enumeration = ☐

FU

WISE ID: _____ ID & Key

Name Code____ ____ TEXT

ID is WISEID + Namecode 1 Variable

FU 6/19/2002 CIRCA

WISE

PATIENT FOLLOW-UP FORM

Date patient contacted: ____/____/____ CTDAT DATE
mm dd yy

Follow-up time: Futime Key

FUTME

1 ( )	6 weeks	5 ( )	4 years	9 ( )	8 years
2 ( )	1 year	6 ( )	5 years	10 ( )	9 years
3 ( )	2 years	7 ( )	6 years		
4 ( )	3 years	8 ( )	7 years		

Date of birth: ____/____/____ BRDTE DATE
mm dd yy

1. SINCE HER LAST FOLLOW-UP REPORT (or INITIAL TESTING IF THIS IS 6 WEEK REPORT), was the patient hospitalized?

1 ( ) Yes 0 ( ) No HOSP YESNO

↓

1.1 Number of hospitalizations NUHSP INT

Please list date(s) and reason(s) for hospitalization.

HPCDE

Length of stay for Hospitalization (in days) RANGE 1-365

	Date	Reason(s) [SEE CODES BELOW]				
1.2	HPDT1 DATE ____/____/____	RS1H1	RS2H1	RS3H1	1.2.1. LNHS1	INT
1.3	HPDT2 DATE ____/____/____	RS1H2	RS2H2	RS3H2	1.3.1. LNHS2	
1.4	HPDT3 DATE ____/____/____	RS1H3	RS2H3	RS3H3	1.4.1. LNHS3	

1.5 Describe vascular event/other/additional hospitalization:

ADHP1

ADHP2

ADHP3

TEXT

REASONS FOR HOSPITALIZATION CODES:
1 = Angina 2 = Myocardial Infarction 3 = CHF
4 = Stroke 5 = Other major vascular event (describe)
6 = Admission for scheduled Revascularization procedure
7 = Other (describe above)

F1.1

WISE ID: _____

2. PROCEDURES SINCE LAST FOLLOW-UP (or INITIAL TESTING IF THIS IS 6 week report):

	Yes 1	No 0	If yes, # of times	Date(s) of Procedure	
CRANG YESNO				DATE	
2.1 Coronary Angiogram	( )	( )	CRTM INT	CRDT1 __/__/__	CRDT2 __/__/__
2.2 PTCA/Percutaneous Intervention PTCAI YESNO	( )	( )	PTTM INT	PTDT1 __/__/__	PTDT2 __/__/__
2.3 CABG CABG YESNO	( )	( )	CBTM INT	CBDT1 __/__/__	CBDT2 __/__/__
CDSGY YESNO 2.4 Other cardiac surgery	( )	( )	SGYTM INT	SGDT1 __/__/__	SGDT2 __/__/__
2.5 Additional/Describe: Prtxt TEXT					

Outpatient Visits:

(In NOTES section, please provide clarifying comments as to the type of procedure/tests.)

	Yes 1	No 0	If yes, # of times (INT; RANGES 1-10)	Notes (TEXT)
(au YESNO)				
FUECG 2.6 Exercise ECG	( )	( )	FECGT	ECGNS
FUSPT 2.7 SPECT	( )	( )	FSPTT	SPTNS
FUPET 2.8 Cardiac PET	( )	( )	FPETT	PETNS
FU2DE 2.9 2-D Rest ECHO	( )	( )	F2DET	DENS2
FUSTE 2.10 Stress ECHO	( )	( )	FSTET	STENS
FUMRI 2.11 Cardiac MRI	( )	( )	FMRIT	MRINS
FUCCT 2.12 Cardiac CT	( )	( )	FCCTT	CCTNS
FUCD1 2.13 Cardiac Other	( )	( )	FCD1T	CD1NS
FUCD2 2.14 Cardiac Other	( )	( )	FCD2T	CD2NS
FUCD3 2.15 Cardiac Other	( )	( )	FCD3T	CD3NS

2.16 Comments: FUCMT TEXT _____

_____

_____

WISE ID: _____

3. In the last 6 weeks has the patient had pain or discomfort above the waist? HIPN YESNO
1 ( ) Yes 0 ( ) No
↓

3.1 Which of the following locations describe(s) most of the discomfort? (Check all that apply):
YESNO
3.1.1 ( ) Center of the chest behind the breast bone CNPN
3.1.2 ( ) Left side of chest L CHT
3.1.3 ( ) Neck or jaw NECK
3.1.4 ( ) Left arm LARM
3.1.5 ( ) Other PNOT
3.1.5.1 Specify: PNOTX TEXT

3.2 Does most of the pain or discomfort occur during physical exertion and/or emotional stress?
1 ( ) Yes 0 ( ) No PEPN YESNO

3.3 Does the pain or discomfort most often go away with rest?
1 ( ) Yes 0 ( ) No GORT YESNO
↓

3.3.1 Minutes until starts going away MINGO INT
3.3.2 Minutes until completely gone away ALLGO

3.4 Has the patient used nitroglycerine?
1 ( ) Yes 0 ( ) No YESNO
↓ USNTG

3.4.1 Does the pain or discomfort most often go away with nitroglycerine?
1 ( ) Yes NIGO 0 ( ) No YESNO
↓

3.4.1.1 Minutes until starts going away MINNI INT
3.4.1.2 Minutes until completely gone away ALLNI

3.5 Does the patient have angina that wakes her at night?
1 ( ) Yes 0 ( ) No AGNA YESNO

WISE ID: _____

In the past 6 weeks, how often has the patient had chest discomfort?

1 ( ) Never
2 ( ) 1 to 3 times
3 ( ) 1 to 3 times a week
4 ( ) Almost every day
5 ( ) 1 to 3 times a day
6 ( ) 4 or more times a day

CHTPN
CHTPN

5. Record all treatment within **the last six weeks :**

YNU

			Yes	No	Unknown
			1	0	2
ARHY	5.1	Antiarrhythmic agents	( )	( )	( )
ACOAG	5.2	Anticoagulants	( )	( )	( )
ADEP	5.3	Antidepressants	( )	( )	( )
ACE	5.4	Antihypertensive: ACE inhibitors	( )	( )	( )
ARB	5.5	Antihypertensive:angiotensin receptor blocker	( )	( )	( )
DIUR	5.6	Antihypertensive: diuretics	( )	( )	( )
VASO	5.7	Antihypertensive: vasodilators or others	( )	( )	( )
APLAT	5.8	Antiplatelet agents other than aspirin	( )	( )	( )
AXIOL	5.9	Anxiolytics, sedatives or hypnotics	( )	( )	( )
ASPRN	5.10	Aspirin	( )	( )	( )
BETAB	5.11	Beta Blockers	( )	( )	( )
CALC	5.12	Calcium supplements (fosamax)	( )	( )	( )
CALAN	5.13	Calcium antagonists	( )	( )	( )
CORT	5.14	Corticosteroids	( )	( )	( )
• DIABM	5.15	Diabetic medications	( )	( )	( )
DIGT	5.16	Digitalis	( )	( )	( )
FOLAT	5.17	Folate or B vitamins	( )	( )	( )
GIMED	5.18	GI medications	( )	( )	( )
• HERBS	5.19	Herbal supplements	( )	( )	( )
LLSTT	5.20	Lipid lowering - statins	( )	( )	( )
LLOTH	5.21	Lipid lowering agents - others	( )	( )	( )
NITR	5.22	Nitrates	( )	( )	( )
NONAA	5.23	Nonsteroidal anti-inflammatory agents	( )	( )	( )
TAMAX	5.24	Tamoxifen or derivatives	( )	( )	( )
THYMD	5.25	Thyroid medications	( )	( )	( )
VICEA	5.26	Vitamin C, E or A(betacarotene)	( )	( )	( )
ORALC	5.27	Oral contraceptives	( )	( )	( )

• NEW

WISE ID: _____

6. Since the last follow-up, has she taken any type of hormonal replacement therapy, such as estrogen (Premarin, etc), progesterone (Provera, etc), estrogen/progesterone combination (Prempro,etc) testosterone or any other hormone medications?

YNU

1 ( )Yes 0 ( )No 2 ( ) Unknown

↓ HRTYP

6.1 Reason(s) unknown: UNKRE TEXT

INT

IF ANSWERED "YES" OR "UNKNOWN"

Specify FHDA1 FHDO1/FHDY1/FHDR1

6.2.1. Date Started 6.2.2. Date Stopped

DATE → ___/___/___ 0-12 10-31 0-2007

mm dd yy mm dd YY

LO 9/3/60 – HI 1/1/07

6.2.3. Type of Hormone TYHRT FHTY1

1( )Estrogen 2( ) Estrogen & Progesterone

3( ) Other

6.2.3.1. Specify FHOT1 TEXT

FHDA2 FHDO2/FHDY2/FHDR2

6.3.1.Date Started 6.3.2. Date Stopped

___/___/___ ___/___/___ INT

mm dd yy LO/HI (See above) mm dd yy LO/HI (SEE ABOVE)

6.3.3. Type of Hormone TYHRT FHTY2

1( )Estrogen 2( ) Estrogen & Progesterone

3( ) Other

6.3.3.1. Specify FHOT2 TEXT

7. Has she ever had menopausal symptoms, such as hot flashes or night sweats? (Her best guess)

1 ( )Yes MENPS YESNO 0 ( )No

↓

7.1 How old was she when she first had symptoms such as hot flashes or night sweats? (Her best guess.)

_____ Years old AGFST INT

7.2 How old was she when she last had symptoms such as hot flashes or night sweats? (If she is still having symptoms such as hot flashes or night sweats, enter current age.)

_____ Years old AGLST INT

F3.2

WISE ID:_____

8. Has she had a natural menstrual period in the **past 12 months**?

1 ( )Yes PERD YESNO 0 ( ) No

↓

8.1 Date of the beginning of her last period ___/___/___ PERDT DATE
mm dd yy

8.2 Today's date ___/___/___ TDAY3 DATE
mm dd yy

8.3 Currently, the pattern that best describes her periods is: PRPAT PRPAT

0 ( ) No menstrual periods
1 ( ) Regular menstrual periods
2 ( ) Irregular menstrual periods
3 ( ) Sometimes regular, sometimes irregular

9. Has she had a hysterectomy (uterus ~~removed~~)?

1 ( ) Yes HYST YESNO 0 ( ) No

↓

9.1 Date of hysterectomy:___/___/___
mm dd yy

HYDTE DATE RANGES LO = 9/3/60 HI = 1/1/2007

10. Has she had any ovaries removed? OVARY OVARY

0 ( )No 1 ( )Yes, one 2 ( )Yes, both

↓ ↓

Date(s) of Ovary Surgery:

10.1 ___/___/___ OVRD1 DATE
mm dd yy

10.2 ___/___/___ OVRD2 DATE
mm dd yy

Use same range as #9.1

11. How old was the patient when she last had **natural** menstrual bleeding (a period?)

(Her best guess.)_____ Years old

PRLST INT

Y 1.3

WISE ID: _____

12. DUKE ACTIVITY STATUS INVENTORY

Within the last six weeks could you:	Yes, with no difficulty 1	Yes, but with some difficulty 2	No, I can't do this 3	Don't do this for other reasons 4
		ACTINV		
12.1 Take care of yourself, that is, eating, dressing, bathing, and using the toilet? CARE	()	()	()	()
12.2 Walk indoors, such as around your house? WKIN	()	()	()	()
12.3 Walk a block or two on level ground? WKBLK	()	()	()	()
12.4 Climb a flight of stairs or walk up a hill? STAIR	()	()	()	()
12.5 Run a short distance? RUN	()	()	()	()
12.6 Do light work around the house such as ting or washing dishes? LTWRK	()	()	()	()
12.7 Do moderate work around the house such as vacuuming, sweeping floors, carrying in groceries? MDWRK	()	()	()	()
12.8 Do heavy work around the house such as scrubbing floors, or lifting or moving heavy furniture? HVWRK	()	()	()	()
12.9 Do yardwork such as raking leaves, weeding, or pushing a power mower? YDWRK	()	()	()	()
12.10 Have sexual relations? SEX	()	()	()	()
12.11 Participate in moderate recreational activities, such as golf, bowling, dancing, doubles tennis, or throwing baseball or football? MDSP	()	()	()	()
12.12 Participate in strenuous sports such as swimming, singles tennis, football, basketball or skiing? STRSP	()	()	()	()

WISE ID: _ _ _ _ _ _

13. Is the patient currently employed, either full or part-time?
1( ) Yes 0( ) No ECEMP YESNO

↓

13.1 Does the patient's current health status impair her ability to work?
ECPHS
1( ) Yes 0( )No 2( ) Unknown YNU

13.2 Does the patient have to spend time at work performing tasks assigned by a health care practitioner, like taking pills? Measuring blood pressure? Measuring blood sugar?
ECPHW
1( ) Yes 0( )No 2( ) Unknown YNU

13.3 Has the patient had to lose any days of work due to heart related symptoms in the last 6 months?
ECPLW
1( ) Yes 0( )No 2( ) Unknown YNU

Does the patient have dual residences?
DUALR
1( ) Yes 0( )No YESNO

15. Approximately how many miles does the patient live (primary residence) from the hospital where she routinely receives her medical care?
_ _ _ _ _ INT ECMIL 1-9999

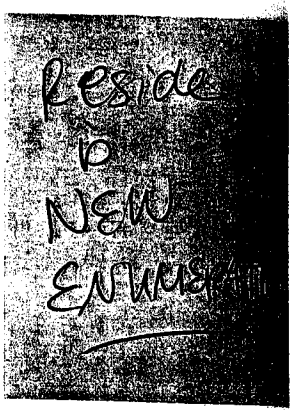
16. Does the patient require a family member or a friend to accompany her to doctor's appointments?
ECFDR
1( ) Yes 0( )No 2( ) Unknown YNU

Resid WISE ID: _____

17. Where does the patient currently reside?

0 ( ) At home alone
1 ( ) At home with spouse or companion
2 ( ) At home with adult child or other non-related adult
3 ( ) At an assisted living facility
4 ( ) At a rehabilitation facility
5 ( ) At a nursing home
6 ( ) Other
17.1. Specify: RESTX TEXT

RESIDE



18. Does the patient receive any of the following health services? (Check all that apply)

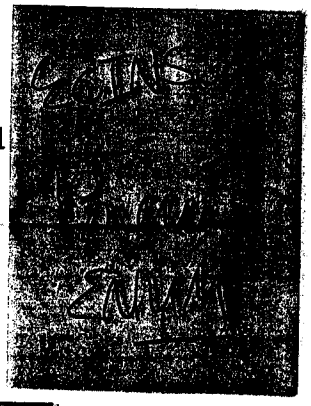
YES/NO

0 ( ) None HSNON
1 ( ) Home health care HSHOM
2 ( ) Assistance with food preparation/purchasing HSASS
3 ( ) Transportation support HSTRN
4 ( ) Cardiac support group HSCRD
5 ( ) Church sponsored health service HSCHR
6 ( ) Housekeeping assistance HSHKG
7 ( ) Other ECHSE
18.1. Specify: ECHTX TEXT
8 ( ) Unknown HSUNK

19. What is the patient's primary source of insurance? ECINS

0 ( ) None 1( ) Own Employer 2( ) Spouse's employer 3 ( ) Self- Purchased
4 ( ) Medicaid 5 ( ) Other
19.1. Specify: EITXT TEXT
6 ( ) Medicare 7 ( ) Unknown

ECINS



↓ ECMED

19.2 If she has Medicare, does the patient have supplemental health insurance?

1( ) Yes 0( )No 2( ) Unknown YNU

F3.3

WISE ID: _ _ _ _ _ _ _ _

20. Is the patient enrolled in an HMO? ECHMO

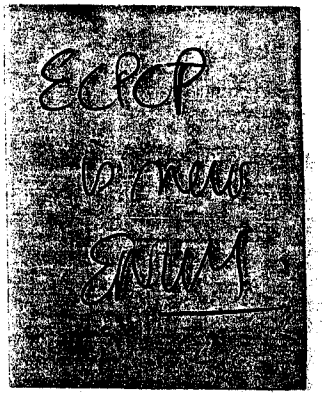
1( ) Yes 0( )No 2( ) Unknown YNU

21. Does the patient receive any insurance coverage for prescription drugs?

1( ) Yes 0( )No 2( ) Unknown ECDRU YNU

22. What type of provider does the patient consider to be her primary care provider (choose 1)?

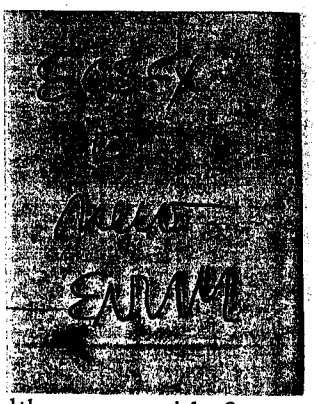
0 ( ) General Internist or Family Practitioner ECPCP
1 ( ) Cardiologist ECPCP
2 ( ) Gynecologist
3 ( ) Cardiovascular Surgeon
4 ( ) Nurse Practitioner/Physician's Assistant
5 ( ) Community Clinic/Walk-in Clinic
6 ( ) None/Does not have
7 ( ) Other
22.1 Specify: ESPCP TEXT



23. What is the approximate age of her primary care provider?

RANGES 25-90 _ _ PCPAG INT

IF UNKNOWN, Check here: 23.1 2( ) Unknown PCUNK YNU



24. Is the primary care provider a man or a woman?

0 ( ) Man 1 ( ) Woman ECSEX ECSEX

25. Approximately how many times in the last 6 months has she seen the following health care provider?

		Number of Times	
25.1	General Internist or Family Practitioner	_____	ECTGI
25.2	Cardiologist	_____	ECTCA
25.3	Gynecologist	_____	ECTGY
25.4	Cardiovascular Surgeon	_____	ECTSU
25.5	Nurse Practitioner/Physician's Assistant	_____	ECTNU
25.6	Community Clinic/Walk-in Clinic	_____	ECTCL
25.7	Other	_____	EOTHE

25.7.1. Specify: EOTXT TEXT RANGES 0-30

INT

WISE ID: _____

26. Has she purchased medical equipment for home use? ECEQU

1( ) Yes 0( )No 2( ) Unknown YNU

↓

26.1 If yes, what?
0 ( ) blood pressure monitoring BPMON YESNO
1 ( ) glucose measurement device GLUME YESNO
2 ( ) Other EQUYE YESNO
26.2 Specify: EQTXT TEXT

27. In general, would she say her health is (mark one) HEALT HEALT

Excellent	Very good	Good	Fair	Poor
1 ( )	2 ( )	3 ( )	4 ( )	5 ( )

Overall, how would the patient rate her quality of life? (mark one of the boxes below) QOL INT

0	1	2	3	4	5	6	7	8	9	10
( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )

Worst
As bad or worse than being dead

Halfway

Best
Best quality of life

29. How satisfied is the patient with her current quality of life? (Mark one of the boxes below) STQOL INT

0	1	2	3	4	5	6	7	8	9	10
( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )

Worst
Not at all happy with quality of life now

Halfway

Best
Very happy with quality of life now

WISE ID: _____

30. Please comment below to clarify current health and activity status:

CMT1

CMT2 } TEXT

CMT3

CMT4

DATE

Date: ___/___/___ FUDTE
mm dd yy

Person completing form: NAME TEXT

F2.4