

30-32 (1) FORM NUMBER

40 (518) SEQUENCE

33 (2) VERSION

GENERAL WELL-BEING

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

(6) 41-46 Acrostic: [][][][][][]

3. Date of Clinic Visit: (36|37) (38|39) (34|35)
Month (7) Day Year

4. Sequence number: (47|48) (8)

Questions in this section are to be asked at every visit. Use phraseology that you are comfortable with.

5. Have you felt unwell in any way since your last clinic visit; has anything been bothering you? (Specify): _____

(9) 49 Yes 1 No 2
↓
Go to 7.

6. Are any of these problems different from the way things were at your last clinic visit?

50 (10) Yes 1 No 2

7. Since your last visit, have you seen a doctor for any reason? (Specify): _____

51 (11) Yes 1 No 2

8. Since your last visit, have you been in the hospital for any reason? How many times? (53|54) (13)

52 (12) Yes 1 No 2
↓
Go to 9.

When? (Start with the first one after your last visit.)

	Hospitalization #1	Hospitalization #2	Hospitalization #3
Hospital name		(16)	(18)
Date of admission (14)	(57 58) (59 60) (55 56) Month Day Year	(65 66) (67 68) (63 64) Month Day Year	(73 74) (75 76) (71 72) Month Day Year
Number of days (15)	(61 62)	(17) (69 70)	(19) (77 78)
Reason			

9. a. Since your last SHEP visit, have you had any sudden feeling of numbness, tingling or loss of feeling in either arm, hand, leg, foot or face? (20) 79

Yes 1 No 2
↓
SKIP to 10.

b. How many attacks of such numbness or tingling have you had? (21) 80

One 1
More than one 2

c. How long did each of the attack(s) usually last? (22) 81

Less than 24 hours 1
More than 24 hours 2

10. a. Since your last SHEP visit, have you had any sudden attacks of paralysis or loss of use of either arm, hand, leg or foot? **(23)** 82 Yes 1 No 2
 ↓
 SKIP to 11.
- b. How many attacks of such paralysis have you had? **(24)** 83 One 1
 More than one 2
- c. How long did the attack(s) usually last? **(25)** 84 Less than 24 hours 1
 More than 24 hours 2
11. a. Since your last SHEP visit, have you had any sudden loss of eyesight or blurring of vision for a short period of time? **(26)** 85 Yes 1 No 2
 ↓
 SKIP to 12.
- b. What part of your vision was affected? **(27)** 86 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? **(28)** 87 One 1
 More than one 2
- d. How long did the attack(s) usually last? **(29)** 88 Less than 24 hours 1
 More than 24 hours 2
12. a. Since your last SHEP visit, have you had any sudden attacks of changes in speech, loss of speech or inability to say words? **(30)** 89 Yes 1 No 2
 ↓
 SKIP to 13.
- b. How many attacks of loss of speech have you had? **(31)** 90 One 1
 More than one 2
- c. How long did the attack(s) usually last? **(32)** 91 Less than 24 hours 1
 More than 24 hours 2
13. Since your last SHEP visit, have you had any of the following:
- a. Dizziness **(33)** 92 Yes 1 No 2
- b. Spinning sensation (vertigo) **(34)** 93 Yes 1 No 2
- c. Loss of balance **(35)** 94 Yes 1 No 2
- d. Difficulty walking **(36)** 95 Yes 1 No 2
- e. Blackouts or fainting Yes 1 No 2
- f. Frequent falls **(37)** 96 **(38)** 97 Yes 1 No 2
- If none of 13a-f are answered "Yes," skip to 14.
- g. About how many total attacks of all of these conditions do you think you ever had? **(39)** 98 One 1
 More than one 2
- h. How long did the attack(s) usually last? **(40)** 99 Less than 24 hours 1
 More than 24 hours 2

14. Since your last SHEP visit, have you been told by a doctor or otherwise learned that you may have had a stroke? **(41)** 100 Yes 1 No 2
15. Thinking about the other medications that you might be taking now, or have taken since your last visit:
- a. Have you stopped taking any medications? **(42)** 101 Yes 1 No 2
(Specify): _____
- b. Have you increased or decreased any medications that you were taking? **(43)** 102 Yes 1 No 2
(Specify): _____
- c. Have you started taking any new medications? **(44)** 103 Yes 1 No 2
(Specify): _____
16. Did the participant bring all non-SHEP medications to the clinic at this visit? **(45)** 104 Yes 1 No 2
Not on any non-SHEP medications 3

Specific queries (Side Effects Form, SH42): Required at the visit after starting or increasing the Step I or Step II medications, or if a positive response is given to any of Questions 5, 7, 8 or 9-14.

17. Is an SH42 required at this visit? **(46)** 105 Yes 1 No 2

↓
Skip to 18.

ADMINISTER SIDE EFFECTS FORM, SH42, IF REQUIRED, AND THEN RETURN TO THIS FORM.

Review

18. Are there any positive responses to Questions 5, 7, 8, **(47)** 106 Yes 1 No 2
9-14, or on the Side Effects Form (SH42)?

↓
Go to 23.

19. In the judgment of the SHEP clinician, are any of these positive or abnormal responses a result of:

- | | | Yes | Possibly | No | |
|---|-----------------|----------------------------|----------------------------|----------------------------|--|
| a. Stroke (48) 107 | (49) 108 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | Arrange for Neurologic Exam for Stroke (SH27) as soon as possible. |
| b. Acute myocardial infarction | | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | |
| c. Left ventricular failure (50) 109 | | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | |
| d. Transient ischemic attack | | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | Arrange for Neurologic Exam for TIA (SH28) as soon as possible. |
| e. Aortic dissection (52) 111 | (51) 110 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | |
| f. Coronary artery bypass surgery (53) 112 | | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | |
| g. Aortic aneurysm (54) 113 | | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | |
| h. Fracture (55) 114 | | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | |
| i. Intermediate or skilled nursing home admission (56) 115 | | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | |
| j. Hospitalization for reason other than above (57) 116 | | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | |

20. Was the participant hospitalized or seen by a physician for any event in 19a-19j?

- 58 Yes 1
- 117 No 2
- Not sure 3

For possible strokes, acute myocardial infarctions, left ventricular failures, and transient ischemic attacks, obtain complete hospital/physician visit record. For other hospitalizations, obtain discharge summary only for participant's SHEP record. Have participant sign Consent to Obtain medical records.

For possible strokes, acute myocardial infarctions, left ventricular failures, and transient ischemic attacks, fill out Form SH20, Initial Report of Morbid Event.

21 Does the participant think that any of these conditions are due to the SHEP medications? 118 59 Yes 1 No 2 DK 3

22. Comments (note pertinent history and physical exam findings and diagnostic impressions):

60 119 P O / I

23. Signature of person completing this form: _____ 61 120-121
Code

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