

4. [ASK WOMEN ONLY – 55 YEARS OR YOUNGER:
 ENTER CODE 4 IF FEMALE 56 YEARS OR >;
 ENTER CODE 5 IF MALE]
 Have you had a menstrual period within the
 past two weeks? No longer menstruating 1
 Yes 2
 No 3
 Female 56/older 4
 Male 5
 Don't Know 7
 Refused 8
 Missing 9

B. GIRTH MEASUREMENTS

5. Waist girth (to the nearest inch) in/8

6. Hip girth (to the nearest inch) in/8

IF INCLUDED IN THE HEIGHT/WEIGHT/BMI COMPARABILITY STUDY, RECORD MEASUREMENTS USING BOTH THE BALANCE BEAM SCALE/WALL MEASURE OF STANDING HEIGHT AND THE TANITA BODY COMPOSITION SCALE AND HEIGHT ROD. FOR BALANCE BEAM MEASURES, BMI IS CALCULATED AUTOMATICALLY. ENTER THE BMI MEASUREMENT FROM THE TANITA OUTPUT

7. Was this participant's height, weight, and BMI measured by:
- | | | | |
|--|----------------------|------------------------------|---|
| | <input type="text"/> | Complete Section C ONLY | |
| | | Balance beam/wall only | 1 |
| | <input type="text"/> | Complete Section D ONLY | |
| | | Tanita body composition only | 2 |
| | <input type="text"/> | Complete Section C AND D | |
| | | Both | 3 |
| | | Don't Know | 7 |
| | | Refused | 8 |
| | | Missing | 9 |

C. BALANCE BEAM/WALL MEASUREMENT

8. Standing height (to nearest inch): 8a feet 8b inches
 IF UNABLE TO MEASURE, ENTER 999
 IF REFUSED, ENTER 888

9. Weight (to nearest tenth of pound): Pounds
IF UNABLE TO MEASURE, ENTER 999.9
IF REFUSED, ENTER 888.8

10. Body mass index (to nearest tenth of percent) Kg/m²
IF UNABLE TO MEASURE, ENTER 99.9
IF REFUSED, ENTER 88.8

D. TANITA MEASUREMENTS

11. Body Type Standard 1
Athletic 2

12. Height (TANITA) 12a Feet 12b Inches
IF UNABLE TO MEASURE, ENTER 99
IF REFUSED, ENTER 88

13. Weight (TANITA) (to the nearest tenth of pound) Pounds
IF UNABLE TO MEASURE, ENTER 999.9
IF REFUSED, ENTER 888.8

14. Body Mass Index (TANITA)
IF UNABLE TO MEASURE, ENTER 99.9
IF REFUSED, ENTER 88.8

15. Percent Body Fat (to the nearest tenth of a percent)
IF UNABLE TO MEASURE, ENTER 999.9
IF REFUSED, ENTER 888.8

16. Basal Metabolic Rate 16a.
IF UNABLE TO MEASURE, ENTER 99999
IF REFUSED, ENTER 88888 16b.

17. Impedance Ω
IF UNABLE TO MEASURE, ENTER 9999
IF REFUSED, ENTER 8888

18. Fat Mass (to the nearest tenth of a percent) %
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IF UNABLE TO MEASURE, ENTER 999.9
IF REFUSED, ENTER 888.8

19. Fat Free Mass (to the nearest tenth of a pound) Pounds
IF UNABLE TO MEASURE, ENTER 999.9
IF REFUSED, ENTER 888.8

20. Total Body Water (to the nearest tenth of a pound) Pounds
IF UNABLE TO MEASURE, ENTER 999.9
IF REFUSED, ENTER 888.8

E. DESIRABLE RANGE

21. Desirable Percent Body Fat - %
IF UNABLE TO MEASURE, ENTER 99
IF REFUSED, ENTER 88

22. Desirable Fat Mass
(to the nearest tenth of a percent)
IF UNABLE TO MEASURE, ENTER 99.9
IF REFUSED, ENTER 88.8

F. GOAL SETTING

23. Target Percent Body Fat %
IF UNABLE TO MEASURE, ENTER 99
IF REFUSED, ENTER 88

24. Predicted Fat Mass Pounds
(to the nearest tenth of a pound)
IF UNABLE TO MEASURE, ENTER 99.9
IF REFUSED, ENTER 88.8

25. Fat to Lose Pounds
(to the nearest tenth of a pound)
IF UNABLE TO MEASURE, ENTER 999.9
IF REFUSED, ENTER 888.8

G. ADMINISTRATIVE INFORMATION

26. Date of data collection: / /
m m d d y y y y

27. Method of data collection: Computer 1
Paper form 2

28. Data collected: In Clinic 1
Off site 2

29. Code number of person completing this form:

--	--	--



Finger Stick

FORM CODE: FST
VERSION A 10/07/2005

ID NUMBER:

CONTACT YEAR

LAST NAME:

INITIALS:

INSTRUCTIONS: This form should be completed during the participant's visit. ID Number, Contact Year, and Name must be entered above. Whenever numerical responses are required, enter the number so that the last digit appears in the rightmost box. Enter leading zeroes where necessary to fill all boxes. If a paper form is used and a number is entered incorrectly, mark through the incorrect entry with an "X". Code the correct entry clearly above the incorrect entry. For "multiple choice" and "yes/no" type questions, circle the number corresponding to the most appropriate response. If a number is circled incorrectly, mark through it with an "X" and circle the correct response.

A. FINGER STICK

1. Do you have any bleeding disorders? Yes 1
- No 2
- Don't know 7
- Refused 8
- Missing 9

2. [IF YES, REVIEW SPECIAL PRECAUTIONS AND SPECIFY IN ITEM 2a]

3a. Date of finger stick: / /
m m d d y y y y

3b. Time of finger stick:
h h m m

4. Number of finger stick attempts:

B. GLUCOSE

5. Glucose

--	--	--

 mg/dl

C. LIPIDS

6. Cholesterol

--	--	--

 mg/dl

7. Triglycerides

--	--	--

 mg/dl

8. HDL.....

--	--	--

 mg/dl

9. LDL.....

--	--	--

 mg/dl

10. Non HDL

--	--	--

 mg/dl

D. ADMINISTRATIVE

11. Method of data collection: Computer 1
Paper form 2

12. Data Collected:In Clinic 1
Off Site 2

13. Code number of person completing this form:

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Health History Form

FORM CODE: HHX
VERSION A 08/16/2005

ID NUMBER:

CONTACT YEAR:

LAST NAME:

INITIALS:

A. PERSONAL HEALTH HISTORY

"I would like to ask you a few questions about your health."

1. Compared to other people your age, would you say that your health is excellent, good, fair, or poor?
- | | |
|------------|---|
| Excellent | 1 |
| Good | 2 |
| Fair | 3 |
| Poor | 4 |
| Don't Know | 7 |
| Refused | 8 |
| Missing | 9 |

2. Since this time last year, would you say your health is
- | | |
|----------------|---|
| Better | 1 |
| Worse | 2 |
| About the same | 3 |
| Don't know | 7 |
| Refused | 8 |
| Missing | 9 |

3. What was your weight at birth?
- | | | |
|--|--|--|
| 3a <input type="text"/> <input type="text"/> | | 3b <input type="text"/> <input type="text"/> |
| pounds | | ounces |
| Don't know | | 77 |
| Refused | | 88 |
| Missing | | 99 |

4a. Were you breast fed?	Yes	1	
	No	2	Go to Item 5a
	Don't Know	7	
	Refused	8	
	Missing	9	

IF YES:

4b. For how long?	< 6 weeks	1
	6 -11 weeks	2
	3- 6 months	3
	> 6 months	4
	Don't know	7
	Refused	8
	Missing	9

ASK WOMEN IF ONLY

5a. Have you ever had a tubal-ligation (had one or more of your tubes tied)?.....	Yes	1	
	No	2	Go to Item 6
	Don't Know	7	
	Refused	8	
	Missing	9	

IF YES:

5b. How old were you when you had a tubal-ligation?.....

--	--	--

age

Don't know	777
Refused	888
Missing	999

ASK WOMEN ONLY IF < 55 YEARS OLD AND "NO" TO ITEM 4a

6. Are you currently pregnant?	Yes	1
	No	2
	Don't Know	7
	Refused	8
	Missing	9

ASK MEN ONLY:

7. Have you ever had a vasectomy?.....	Yes	1
	No	2
	Don't Know	7
	Refused	8
	Missing	9

B. PERSONAL HEALTH PROBLEMS

"Now I am going to read a list of some health problems. I am interested in any new health problems you may have learned about since your last Jackson Heart Study exam, that is in (mm/dd/yyyy). For each one, please tell me if your health care provider has told you for the first time since [date of JHS exam] that you have this problem."

Since your last Jackson Heart Study exam has your doctor or health professional ever said you have:

8a. High blood pressure or hypertension? :	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

Go to Item 9a

8b. How old were you when you were told that you had high blood pressure or hypertension?
age

Don't know	777
Refused	888
Missing	999

9a. High blood cholesterol? Yes 1
 No 2
 Don't know 7
 Refused 8
 Missing 9

Go to Item 10a

9b. How old were you when you were told that you had high blood cholesterol?

--	--	--

age

Don't know 777
 Refused 888
 Missing 999

10a. Heart attack? Yes 1
 No 2
 Don't know 3
 Refused 8
 Missing 9

Go to Item 11a

10b. How old were you when you were told that you had a heart attack?

--	--	--

age

Don't know 777
 Refused 888
 Missing 999

11a. Stroke? Yes 1
 No 2
 Don't know 7
 Refused 8
 Missing 9

Go to Item 12a

11b. How old were you when you were told that you
 had a stroke? age

- Don't know 777
- Refused 888
- Missing 999

Since your last Jackson Heart Study exam [date], has your doctor or health professional ever said you have:

12a. Sugar in the blood or diabetes? Yes 1
 No 2
 Don't know 7
 Refused 8
 Missing 9

Go to Item 13a

12b. How old were you when you were told that you
 had sugar in the blood or diabetes? age

- Don't know 777
- Refused 888
- Missing 999

13a. Kidney problem?..... Yes 1
 No 2
 Don't know 7
 Refused 8
 Missing 9

Go to Item

13b. How old were you when you were told that you
 had a kidney problem?..... age

- Don't know 777
- Refused 888
- Missing 999

14a. Cancer?	Yes	1	
	No	2	<div style="border: 1px solid black; padding: 5px; display: inline-block;">Go to Item 15a</div>
	Don't know	7	
	Refused	8	
	Missing	9	

14b. How old were you when you were told that you had cancer.....

--	--	--

age

Don't know	777
Refused	888
Missing	999

15a. Chronic lung disease (other than asthma), such as COPD, bronchitis or emphysema?	Yes	1	
	No	2	<div style="border: 1px solid black; padding: 5px; display: inline-block;">Go to Item</div>
	Don't know	7	
	Refused	8	
	Missing	9	

15b. How old were you when you were told that you had chronic lung disease?.....

--	--	--

age

Don't know	777
Refused	888
Missing	999

16a. Asthma?	Yes	1	
	No	2	<div style="border: 1px solid black; padding: 5px; display: inline-block;">Go to Item 17a</div>
	Don't know	3	
	Refused	8	
	Missing	9	

16b. How old were you when you were told that you had asthma?

--	--	--

age

- Don't know 777
- Refused 888
- Missing 999

17a. A blood circulation problem?.....

- Yes 1
- No 2
- Don't know 7
- Refused 8
- Missing 9

Go to Item 18a

17b. How old were you when you were told that you had a blood circulation problem?

--	--	--

age

- Don't know 777
- Refused 888
- Missing 999

18a. Have you stayed overnight as a patient in a hospital during the past year?

- Yes 1
- No 2
- Don't know 7
- Refused 8
- Missing 9

Go to Item 19

18b. Reason:

C. HEALTH BEHAVIORS

19. What is the most that you have ever weighed
(WOMEN: except when you were pregnant)?

- Pounds
- Don't know 777
 - Refused 888
 - Missing 999

19a. How old were you when you weighed this much?

- Age
- Don't know 777
 - Refused 888
 - Missing 999

20. What did you weigh when you were age 18?

- Pounds
- Don't know 777
 - Refused 888
 - Missing 999

21. Do you consider yourself now to be overweight, underweight, or about the right weight?

- Overweight 1
- Underweight 2
- About right weight 3
- Don't know 7
- Refused 8
- Missing 9

22. Have you ever been on a diet to lose weight? Yes 1

- No 2
- Don't know 7
- Refused 8
- Missing 9

Go to Item 23

- 22a. Are you on such a diet now? Yes 1
 No 2
 Don't Know 7
 Refused 8
 Missing 9

23. During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?

- Yes 1
 No 2
 Don't know 7
 Refused 8
 Missing 9

Go to Item 24

23a. When you are exercising in your usual fashion, how would you rate your level of exertion (degree of effort)? Using this card, give me a number from 0 to 10 that represent how much exertion or effort you use. [GIVE RESPONDENT CARD].

24. During the past year, how often did you watch television [GIVE RESPONDENT CARD]

- Less than 1 hour per week 1
 At least 1 hour a week but
 Less than 7 hours a week 2
 At least 1 hour a day but
 Less than 2 hours a day 3
 At least 2 hours a day but
 Less than 4 hours a day 4
 4 hours or more a day 5
 Don't know 7
 Refused 8
 Missing 9

D. HEALTH CARE ACCESS

25. When was the last time you saw a health care provider for treatment of a medical problem?
[HAND RESPONSE CARD]

Within the past year	1
At least 1 year, but less than 2 years ago	2
At least 2 years, but less than 4 years ago	3
5 or more years ago	4
Never	5
Don't know	7
Refused	8
Missing	9

26. When was the last time you saw a health care provider for a routine physical exam or general
checkup, that is when you were not sick or pregnant? [HAND REPOSENSE CARD]

Within the past year	1
At least 1 year but, less than 2 year ago	2
At least 2 years, but less than 4 years ago	3
5 or more years ago	4
Never	5
Don't know	7
Refused	8
Missing	9

27. Overall how hard has it been for you to get the health services you have needed? Would you say it has
been very hard, fairly hard, not too hard, or not hard at all?

Very hard	1
Fairly hard	2
Not too hard	3
Not hard at all	4
Don't know	7
Refused	8
Missing	9

7. During the past month, excluding naps, how many hours of actual sleep did you get at night (or day, if you work at night) on average? This may be different from the number of hours spent in bed..... Hours
 (Don't Know = 77, Refused = 88, Missing =99)

B. CHEST PAIN ON EFFORT

8. Since your last Jackson Heart Study exam on (mm/dd/yyyy) have you had any pain or discomfort in your chest? Yes 1

Go to Item 32	No	2
	Don't Know	7
	Refused	8
	Missing	9

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

Go to Item 29	Yes	1
	No	2
	Never hurries or walks uphill	3
	Don't Know	7
	Refused	8
	Missing	9

10. Do you get it when you walk at an ordinary pace on the level? Yes 1

Go to Item 29	No	2
	Don't know	7
	Refused	8
	Missing	9

11. What do you do if you get it while you are walking? Stop or slow down 1

[RECORD "STOP OR SLOW DOWN" IF SUBJECT CARRIES ON AFTER TAKING NITROGLYCERIN]	Carry on	2
	Don't Know	7
	Refused	8
	Missing	9

12. If you stand still, what happens to it? Relieved 1

- Not relieved 2
 - Don't Know 7
 - Refused 8
 - Missing 9
- Go to Item 29

13. How soon? 10 minutes or less 1

- More than 10 minutes 2
 - Don't Know 7
 - Refused 8
 - Missing 9
- Go to Item 29

14. Will you show me where it was? [CIRCLE "1" OR "2" FOR ALL AREAS]

	<u>Yes</u>	<u>No</u>	<u>Don'tKnow</u>	<u>Refused</u>	<u>Missing</u>
14a. Sternum (upper or middle).....	1	2	7	8	9
14b. Sternum (lower).....	1	2	7	8	9
14c. Left anterior chest.....	1	2	7	8	9
14d. Left arm	1	2	7	8	9
14e. Other	1	2	7	8	9

14f. Specify:.....

15. Do you feel it anywhere else? [IF "YES", RECORD ABOVE] Yes 1

- No 2
- Don't Know 7
- Refused 8
- Missing 9

16. Did you see a doctor because of this pain or discomfort?..... Yes 1

- No 2
 - Don't know 7
 - Refused 8
 - Missing 9
- Go to Item 18

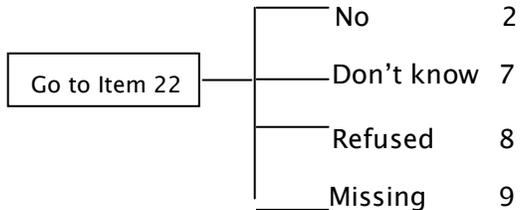
17. What did the doctor say it was?	Angina	1
	Heart attack	2
	Other Heart Disease	3
	Other	4

18. Have you been hospitalized because of this pain?	Yes	1
	No	2
	Don't Know	7
	Refused	8
	Missing	9

19. How long ago did you start getting this pain? Within the past:	1 month	1
	6 months	2
	1 year	3
	2 years	4
	Over 2 years	5
	Don't Know	7
	Refused	8
	Missing	9

“The next 3 questions on chest pain refer to 3 aspects: how often it occurs, how severe it is, and how long it lasts.”

20. Within the past 2 months, has your chest discomfort occurred more often?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

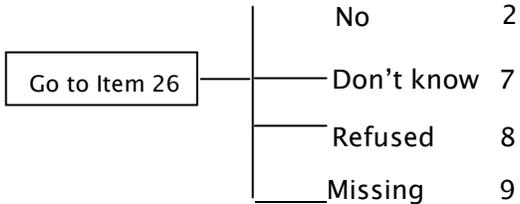


21. Has it occurred at least twice as often as before? Yes 1
 No 2
 Don't know 7
 Refused 8
 Missing 9

22. Within the past 2 months, has the pain become more severe? Yes 1
 No 2
 Don't know 7
 Refused 8
 Missing 9

23. Within the past 2 months, has the pain lasted longer when it occurs? Yes 1
 No 2
 Don't know 7
 Refused 8
 Missing 9

24. Do you ever use nitroglycerin to relieve the pain? Yes 1
 No 2
 Don't know 7
 Refused 8
 Missing 9

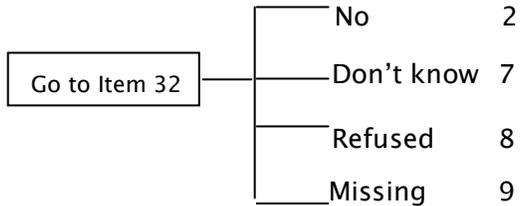


25. Within the past 2 months, has the pain required more nitroglycerin to relieve it? Yes 1
 No 2
 Don't know 7
 Refused 8
 Missing 9

26. Within the past 2 months, have you started getting the pain with less exertion? Yes 1
 No 2
 Don't know 7
 Refused 8
 Missing 9
27. Within the past 2 months have you started getting the pain when sitting still? Yes 1
 No 2
 Don't know 7
 Refused 8
 Missing 9
28. Within the past 2 months, have you started getting the pain when sleeping? Yes 1
 No 2
 Don't know 7
 Refused 8
 Missing 9

C. POSSIBLE INFARCTION

29. Since your last Jackson Heart Study exam, have you ever had a severe pain across the front of your chest lasting for half an hour or more? Yes 1
 No 2
 Don't know 7
 Refused 8
 Missing 9



30. Did you see a doctor because of this pain? Yes 1
 No 2
 Don't know 7
 Refused 8
 Missing 9

31. What did the doctor say it was? Heart Attack 1
 Other disorder 2
 Don't Know 7
 Refused 8
 Missing 9

32. Since your last Jackson Heart Study exam, have you ever had a heart attack for which you were hospitalized one week or more? Yes 1
 No 2
 Don't Know 7
 Refused 8
 Missing 9
-

33. How many such heart attacks have you had?
 (Don't know = 7, Refused = 8, Missing = 9)

34. How old were you when you had your (first) heart attack?
 (Don't know = 777, Refused = 888, Missing = 999)

35. Have you ever had a test in which you were asked to exercise while an electrocardiogram was taken? Yes 1
 No 2
 Don't know 7
 Refused 8
 Missing 9
-

36. Were you told that the results were normal or abnormal? Normal 1
 Abnormal 2
 Don't know 7
 Refused 8
 Missing 9

D. INTERMITTENT CLAUDICATION

37. Do you get pain in either leg on walking? Yes 1

Go to Item 47
No 2
Don't know 7
Refused 8
Missing 9

38. Does this pain ever begin when you are standing still or sitting? Yes 1 Go to Item 46

No 2
Don't know 7
Refused 8
Missing 9

39. In what part of your leg do you feel it? [IF CALVES NOT MENTIONED, ASK: "ANYWHERE ELSE?"] Pain includes calf/calves 1

Go to Item 46
Pain does not include calf/calves 2
Don't Know 7
Refused 8
Missing 9

40. Do you get it if you walk uphill or hurry? Yes 1

No 2
Never hurries or walks uphill 3
Don't Know 7
Refused 8
Missing 9

41. Do you get it if you walk at an ordinary pace on the level? Yes 1

No 2
Don't know 7
Refused 8
Missing 9

42. Does the pain ever disappear while you are walking? Yes 1 — Go to Item 46

No 2

Don't know 7

Refused 8

Missing 9

43. What do you do if you get it when you are walking? Stop or slow down 1

Go to Item 46 — Carry on 2

Don't Know 7

Refused 8

Missing 9

44. What happens to it if you stand still? Relieved 1

Not relieved 2

— Don't Know 7

Refused 8

Missing 9

45. How soon? 10 minutes or less 1

More than 10 minutes 2

Don't Know 7

Refused 8

Missing 9

46. Were you hospitalized for this problem in your legs? Yes 1

No 2

Don't know 7

Refused 8

Missing 9

E. CONGESTIVE HEART FAILURE

47. Since your last Jackson Heart Study exam, have you had to sleep on 2 or more pillows to help you breathe? Yes 1
 No 2
 Don't know 7
 Refused 8
 Missing 9

48. Have you been awakened at night by trouble breathing? Yes 1
 No 2
 Don't know 7
 Refused 8
 Missing 9

49. Have you had swelling of your feet or ankles (excluding during pregnancy)? Yes 1
 [INCLUDE PARENTHETICAL COMMENT FOR FEMALES ONLY] No 2
 Go to Item 51 Don't know 7
 Refused 8
 Missing 9

50. Did it tend to come on during the day and go down overnight? Yes 1
 No 2
 Don't know 7
 Refused 8
 Missing 9

F. INVASIVE PROCEDURES

51. Since your last Jackson Heart Study exam, have you had surgery on your heart, or the arteries of your neck or legs, excluding surgery for varicose veins? Yes 1
 No 2
 Go to Item 53 Don't know 7
 Refused 8
 Missing 9

52. Did you have:

52a. Coronary bypass:	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

52b1. Other heart procedure:.....	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

Go to Item 52c

52b2. Specify:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

52c. Carotid endarterectomy:	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

Go to Item 52e1

52d. Site:	Right	1
	Left	2
	Both	3
	Don't know	7
	Refused	8
	Missing	9

52e1. Other arterial revascularization or bypass: Yes 1

Go to Item 52f	No	2
	Don't know	7
	Refused	8
	Missing	9

52e2. Specify:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

52f. Any other type of surgery on your heart or the arteries of your neck or legs? Yes 1

No	2
Don't know	7
Refused	8
Missing	9

53. Since your last Jackson Heart Study exam, have you had a balloon angioplasty on the arteries of your heart, neck, or legs? Yes 1

Go to Item 55	No	2
	Don't know	7
	Refused	8
	Missing	9

54. Did you have:

54a. Angioplasty of the coronary arteries? Yes 1

No	2
Don't know	7
Refused	8
Missing	9

54b. Angioplasty in the arteries of your neck? Yes 1

No	2
Don't know	7
Refused	8
Missing	9

54c. Angioplasty of lower extremity arteries?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

55. Since your last Jackson Heart Study exam, have you had:

55a. Heart catheterization?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

55a1. What was the reason for this procedure?

Emergency for a heart attack	1
Chest pain/discomfort	2
Doctors suspected disease/blockage	3
Follow up after heart attack or procedure (surgery or stent)	4
Other (Specify)	5
Don't Know	7
Refused	8
Missing	9

55a2. Specify:

55b. Carotid artery catheterization?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

55b1. What was the reason for this procedure?

- Emergency for a stroke 1
- Doctors suspected disease/blockage 2
- Other (Specify) 3
- Don't Know 7
- Refused 8
- Missing 9

55b2. Specify:

55c1.

Other arterial catheterization?..... Yes 1

- | | | |
|---------------|------------|---|
| Go to Item 56 | No | 2 |
| | Don't know | 7 |
| | Refused | 8 |
| | Missing | 9 |

55c2. Specify:

55c3. What was the reason for this procedure?

- Leg pain on walking short distance 1
- Doctor suspected disease/blockage 2
- Other (Specify) 5
- Don't Know 7
- Refused 8
- Missing 9

55c4. Specify:

G. DIAGNOSTIC PROCEDURES

56. Since your last Jackson Heart Study exam, have you had any of the following procedures performed for a medical reason?

Please do not include any procedures done for research studies or a fitness program.

	<u>Yes</u>	<u>No</u>	<u>Don'tKnow</u>	<u>Refused</u>	<u>Missing</u>
56a. Echocardiogram?	1	2	7	8	9

IF YES ASK:

56a1. What was the reason for this procedure?

- Heart failure/fluid on lungs 1
- Heart murmur / Valvular heart disease 2
- High blood pressure 3
- Follow up after heart attack or surgery 4
- Other (Specify) 5
- Don't know..... 7
- Refused 8
- Missing..... 9

56a2. Specify:

56b. Electrocardiogram?	1	2	7	8	9
-------------------------------	---	---	---	---	---

IF YES ASK:

56b1. What was the reason for this procedure?

- Chest pain / discomfort 1
- Rhythm disturbance 2
- High blood pressure 3
- Other (Specify)..... 4
- Don't know..... 7
- Refused 8
- Missing..... 9

56b2. Specify:

56c. Treadmill or cardiac stress test? 1 2 7 8 9

IF YES ASK:

56c1. What was the reason for this procedure?

- Chest pain / discomfort 1
- Follow up after heart attack or procedure 2
- Other (Specify)..... 3
- Don't know..... 7
- Refused 8
- Missing 9

56c2. Specify:

56d. MRI exam of the brain? 1 2 7 8 9

IF YES ASK:

56d1. What was the reason for this procedure?

- Passing out 1
- Forgetfulness 2
- TIA (little strokes) 3
- Stroke 4
- Blocked arteries 5
- Other (Specify)..... 6
- Don't know..... 7
- Refused 8
- Missing 9

56d2. Specify:

H. ADMINISTRATIVE INFORMATION

57. Date of data collection:.....

		/			/				
m	m		d	d		y	y	y	y

58. Method of data collection: Computer 1
Paper form 2

59. Data Collected In Clinic 1
Off Site 2

60. Code number of person completing this form:

--	--	--



Medication Survey Form

FORM CODE: MSR
VERSION B 10 /13/2005

ID NUMBER:

CONTACT YEAR:

LAST NAME:

INITIALS:

INSTRUCTIONS: This form is completed during the participant's clinic visit in several stages by appropriately trained persons at the workstations identified for this purpose. If the paper form is used for data collection, data are keyed into the data entry system as soon as possible following its completion. ID Number, Contact Year, and Name are entered above. Whenever numerical responses are required, enter the number so that the last digit appears in the rightmost box. Enter leading zeros where necessary to fill all boxes. If a number is entered incorrectly on a paper form, mark through the correct entry with an "X". Code the correct entry clearly above the incorrect entry. For "multiple choice" and "yes/no" type questions, circle the letter corresponding to the most appropriate response. If a letter is circled incorrectly, mark through it with an "X" and circle the correct response.

At the reception station, verify that the medication bag is clearly identified with the participant's name and ID number. Do not open the medication bag or transcribe medications until the participant has signed the informed consent. The transcription section of Section B is completed while the participant proceeds with the visit. Medications are coded by trained field center personnel after the transcription and interview portions have been completed. Code numbers of the interviewer, transcriber and coder are recorded in the appropriate locations.

A. RECEPTION

1. Have you taken any medications in the past two weeks?
This includes all prescription medications, all over-the-counter medications, all vitamins, minerals, herbs and dietary supplements?

- Yes 1
- No 2
- Don't know 7
- Refused 8
- Missing 9

Go to Item 30a

B. MEDICATION TRANSCRIPTION

Transcribe the NAME followed by the CONCENTRATION and INSTRUCTIONS FOR ADMINISTRATION of each medication in the spaces below. List all ingredients for nutritional supplements OR make a copy of label and affix to form (continue on the second line if needed). For EACH medication, ask the participant if the medication was taken in the last 24 hours and to provide the reason they take the medication.

	<u>A MEDICATION NAME</u>		<u>B CONCENTRATION</u>	<u>C INSTRUCTIONS FOR ADMINISTRATION</u>		<u>D -DID YOU TAKE THIS MEDICATION IN PAST 24 HOURS? </u>		<u>E -WHAT IS THE REASON YOU TAKE THIS MEDICATION? </u>
	ENTER NAME EXACTLY AS PRINTED ON LABEL.. ENTER -888 ... IF LABEL UNCLEAR...INCLUDE YOUR BEST EFFORT AT TRANSCRIBING. ENTER -999' IF MEDICATION CANNOT BE TRANSCRIBED AND NOTE REASON IN NOTES.					YES - 1, NO - 2 DON'T KNOW - 7 REFUSED - 8 MISSING - 9		SPECIFY REASON DON'T KNOW - 7 REFUSED - 8 MISSING - 9
INITIAL VISIT - 1 OR FOLLOW-UP - 2								
4 (1)						1 2 7 8 9		1 2 7 8 9
5 (2)						1 2 7 8 9		1 2 7 8 9
6 (3)						1 2 7 8 9		1 2 7 8 9
7 (4)						1 2 7 8 9		1 2 7 8 9
8 (5)						1 2 7 8 9		1 2 7 8 9
9 (6)						1 2 7 8 9		1 2 7 8 9
10 (7)						1 2 7 8 9		1 2 7 8 9
11 (8)						1 2 7 8 9		1 2 7 8 9
12 (9)						1 2 7 8 9		1 2 7 8 9

A MEDICATION NAME

ENTER NAME EXACTLY AS PRINTED ON LABEL..
 ENTER -888| IF LABEL UNCLEAR...INCLUDE YOUR BEST EFFORT AT TRANSCRIBING.
 ENTER -999' IF MEDICATION CANNOT BE TRANSCRIBED AND NOTE REASON IN NOTES.

INITIAL VISIT - 1
 OR
 FOLLOW-UP - 2

B CONCERN

C INSTRUCTIONS FOR ADMINISTRATION

D -DID YOU TAKE THIS MEDICATION IN PAST 24 HOUR S? ||

YES - 1, NO - 2
 DON'T KNOW - 7
 REFUSED - 8
 MISSING - 9

E -WHAT IS THE REASON YOU TAKE THIS MEDICATION? ||

SPECIFY REASON
 DON'T KNOW - 7
 REFUSED - 8
 MISSING - 9

13 (10)				1	2	7	8	9	1	2	7	8	9
14 (11)				1	2	7	8	9	1	2	7	8	9
15 (12)				1	2	7	8	9	1	2	7	8	9
16 (13)				1	2	7	8	9	1	2	7	8	9
17 (14)				1	2	7	8	9	1	2	7	8	9
18 (15)				1	2	7	8	9	1	2	7	8	9
19 (16)				1	2	7	8	9	1	2	7	8	9
20 (17)				1	2	7	8	9	1	2	7	8	9
21 (18)				1	2	7	8	9	1	2	7	8	9
22 (19)				1	2	7	8	9	1	2	7	8	9
23.(20)				1	2	7	8	9	1	2	7	8	9
24 (21)				1	2	7	8	9	1	2	7	8	9
25 (22)				1	2	7	8	9	1	2	7	8	9
26 (23)				1	2	7	8	9	1	2	7	8	9

27a. Is the transcription being done at the initial visit or a follow-up contact? Initial 1
 IF INITIAL, PROCEED TO QUESTION 27b, IF A FOLLOW-UP, SKIP TO 27g
 Follow-Up 2

27b. Total number of medications in participant medication bag:

27c. Is additional follow-up needed?Yes 1
 IF NO, THE SKIP TO 27f

Go to 28a	No	2
	Don't Know	7
	Refused	8
	Missing	9

27d. Reason for follow-up:

27e. Method of follow-up up:

Code numbers for persons transcribing and coding medications:

27f. Code number of medication transcriber at the visit:

ASK THESE ITEMS FOR FOLLOW-UP ONLY

Go to Item 29a

27g. Participant has provided information on:All medications taken in the past 2 weeks

		/			/				
--	--	---	--	--	---	--	--	--	--

28b. Date of medication coding:..... m m d d y y y y

C. INTERVIEW

"Now I know these next questions may seem repetitive, but it is important that we make sure we know the reasons that you are taking various medications. Please bear with me."

Were any of the medications you took during the past two weeks for:

[IF YES, VERIFY THAT MEDICATION NAME IS ON MEDICATION RECORD.]

	<u>Yes</u> 1	<u>No</u> 2	<u>Don't Know</u> 7	<u>Refused</u> 8	<u>Missing</u> 9
29a. High blood pressure?	1	2	7	8	9
29b. High blood cholesterol?	1	2	7	8	9
29c. Angina or chest pain?	1	2	7	8	9
29d. Control of heart rhythm?	1	2	7	8	9
29e. Heart failure or fluid on the lungs.....	1	2	7	8	9
29f. Blood thinning?	1	2	7	8	9
29g. Diabetes or high blood sugar?	1	2	7	8	9
29h. Stroke?	1	2	7	8	9
29i. Leg pain when walking?	1	2	7	8	9

D. MEDICATION-TAKING BEHAVIORS

–There are many things that keep people from taking medicines exactly as prescribed. I am going to read a list of typical reasons people have for not taking prescribed medicines. For each reason I list, please tell me if you have not taken a prescribed medicine for this reason.||

<u>Reason Indicated</u>	<u>Not a Reason</u>	<u>Don't Know</u>	<u>Refused</u>	<u>Missing</u>
-------------------------	---------------------	-------------------	----------------	----------------

- 30a. You were in a hurry, too busy, or forgot.....1 2 7 8 9
- 30b. It was inconvenient, for example, the medication
needed to be refrigerated, or had to be taken
with food 1 2 7 8 9
- 30c. You thought the medication wouldn't do you any
good.....1 2 7 8 9
- 30d. The medication made you feel bad.....1 2 7 8 9
- 30e. If you took the medication, you wouldn't be able
to carry out your normal activities—for example,
driving.....1 2 7 8 9
- 30f. You thought you might become addicted or hooked
on the medication.....1 2 7 8 9
- 30g. You don't like to take medicine..... 1 2 7 8 9
- 30h. You were trying to do without it..... 1 2 7 8 9
- 30i. You did not have money to purchase the
medication (or its refills) 1 2 7 8 9
- 30j. Did not have the medication available.....1 2 7 8 9
- 30k. Are there any other reasons why you haven't
taken a prescribed medication?1 2 7 8 9



Go to Item 31

30l. If yes, specify reason:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

E. ASPIRIN AND NSAID USE

31. During the past two weeks, did you take any aspirin, Alka-Seltzer, cold medicine or headache powder?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

Go to Item 34a

"Next I would like to ask you about your regular use of aspirin alone or an aspirin-containing medication, for example, aspirin+caffeine+codeine. By regular, I mean at least once a week for several months."

32. Are you NOW taking aspirin, or a medicine containing aspirin, on a regular basis? This does not include Tylenol nor Advil.....	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

Go to Item 34a

33a. What is the strength of aspirin in the pill? [CHECK THE PREPARATION, IF AVAILABLE; OTHERWISE SHOW RC #1]	Less than 300 mg (Baby)	1
	300 - 499 mg (Regular)	2
	500 mg or greater (Extra strength)	3
	Don't know	7

Refused	8
Missing	9

33b. How many days a week, on average, are you taking this medication? Days

33c. How many pills are you taking per week, on average? Pills

33d. For what purpose are you taking this medication? Participant mentioned to avoid heart attack or stroke 1
 Participant did NOT mention to avoid heart or attack or stroke 2

33e. When did you start taking aspirin, or a medicine containing aspirin, on a regular basis? /
 m m y y y y

34a. Except for aspirin or Tylenol, are you NOW taking other non-steroidal anti-inflammatory drugs or arthritis medicines on a regular basis? Examples include Ibuprofen, Advil, Nuprin, Motrin, Aleve, Naprosyn, Feldene and Clinoril.....Yes 1

Go to Item 35a	No	2
	Don't know	7
	Refused	8
	Missing	9

34b. What is the brand name of the medicine? [CHECK THE PREPARATION, IF AVAILABLE] Ibuprofen or Advil 1 — Go to Item 34d
 Other 2
 Don't Know 7
 Refused 8

Missing

9

34c. If "Other", specify:

34d. How many pills per week are you taking, on average?

--	--

Pills

34e. When did you start taking [INSERT NAME] on a regular basis?.....

		/				
m	m		y	y	y	y

F. FOLK MEDICINE

–Other than medicines prescribed by your doctor or health professional, what other home remedies, teas, roots or herbs have you used in the last 2 weeks for medical reasons only: Have you used...||

35a. Vinegar?

..... Yes	1
Go to Item 36a — No	2
— Don't Know	7
— Refused	8
— Missing	9

35b. How many days during the past 2 weeks?

--	--

Days

35c. For what purpose?

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Missing 9

41b. How many days during the past 2 weeks?

Days

41c. For what purpose?

41d. Specify type:

42a. Have you ever used any other home remedies, teas, roots, herbs or other medicines?

Yes 1

Go to Item 43

No 2

Don't Know 7

Refused 8

Missing 9

42b. Was this for your heart or for other symptoms?

Heart 1

Other 2

Don't Know 7

Refused 8

Go to Item 42d

Missing 9

42c. For what other symptoms?

Grid of 24 empty boxes for recording symptoms.

42d. About how often would you say you have used any of these remedies? Would you say daily, weekly, several times a month, monthly, several times a year, yearly, rarely, almost never, or never? [SHOW RC #2]

- Daily 1
Weekly 2
Several times a month 3
Monthly 4
Several times a year 5
Yearly 6
Rarely 7
Almost never 8
Never 9
Don't Know 77
Refused 88
Missing 99

G. ADMINISTRATIVE INFORMATION

43. Date of data collection: Grid for month, day, and year with labels m, m, /, d, d, /, y, y, y, y.

- 44. Method of data collection: Computer 1
Paper form 2
- 45. Place of data collection In Clinic 1
Off site 2

46. Code number of Interviewer:

--	--	--

2. Have you ever been told by a health care provider that you had a:

	<u>Yes</u>	<u>No</u>	<u>Don't Know</u>	<u>Refused</u>	<u>Missing</u>
2a. Kidney stone?	1	2	7	8	9
2b. Frequent bladder or urinary tract infections?	1	2	7	8	9
2c. Anemia (low blood count)?	1	2	7	8	9
2d. Autoimmune disease, such as lupus?	1	2	7	8	9
2e. Polycystic kidney diseases?.....	1	2	7	8	9
2f. Venereal disease (Chlamydia, syphilis, or gonorrhea)?	1	2	7	8	9
2g. Kidney damage due to dehydration?.....	1	2	7	8	9
2h. Protein in your urine?	1	2	7	8	9
2i. Blood in your urine?	1	2	7	8	9
2j. Temporary or acute renal failure or damage?	1	2	7	8	9
2k. Chronic or ongoing renal insufficiency or damage (e.g. not requiring dialysis)?	1	2	7	8	9

3. Are you now, or have you ever been on kidney dialysis or a kidney machine

Yes	1
No	2
Don't Know	7
Refused	8
Missing	9

4. Were you or have you ever been on kidney dialysis for more than one month? Yes 1
-
- No 2
 Don't Know 7
 Refused 8
 Missing 9
- 4a. In total, how many years and months were you on/have been on dialysis? [IF MORE THAN 6 MONTHS, RECORD AS ENTIRE YEAR. IF LESS THAN 6 MONTHS, ENTER LOWER VALUE] Years
- Don't Know 77
 Refused 88
 Missing 99
5. Have you ever been evaluated to receive a kidney transplant?..... Yes 1
- No 2
 Don't Know 7
 Refused 8
 Missing 9
6. Since your last JHS exam, that is in [date], have you been told that you have kidney disease? Yes 1
- No 2
 Don't Know 7
 Refused 8
 Missing 9

ADMINISTRATIVE INFORMATION

7. Date of data collection: / /

m m d d y y y y

8. Method of data collection:..... Computer 1
Paper form 2

9. Data collected: In Clinic 1
Off site 2

10. Code number of person completing this form:

--	--	--



Sitting Blood Pressure Form

FORM CODE: SBP
VERSION B 08/13/2005

ID NUMBER:

CONTACT YEAR:

LAST NAME:

INITIALS:

INSTRUCTIONS: This form should be completed during the participant's visit. ID Number, Contact Year, and Name must be entered above. Whenever numerical responses are required, enter the number so that the last digit appears in the rightmost box. Enter leading zeroes where necessary to fill all boxes. If a number is entered incorrectly, mark through the incorrect entry with an "X". Code the correct entry clearly above the incorrect entry. For "multiple choice" and "yes/no" type questions, circle the letter corresponding to the most appropriate response. If a letter is circled incorrectly, mark through it with an "X" and circle the correct response.

A. TEMPERATURE

1. Room Temperature (degrees centigrade):.....

B. TOBACCO AND CAFFEINE USE, PHYSICAL ACTIVITY, AND MEDICATION

2. Have you smoked or used chewing tobacco, nicotine gum or snuff today or do you wear a nicotine patch?.....Yes 1

No 2

Don't Know 7

Refused 8

Missing 9

Go to Item 4

3. How long ago did you last use chewing last used chewing tobacco or snuff?

3a. hours 3b. minutes.

4. Have you had any caffeinated beverages, such as coffee, tea, or colas, or any chocolate today?.....Yes 1

No 2

Don't Know 7

Refused 8

Missing 9

Go to Item 6

5. About what time was it when you had any caffeinated beverage (tea, cola, coffee, or chocolate)?

6. Have you participated in any intense physical activity in the past 2 hours?
- | | |
|------------|---|
| Yes | 1 |
| No | 2 |
| Don't Know | 7 |
| Refused | 8 |
| Missing | 9 |

7. Do you take any medications for high blood pressure?
- | | |
|------------|---|
| Yes | 1 |
| No | 2 |
| Don't Know | 7 |
| Refused | 8 |
| Missing | 9 |

[IF YES, ASK 7a]

- 7a. Have you taken your blood pressure medication in the past 2 hours?
- | | |
|------------|---|
| Yes | 1 |
| No | 2 |
| Don't Know | 7 |
| Refused | 8 |
| Missing | 9 |

Go to Item

C. PRELIMINARY MEASUREMENTS

8. Right Arm Circumference (cm):.....

9. Cuff Size:
 {arm circumference in brackets}.....
- | | |
|------------------------|---|
| Small adult {<24 cm} | 1 |
| Regular Arm {24-32 cm} | 2 |
| Large Arm {33-41 cm} | 3 |
| Thigh {>41 cm} | 4 |

10. Heart Rate (30 seconds):.....

11a. Time of Day:

h	h	m	m

[IF PARTICIPANT IS INCLUDED IN BLOOD PRESSURE COMPARABILITY STUDY, OBTAIN BLOOD PRESSURE USING BOTH RANDOM ZERO AND OMRON MEASUREMENTS.]

12. The participants' blood pressure was determined by :

Random Zero Only 1

Omron Only 2

Both 3

D. RANDOM ZERO CALIBRATION

13. Pulse Obliteration Pressure:.....

14. Maximum Zero:.....

+ 30

15. Peak Inflation Level
{Computation--Item #10
+ Item #11 + 30}:.....

E. FIRST RANDOM ZERO BLOOD PRESSURE MEASUREMENT

16. Systolic:.....

17. Diastolic:.....

68. Zero Reading:.....

F. SECOND RANDOM ZERO BLOOD PRESSURE MEASUREMENT

19. Systolic:.....

20. Diastolic:.....

21. Zero Reading:.....

G. COMPUTED NET AVERAGE OF FIRST AND SECOND RANDOM ZERO BLOOD PRESSURE MEASUREMENTS
(See Worksheet)

22. Systolic:.....

23. Diastolic:.....

--	--	--

H. OMRON CALIBRATION:

24. P – Set Level:..... |

I. FIRST OMRON BLOOD PRESSURE MEASUREMENT

25. Systolic:..... mm/hg
|

J. SECOND OMRON BLOOD PRESSURE MEASUREMENT

27. Systolic mm/hg
|

K. COMPUTED NET AVERAGE OF FIRST AND SECOND OMRON BLOOD PRESSURE MEASUREMENTS

29. Systolic

--	--	--

 mm/hg

30. Diastolic.....

--	--	--

 mm/hg

L. ADMINISTRATIVE INFORMATION

31. Date of data collection:.....

		/			/				
m	m		d	d		y	y	y	y

32. Method of Data Collection: Computer 1
Paper Form 2

33. Data Collected: In Clinic 1
Off Site 2

34. Code number of random zero technician.....

--	--	--

--	--	--

35. Code number of Omron technician:

Don't know	7	Go to Item 5
Refused	8	
Missing	9	

4b. Follow up SMBP call scheduled for: /

m m d d m m m m

4c. Time of day:

Early morning	1
Late morning	2
Early afternoon	3
Late afternoon	4

5. Did the participant successfully complete a SMBP measurement? Yes 1

No 2

Don't know 7

Refused 8

Missing 9

6. Date SMBP Dispensed: /

m m d d m m m m

7. SMBP Serial Number:

B. SMBP PRELIMINARY

8. Arm [RIGHT ARM PREFERRED]: Left 1

Right 2

Don't know 7

Refused 8

Missing 9

9. Is right arm used? Yes 1 Go to Item 11

No 2

Don't Know	7
Refused	8
Missing	9

10a. Unable to use right arm: Dialysis graft 1

Mastectomy on nondominant side 2

Infection 3

Other (specify) 4

Don't know 7

Refused 8

Missing 9

10b. Specify:

11. Is SMBP being done?..... Yes 1

No 2

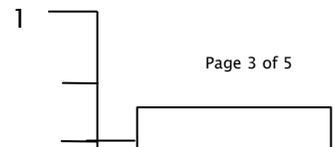
Don't know 7

Refused 8

Missing 9

Go to Item 13

12a. Unable to use SMBP: Exceeded maximum cuff size 1



Other (Specify)	2
Don't know	7
Refusal (specify)	8
Missing	9

12b. Specify:

C. SMBP MEASUREMENT (BY PARTICIPANT)

13. First SMBP

13a. Systolic:

--	--	--

 mm Hg

13b. Diastolic:

--	--	--

 mm Hg

14. Second SMBP

14a. Systolic:

--	--	--

 mm Hg

14b. Diastolic:

--	--	--

 mm Hg

15. Average of First and Second SMBP

15a. Systolic:

--	--	--

 mm Hg

15b. Diastolic

--	--	--

 mm Hg

16. Time of SMBP Measurement.....

h	h	m	m

ADMINISTRATIVE INFORMATION

		/			/				
m	m		d	d		m	m	m	m

17. Date of data collection

18. Method of data collection: Computer 1
Paper form 2

19. Data collected: In clinic 1
Off site 2

20. Code number of person completing this form: |

4. Did the episode come on suddenly?.....	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

5. Do any of the following describe your change in speech?
[READ ALL CHOICES]

	<u>Yes</u>	<u>No</u>	<u>D on 't Kn</u> <u>ow</u>	<u>Refused</u>	<u>Missing</u>
5a. Slurred speech like you were drunk?	1	2	7	8	9
5b. Could talk but the wrong words came out?	1	2	7	8	9
5c. Know what you wanted to say, but the words would not come out?	1	2	7	8	9
5d. Could not think of the right words?	1	2	7	8	9
5e. [IF MORE THAN ONE OF ITEMS A–D INDICATED, ASK “WHICH OF THESE MOST CLOSELY DESCRIBES THE PROBLEMS?”].....					
			Slurred speech		1
			Wrong words came out		2
			Words would not come out		3
			Could not think of the right		4

6. While you were having your episode of change in speech,
did any of the following occur? [INCLUDE ALL THAT APPLY]

6a. Numbness or tingling?	Yes	1
	<div style="border: 1px solid black; display: inline-block; padding: 2px;">Go to Item 6c</div> — No	2
	Don't know	7
	Refused	8
	Missing	9

6b. Did you have difficulty on:	The right side only	1
[READ ALL CHOICES]		
	The left side only	2
	Both sides	3
	Don't know	7
	Refused	8
	Missing	9

6c. Paralysis or weakness?	Yes	1
	<input type="checkbox"/> No	2
	Don't know	7
	Refused	8
	Missing	9

6d. Did you have difficulty on:	The right side only	1
[READ ALL CHOICES]		
	The left side only	2
	Both sides	3
	Don't know	7
	Refused	8
	Missing	9

6e. Lightheadedness, dizziness, or loss of balance?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

6f. Blackouts or fainting?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9
6g. Seizures or convulsions?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9
6h. Headache?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9
6i. Visual disturbances?	Yes	1
	<input type="checkbox"/> No	2
	Don't know	7
	Refused	8
	Missing	9

Go to Item 7

6j. Did you have: [READ ALL CHOICES UNTIL A POSITIVE RESPONSE IS GIVEN]

Double vision	01
Vision loss in right eye only	02
Vision loss in left eye only	03
Total loss of vision in both eyes	04
Trouble in both eyes seeing to the right	05
Trouble in both eyes seeing to the left	06
Trouble in both eyes seeing to both sides or straight ahead	07
Don't know	77
Refused	88
Missing	99

C. SUDDEN LOSS OF VISION

7. In the past 5 years, since your last Jackson Heart Study exam, have you had any sudden loss of vision, or blurring, lasting 24 hours or longer? Yes 1

Go to Item 11a	{	No	2
		Don't know	7
	Refused	8	
	Missing	9	

8. Did the episode come on suddenly?..... Yes 1

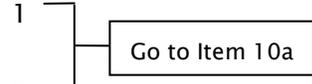
No 2

Don't know 7

Refused	8
Missing	9

9a. During the episode, which of the following parts of your vision were affected?
 [READ ALL CHOICES]

Only the right eye	1
Only the left eye	2
Both eyes	3
Don't know	7
Refused	8
Missing	9



9b. Did you have:
 [READ ALL CHOICES UNTIL A POSITIVE RESPONSE IS GIVEN]

Trouble seeing to the right, but not the left	1
Trouble seeing to the left, but not the right	2
Trouble seeing both sides or straight ahead	3
Don't know	7
Refused	8
Missing	9

10. While you were having your loss of vision, did any of the following occur? [INCLUDE ALL THAT APPLY]

10a. Speech disturbance?	Yes	Y
	No	N
	Don't know	7
	Refused	8
	Missing	9

10b. Numbness or tingling?	Yes	1
	<input type="checkbox"/> No	2
	Don't know	7
	Refused	8
	Missing	9

10c. Did you have difficulty on:	The right side only	1
[READ ALL CHOICES]		
	The left side only	2
	Both sides	3
	Don't know	7
	Refused	8
	Missing	9

10d. Paralysis or weakness?	Yes	1
	<input type="checkbox"/> No	2
	Don't know	7
	Refused	8
	Missing	9

10e. Did you have difficulty on:	The right side only	1
[READ ALL CHOICES]		
	The left side only	2
	Both sides	3
	Don't know	7

	Refused	8
	Missing	9
10f. Lightheadedness, dizziness, or loss of balance?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9
10g. Blackouts or fainting?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9
10h. Seizures or convulsions?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9
10i. Headache?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

10j. Flashing lights?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

D. DOUBLE VISION

11a. In the past 5 years, since your last Jackson Heart Study visit, have you had a sudden spell of double vision, which lasted 24 hours or longer?	Yes	1
---	-----	---

Go to Item 14	No	2
	Don't know	7
	Refused	8
	Missing	9

11b. If you closed one eye, did the double vision go away?	Yes	1
---	-----	---

Go to Item 14	No	2
	Don't know	7
	Refused	8
	Missing	9

12. Did the episode come on suddenly?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

13. While you were having your double vision did any of the following occur? [INCLUDE ALL THAT APPLY]

13a. Speech disturbance? Yes 1
No 2
Don't know 7
Refused 8
Missing 9

13b. Numbness or tingling? Yes 1
 Go to Item 13d — No 2
Don't know 7
Refused 8
Missing 9

13c. Did you have difficulty on: The right side only 1
[READ ALL CHOICES]
The left side only 2
Both sides 3
Don't know 7
Refused 8
Missing 9

13d. Paralysis or weakness? Yes 1
 Go to Item — No 2
Don't know 7
Refused 8
Missing 9

13e. Did you have difficulty on.....	The right side only	1
[READ ALL CHOICES]		
	The left side only	2
	Both sides	3
	Don't know	7
	Refused	8
	Missing	9

13f. Lightheadedness, dizziness, or loss of balance?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

13g. Blackouts or fainting?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

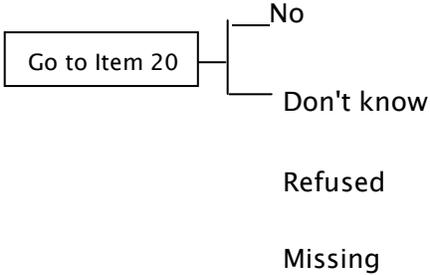
13h. Seizures or convulsions?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

13i. Headache?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

E. SUDDEN NUMBNESS OR TINGLING

14. In the past 5 years, since your last Jackson Heart Study exam, have you ever had sudden numbness, tingling, or loss of feeling on one side of your body, including your face, arm, or leg which lasted 24 hours or longer?

	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9



15. Did the feeling of numbness or tingling occur only when you kept your arms or legs in a certain position?

	Yes	1	<input type="text" value="Go to Item 20"/>
	No	2	
	Don't know	7	
	Refused	8	
	Missing	9	

16. Did the episode come on suddenly?

	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

17. During the episode of sudden numbness or tingling, which part or parts of your body were affected?
 [READ ALL CHOICES]

	<u>Yes</u>	<u>No</u>	<u>Don't Know</u>	<u>Refused</u>	Missing
17a. Left arm or hand?	1	2	7	8	9
17b. Left leg or foot?	1	2	7	8	9
17c. Left side of face?	1	2	7	8	9
17d. Right arm or hand?.....	1	2	7	8	9
17e. Right leg or foot?	1	2	7	8	9
17f. Right side of face?.....	1	2	7	8	9
17g. Other?	1	2	7	8	9

18. During this episode, did the abnormal sensation start in one part of your body and spread to another, or did it stay in the same place?

Started in one part and spread to another	1
Stayed in one part	2
Don't know	7
Refused	8
Missing	9

19. While you were having your episode of numbness, tingling or loss of sensation, did any of the following occur?
 [INCLUDE ALL THAT APPLY]

19a. Speech disturbance?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

19b. Paralysis or weakness?	Yes	1
	<input type="checkbox"/> No	2
	Don't know	7
	Refused	8
	Missing	9

Go to Item 19d

19c. Did you have difficulty on:	The right side only	1
[READ ALL CHOICES]		
	The left side only	2
	Both sides	3
	Don't know	7
	Refused	8
	Missing	9

19d. Lightheadedness, dizziness, or loss of balance?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

19e. Blackouts or fainting?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

19f. Seizures or convulsions?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9
19g. Headache?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9
19h. Pain in the numb or tingling arm, leg or face?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9
19i. Visual disturbances?	Yes	1
	<input type="checkbox"/> No	2
	Don't know	7
	Refused	8
	Missing	9

Go to Item 20

19j. Did you have: [READ ALL CHOICES UNTIL A POSITIVE RESPONSE IS GIVEN]

Double vision	01
Vision loss in right eye only	02
Vision loss in left eye only	03
Total loss of vision in both eyes	04
Trouble in both eyes seeing to the right	05
Trouble in both eyes seeing to the left	06
Trouble in both eyes seeing to both sides or straight ahead	07
Don't know	77
Refused	88
Missing	99

F. SUDDEN PARALYSIS OR WEAKNESS

20. In the past 5 years, since your last Jackson Heart Study exam, have you had any sudden episode of paralysis or weakness on one side of your body, including your face, arm, or leg which lasted at least 24 hours?

Yes	1
No	2
Don't know	7
Refused	8
Missing	9

Go to Item 25

21. Did the episode come on suddenly? Yes 1

No 2

Don't know	7
Refused	8
Missing	9

22. During this episode, which part or parts of your body were affected? [READ ALL CHOICES]

	<u>Yes</u>	<u>No</u>	<u>Don't Know</u>	<u>Refused</u>	<u>Missing</u>
22a. Left arm or hand?	1	2	7	8	9
22b. Left leg or foot?	1	2	7	8	9
22c. Left side of face?	1	2	7	8	9
22d. Right arm or hand?	1	2	7	8	9
22e. Right leg or foot?	1	2	7	8	9
22f. Right side of face?	1	2	7	8	9
22g. Other?.....	1	2	7	8	9

23. During this episode, did the paralysis or weakness start in one part of your body and spread to another, or did it stay in the same place?

Started in one part and spread to another	1
Stayed in one part	2
Don't know	7
Refused	8
Missing	9

24. While you were having your episode of paralysis or weakness, did any of the following occur? [INCLUDE ALL THAT APPLY]

24a. Speech disturbances?	Yes	1
	No	2

Don't know 7

Refused 8

Missing 9

24b. Numbness or tingling? Yes 1

Go to Item 24d — No 2

Don't know 7

Refused 8

Missing 9

24c. Did you have difficulty on: The right side only 1
[READ ALL CHOICES]

The left side only 2

Both sides 3

Don't know 7

Refused 8

Missing 9

24d. Lightheadedness, dizziness, or loss of
balance?..... Yes 1

No 2

Don't know 7

Refused 8

Missing 9

24e. Blackouts or fainting? Yes 1

No 2

	Don't know	7
	Refused	8
	Missing	9
24f. Seizures or convulsions?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9
24g. Headache?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9
24h. Pain in the weak arm, leg or face?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9
24i. Visual disturbances?	Yes	1
	<input type="button" value="Go to Item 25"/> No	2
	Don't know	7
	Refused	8

	Missing	9
24j. Did you have: [READ ALL CHOICES UNTIL A POSITIVE RESPONSE IS GIVEN]		
	Double vision	01
	Vision loss in right eye only	02
	Vision loss in left eye only	03
	Total loss of vision in both eyes	04
	Trouble in both eyes seeing to the right	05
	Trouble in both eyes seeing to the left	06
	Trouble in both eyes seeing to both sides or straight ahead	07
	Don't know	77
	Refused	88
	Missing	99

G. SUDDEN SPELLS OF DIZZINESS OR LOSS OF BALANCE

25. In the past 5 years, since your last Jackson Heart Study exam, have you had any sudden spells of dizziness, loss of balance, or sensation of spinning which lasted 24 hours or longer?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

Go to Item 29

- No
- Don't know
- Refused
- Missing

26. Did the dizziness, loss of balance or spinning sensation occur only when changing the position of your head or body?

Yes	1	<input type="checkbox"/> Go to Item 29
No	2	
Don't know	7	
Refused	8	
Missing	9	

27. While you were having your episode of dizziness, loss of balance or spinning sensation, did any of the following occur? [INCLUDE ALL THAT APPLY]

27a. Speech disturbances?

Yes	1
No	2
Don't know	7
Refused	8
Missing	9

27b. Paralysis or weakness?

Yes	1	
<input type="checkbox"/> Go to Item 27d	No	2
	Don't know	7
	Refused	8
	Missing	9

27c. Did you have difficulty on: [READ ALL CHOICES]

The right side only	1
The left side only	2
Both sides	3
Don't know	7

	Refused	8
	Missing	9
27d. Numbness or tingling?	Yes	1
	Go to Item 27f — No	2
	Don't know	7
	Refused	8
	Missing	9
27e. Did you have difficulty on:	The right side only	1
[READ ALL CHOICES]	The left side only	2
	Both sides	3
	Don't know	7
	Refused	8
	Missing	9
27f. Blackouts or fainting?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9
27g. Seizures or convulsions?	Yes	1
	No	2
	Don't know	7
	Refused	8

	Missing	9
27h. Headache?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

27i. Visual disturbances?	Yes	1
	<input type="checkbox"/> No	2
	Don't know	7
	Refused	8
	Missing	9

27j. Did you have:		
	[READ ALL CHOICES UNTIL A POSITIVE RESPONSE IS GIVEN]	
	Double vision	01
	Vision loss in right eye only	02
	Vision loss in left eye only	03
	Total loss of vision in both eyes	04
	Trouble in both eyes seeing to the right	05
	Trouble in both eyes seeing to the left	06
	Trouble in both eyes seeing to both sides or straight ahead	07
	Don't know	77

Go to Item 28

Refused	88
Missing	99

28. Did the episode of dizziness, loss of balance, or spinning sensation come on suddenly?	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

H. ADMINISTRATIVE INFORMATION

29. Date of data collection:

		/			/				
m	m		d	d		y	y	y	y

30. Method of data collection:	Computer	1
	Paper form	2

31. Data Collected:	In clinic	1
	Off site	2

32. Code number of person completing this interview: