in the columns, but you are to enter "1" in the fields instead of "X".

If you finish the data and there are still blank lines on the page to be filled out, you may finish the page with no trouble by returning to the first field up at the left. This is the field which has the note: 'To SKIP to the end of the page, ENTER "1" here:'. You go back to this field by pushing the Previous Screen key. As soon as you put a "1" in this field, the computer will skip to the end of the page and show you a new page, and you can request a menu so you can EXIT from the entry program.

The exit menu, as usual, looks like Figure 4, below.

RECORD FORM INTERRUPT MENU
A. RETURN TO CURRENT RECORD
B. ENTER FILE SEARCH DATA
C. CONTINUE SEARCHING FILE
D. QUIT AND DELETE FILE
E. EXIT

YOUR SELECTION IS: _

Figure 4. Record Interruption Menu

You may choose any name you want for the various files of data records, but the first two letters in the file name should be "LV". Do not enter more than 50 pages into any single file.

If any questions arise, contact Lynne Mutchler.