EXAM 6 [_____] ID type/ID [_____]Last Name, First Name

_____ _____

Date Patient Name

_____ _____

Personal Physician Patient Address

_____

Framingham Heart Study
Offspring Exam 6

Summary Sheet to Personal Physician

Blood Pressure	First Reading	Second Reading
Systolic		
Diastolic		

ECG Diagnosis _____

_____

The following tests are done on a routine basis: Echocardiogram; Blood Glucose; Methionine load and homocystine levels, Blood Lipids; Carotid Doppler. Only abnormal findings will be forwarded at a later date

Summary of Findings_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Examining Physician
Framingham Heart Study
National Heart, Lung, and Blood Institute
National Institutes of Health
5 Thurber Street
Framingham, MA 01701

EXAM 6 [_____] ID type/ID [_____]Last Name, First Name

|6|0|1|0|1 FORM NUMBER **RESPIRATORY QUESTIONNAIRE** Date ___/___/___

This questionnaire asks about symptoms which may relate to allergy, asthma, or other lung disease. Your answers to these questions will help us to interpret the results of your lung function tests. Together with other tests performed as part of the Framingham Study, this questionnaire will provide important information about the aging process and the development of lung disease.

TO ANSWER THE QUESTIONS, PLEASE CIRCLE THE APPROPRIATE ANSWER;
IF YOU ARE UNSURE OF THE ANSWER, PLEASE CHOOSE "NO"

	Wheeze and Tightness in the Chest	Coding Use
1	Have you had wheezing or whistling in your chest at any time in the last 12 months? **NO YES**	0 1 9
2	Have you awakened with a feeling of tightness in your chest first thing in the morning at any time in the last 12 months? **NO YES**	0 1 9

	Shortness of Breath	Coding Use
3	Have you, at any time in the last 12 months, had an attack of shortness of breath that came on during the day when you were not doing anything strenuous? **NO YES**	0 1 9
4	Have you had an attack of shortness of breath that came on after you stopped exercising at any time in the last 12 months? **NO YES**	0 1 9
5	Have you, at any time in the last 12 months, been awakened at night by an attack of shortness of breath? **NO YES**	0 1 9

	Cough and Phlegm from the Chest	Coding Use
6	Have you, at any time in the last 12 months, been awakened at night by an attack of coughing? **NO YES**	0 1 9
7	Do you usually cough first thing in the morning? **NO YES**	0 1 9
8	Do you usually bring up phlegm from your chest first thing in the morning? **NO YES**	0 1 9
9	Have you brought up phlegm from your chest like this on most mornings for at least 3 months a year? **NO YES**	0 1 9

	Breathing		Coding Use
10	Which of the following statements best describes your breathing?	**Circle one A, B, OR C**	0 1 2 3 9
a	I never or only rarely get trouble with my breathing	A	
b	I get repeated trouble with my breathing, but it always gets completely better.	B	
c	My breathing is never quite right.	C	

EXAM 6 [_____] ID type/ID [_____]Last Name, First Name

|6|0|1|0|2 FORM NUMBER

Animals, Dust, Feathers		Coding Use
When you are in a dusty part of the house or with animals (for instance, dogs, cats, or horses) or near feathers (including pillows, quilts, and down) do you ever:		
11	Get a feeling of tightness in your chest? **NO YES**	0 1 9
12	Start to feel short of breath? **NO YES**	0 1 9

Asthma		Coding Use
13	Have you ever had asthma? **NO YES**	0 1 9
14	Have you had an attack of asthma at any time in the last 12 months? **NO YES**	0 1 9
15	Are you currently taking any medicines (including inhalers, aerosols,or tablets) for asthma? **NO YES**	0 1 9

Smoking		Coding Use
16	Do you now smoke cigars or pipes? **NO YES**	0 1 9
17	Do you now smoke cigarettes (i.e. within the last week)? **NO YES**	0 1 9
18	Have you ever smoked cigarettes for as long as a year? **NO YES** (if yes answer 18 a,b,&c)	0 1 9
18a	How many years have you smoked / did you smoke? _____	|__|__|
18b	How many cigarettes do/did you smoke a day?_____	|__|__|__|
18c	If you no longer smoke, when did you Quit? **Less than 4 Weeks Ago More than 4 Weeks Ago**	0 1 2 9

Steroid Medications		Coding Use
	Steroid medications are commonly prescribed for lung diseases such as asthma. They are also prescribed for a variety of other conditions including psoriasis and other skin conditions, and some types of arthritis and bowel disease. These medications can be taken by mouth, by inhalation, or applied to the skin, or may be given as injections. (Some commonly used steroid medications are listed below.)	
19	Are you currently taking any steroid medications? **NO YES**	0 1 9
20	If yes, by what route (check as many as apply) ORAL INJECTED INHALED NASAL SKIN	0 1 2 3 4 5 9

Cortone	Aerobid	Beconase	Aristocort
Decadron	Azmacort	Nasacort	Diprolene
Deltasone	Beclovent	Nasalide	Hydrocortisone
Hydrocortisone	Vanceril	Vancenase	Hytone
Medrol			Kenalog
Prednisone			Lidex
Westcort			Synalar

EXAM 6 [_____] ID type/ID [_____]Last Name, First Name

Cancer Screening Information

|6|0|1|0|3 FORM NUMBER Rev 4/2/96

Women Only

Yes No Unsure Unknown Man circle, and if yes, fill to right

Have you ever had a mammogram?

19 |__|__| Year of last mammogram? (00=not done, 99=Unknown)

|__| How many mammograms have you had in the past five years? (0=None, 1-5 for number, 6=6+, 9=Unknown)

Yes No Unsure Unknown Man circle, and if yes, fill to right

A clinical breast exam is when a doctor, nurse, or other health professional feels the breast for lumps. Have you ever had a clinical breast exam?

19 |__|__| Year of last breast exam? (00=not done, 99=Unknown)

|__| How many breast exams have you had in the past five years? (0=None, 1-5 for number, 6=6+, 9=Unknown)

Yes No Unsure Unknown Man circle, and if yes, fill to right

A Pap smear is a test for cancer of the cervix. Have you ever had a Pap smear?

19 |__|__| Year of last Pap smear? (00=not done, 99=Unknown)

|__| How many Pap smears have you had in the past five years? (0=None, 1-5 for number, 6=6+, 9=Unknown)

Men Only

Yes No Unsure Unknown Woman circle, and if yes, fill to right

Have your ever had a blood test for prostate cancer? (Prostate specific antigen)

19 |__|__| Year when blood test for prostate cancer last done? (00=not done, 99=Unknown)

|__| How many times was a blood test for prostate cancer done during the past five years? (0=None, 1-5 for number, 6=6+, 9=Unknown

Men and Women

Yes No Unsure Unknown circle, and if yes, fill to right

Have you ever had a rectal exam?

19 |__|__| Year of last rectal exam? (00=not done, 99=Unknown)

|__| How many rectal exams during the past five years? (0=None, 1-5 for number, 6=6+, 9=Unknown)

Yes No Unsure Unknown circle, and if yes, fill to right

Have you ever had your stool tested for blood?

19 |__|__| Year when stool last tested for blood? (00=not done, 99=Unknown)

|__| How many times stool tested for blood during the past five years? (0=None, 1-5 for number, 6=6+, 9=Unknown)

Yes No Unsure Unknown circle, and if yes, fill to right

Have you ever had a sigmoidoscopy exam? (tube with light that looks up the rectum)

19 |__|__| Year when sigmoidoscopy last done? (00=not done, 99=Unknown)

|__| How many times was a sigmoidoscopy done during the past five years? (0=None, 1-5 for number, 6=6+, 9=Unknown)

EXAM 6 [_____] ID type/ID [_____]Last Name, First Name

Awareness of Coronary Factors

|6|0|1|0|5 FORM NUMBER

Heart Disease and Factors for Self and Family

	Father (circle best answers below)	**Mother** (circle best answers below)
Did your parents...	**Father's Name** _____	**Mother's Name** _____
Ever have high blood pressure	No Yes Unsure Unknown	No Yes Unsure Unknown
Ever have high blood cholesterol (>240 mg/dL)	No Yes Unsure Unknown	No Yes Unsure Unknown
Ever have diabetes mellitus	No Yes Unsure Unknown	No Yes Unsure Unknown
Have a heart attack before age 55	No Yes Unsure Unknown	No Yes Unsure Unknown
Have heart bypass surgery before age 55	No Yes Unsure Unknown	No Yes Unsure Unknown
Have a stroke before age 65	No Yes Unsure Unknown	No Yes Unsure Unknown
Die of heart disease	No Yes Unsure Unknown	No Yes Unsure Unknown

	Yourself (circle best answers below)	**Current or most recent Spouse** **Spouse's Name Age** ____ _____ (circle best answers below)
Did you or your spouse...		
Ever have high blood pressure	No Yes Unsure Unknown	No Yes Unsure Unknown
Ever have high blood cholesterol (>240 mg/dl)	No Yes Unsure Unknown	No Yes Unsure Unknown
Ever have diabetes mellitus	No Yes Unsure Unknown	No Yes Unsure Unknown
Have a heart attack before age 55	No Yes Unsure Unknown	No Yes Unsure Unknown
Have heart bypass surgery before age 55	No Yes Unsure Unknown	No Yes Unsure Unknown
Have a stroke before age 65	No Yes Unsure Unknown	No Yes Unsure Unknown
Die of heart disease		No Yes Unsure Unknown

EXAM 6 [_____] ID type/ID [_____]Last Name, First Name

The Relationship Between Exercise and Health

Framingham Heart Study

Version 4/2/96

This survey of Framingham Study patients is part of a longitudinal study on exercise and health. This is an opportunity to help determine the beneficial effects of exercise. Most individuals find that the questionnaire can be completed in approximately 5 minutes. Please answer the questions to the best of your ability and be as complete as possible.

If you wish to comment on any of the questions or to qualify your answers, please write in the margins. Your comments are welcome and will be taken into account.

It is very important that we have replies from as many individuals as possible. Your responses are important to us.

Please fill in the questionnaire today.

Thank you for your help.

EXAM 6 [_____] ID type/ID [_____]Last Name, First Name

Physical Activity Questionnaire--Framingham Heart Study

|6|0|1|1|0| FORM NUMBER revised 3/21/96

We would like to ask you several questions about your current exercise habits. Please answer as accurately as possible. Circle your answers or supply a specific number on the line when asked (only one answer per question).

General Questions	Coding Use Only
1. How many times per week do you engage in intense physical activity? (enough to work up a sweat)_____.	|__|__|
2. How would you compare last week's activity to your usual activity during the year? (Circle the appropriate response Less active [1] Same as usual [2] More active [3]	|__|
3. How would you compare your activity level to others your age? Less active [1] Same as usual [2] More active [3]	|__|
4. What is your occupation now?_____ (If working outside the home less than 20 hours/week put retired or homemaker. Specify part-time if only work part-time Code your occupation according to attached sheet |__|__|__| Occupation code (see attached coding sheet)	|__|__|__|

Climbing Stairs and Walking	Enter value	Coding Use Only
How many **flights of stairs** do you **climb up** each day? (Let 1 flight=10 steps, 99=Unknown)	_____	|__|__|__|
How many **city blocks (**or their equivalent) do you **walk** each day? (Let 12 blocks= 1 mile, 99=Unknown)	_____	|__|__|

EXAM 6 [_____] ID type/ID [_____]Last Name, First Name

Numerical Data--Part I

VERSION 01/19/95

|6|0|2|0|1| FORM NUMBER

Basic Information	
|__|	**Sex of Patient** (1=Male, 2=Female)
|__|__|	**Age of Patient** (years)
|__|	**Site of Exam** (0=Heart Study,1=Nursing home,2=Residence)
If 0 skip down If 1 or 2 fill ☞	|__| **Nursing Home Level of Care 0**=None; **1**=Skilled care 24hrs,Medicare **2**=Skilled care 24 hrs, Medicaid or private; **3**=Skilled care 8-16 hrs; **4**=Self care**; 9**=unknown
|__|	**Marital Status** (1=Single, 2=Married, 3=Widowed, 4=Divorced, 5=Separated)
|__|__|	**Nurse Examiner's Number** (99= unknown)
|__|__|__|	**Weight** (to nearest pound)
|__|__|*|__|__|	**Height** (inches, to next lower 1/4 inch)

Regional Anthropometry

Left	Right	(Code boxes below with 9's if not done or unknown)
|99|	|99|	**Skinfold Triceps** (millimeters)
|99|	|99|	**Skinfold Subscapular** (millimeters)
| 999 |		**Skinfold Abdomen** (millimeters)
|__|__|*|__|__|		**Neck Circumference** (inches, to next lower1/4 inch)
|__|__|*|__|__|		**Right Arm Girth--Upper Third** (inches, to next lower 1/4 inch)
|__|__|*|__|__|		**Waist Girth** (inches, to next lower 1/4 inch)
|__|__|*|__|__|		**Hip Girth** (inches, to next lower 1/4inch)
|__|__|*|__|__|		**Thigh Girth** (inches, to next lower 1/4 inch)
|__|__|		**Carbon Monoxide Level**
|__|__|*|__|		**Knee Height** (centimeters)
| __|__|		**Number of Hours Fasting** (99=Unknown)
|__|__|		**Number of Days since Last Dose of Aspirin** (00=Never, 01=Within 1 day, 98=98 days or more, 99=Unknown) typical value 01 to 07 for use in past week
|__|__|		**Hamilton Baldness Scale (01-12 from table, 88=woman, 99=Unknown)**
|__|		**Hand preferred for eating (1=right, 2=left, 9=unknown)**
|__|		**Hand preferred for writing (1=right, 2=left, 9=unknown)**

Nurse's Blood Pressure to nearest 2 mm Hg	Systolic	Diastolic	Nurse's Blood Pressure ID
	|__|__|__|	|__|__|__|	|__|__|__|

Body Comp	Resistance	Reactance	Nurse ID for Body Composition
Trial #1	|__|__|__|	|__|__|__|	|__|__|__|
Trial #2	|__|__|__|	|__|__|__|	
Trial #3	|__|__|__|	|__|__|__|	

EXAM 6 [_____] ID type/ID [_____]Last Name, First Name

Numerical Data--Part II

|6|0|2|0|2| FORM NUMBER

|__|__|	**Nurse Examiner's Number**

Urinalysis

|__| **If Yes, continue below**	**Urinalysis Specimen Obtained** (0=No, 1=Yes, 9=Unknown) If no, then skip to next section						
	Test	**Neg**	**Unk**	**Trace**	**Small**	**Moderate**	**Large**
|__|__|	**Blood**	0	99	10	1	2	3
|__|__|__|	**Ketones**	0	999	5	15	40	080-160
|__|__|	**Glucose**	0	99	10	1	2	03-04
|__|__|__|__|	**Albumin**	0	9999	10	30	100	0300-2000
|__|.|__|	**pH**		99	Values= 5.0, 6.,0, 6.5, 7.0, 7.5, 8.0, 8.5			

Exam 6 Procedures Sheet

|__|	**Echocardiogram**
|__|	**Echo Doppler**
|__|	**Carotid Doppler**
|__|	**Body Composition**
|__|	**Ankle-arm blood pressure**
|__|	**Exercise Questionnaire**
|__|	**Spirometry Done (If no, code reason below)**
|__|	**Blood Lipids**
|__|	**Diet Questionnaire**
|__|	**Glucose Tolerance Test**
|__|	**Methionine Challenge Test**
|__|	**ECG Done**
|__|	**Hearing Test**
|__|	**Osteoporosis Test**
|__|	**Exercise Test**
|__|	**Heart Rate Monitor**
|__|	**Urinalysis Abnormal Results**
|__|	**Reason Spirometry Refused** 1=Major Surgery, 2=Heart Attack, 3=Stroke, 4=Aneurysm, 5=BP>210/110 6=Refused, 7=Test Aborted, 8=Other, 9=Unk

Coding for all items to left
0=No,
1=Yes,
9=Unknown

(0=No, 1=Yes, and list below,
9=Unk

_____

_____

EXAM 6 [_____] ID type/ID [_____]Last Name, First Name

Sentence and Design Handout for Patient

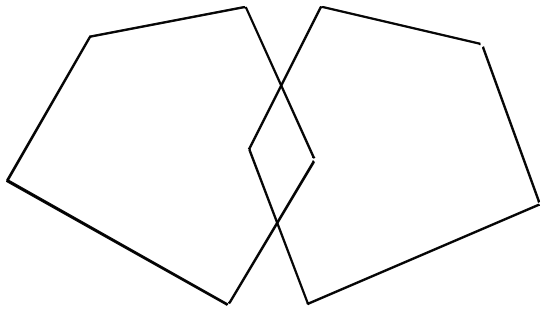
PLEASE WRITE A SENTENCE

_____

_____

_____

PLEASE COPY THIS DESIGN



EXAM 6 [_____] ID type/ID [_____]Last Name, First Name
VERSION 02/28/91

Cognitive Function--Part I

|6|0|2|0|3| FORM NUMBER

|__|__|	**Nurse Examiner's Number**

SCORE CORRECT **No Try=6 Unknown=9**	**Write all responses on exam form.**
0 1 2 3 6 9	**What Is the Date Today?** (Month, day, year, correct score=3)
0 1 6 9	**What Is the Season?**
0 1 6 9	**What Day of the Week Is it?**
0 1 2 3 6 9	**What Town, County and State Are We in?**
0 1 6 9	**What Is the Name of this Place?** (any appropriate answer all right, for instance my home, street address, heart study ..max score=1)
0 1 6 9	**What Floor of the Building Are We on?**
0 1 2 3 6 9	**I am going to name 3 objects. After I have said them I want you to repeat them back to me. Remember what they are because I will ask you to name them again in a few minutes: Apple,Table, Penny**
|__|__|__|__|__|	**Now I am going to spell a word forward and I want you to spell if backwards. The word is world. WO-R-L-D.** **Please Spell it in Reverse Order.** **Write in Letters,_____** (Letters Are Entered and Scored Later)
0 1 2 3 6 9	**What are the 3 objects I asked you to remember a few moments ago?**

EXAM 6 [_____] ID type/ID Last Name, First Name

Cognitive Function --Part II

|6|0|2|0|4| FORM NUMBER

SCORE CORRECT No Try=6 Unknown=9	Write all responses on exam form.
0 1 6 9	**What Is this Called?** (Watch)
0 1 6 9	**What Is this Called?** (Pencil)
0 1 6 9	**Please Repeat the Following: "No Ifs, Ands, or Buts."** (Perfect=1)
0 1 6 9	**Please Read the Following & Do What it Says** (performed=1, code 6 if low vision)
0 1 6 9	**Please Write a Sentence** (code 6 if low vision)
0 1 6 9	**Please Copy this Drawing** (code 6 if low vision)
0 1 2 3 6 9	**Take this piece of paper in your right hand, fold it in half with both hands, and put it in your lap** (score 1 for each correctly performed act, code 6 if low vision)
|__|	**Examiner's Assessment of Subject's Mental Status** 1 = normal, 2 = possible dementia, 3 = factors such as illiteracy, not fluent in English, or depression cause poor testing 4 = dementia present 9 = unknown

EXAM 6 [_____] ID type/ID [_____]Last Name, First Name
(HOME 1) VERSION 02/28/91

Functional Performance

|6|0|0|0|4| FORM NUMBER

|__|__|	**Nurse Examiner's Number**

Basic Functions

|__|	**Where do you live:** (0 = Private Residence, 1 = Nursing home, 2 = Other institution, such as: home-self care retirement village, 9=Unknown)

|__| **Does anyone live with you**: (0=No, 1=Yes, 9=Unknown)
(Code Nursing Home Residents as NO to these questions)

If Yes ☞

If 0 or 9 skip down

|__| Spouse
|__| Significant Other
|__| Children
|__| Friends
|__| Relatives

0=No
1=Yes, **less** than 3 months per year
2=Yes, **more** than 3 months per year
9=Unknown

|__|	**In general, how is your health now**: (1=Excellent, 2=Good, 3=Fair, 4=Poor,9=Unkn)
|__|	**Compare your health to most people your own age:** (1=Better, 2=About the same, 3=Worse, than most people your own age, 9=Unknown)
|__|	**Are you working now:** (0=No, 1=Yes,Full time, 2=Yes, Part time, 9=Unknown)
|__|__|__|	**During the past 6 months (180 days) how many days were you so sick that you were unable to carry out your usual activities?** (999=Unknown)

Activities of Daily Living

During the Course of a Normal Day, How Do You Carry out the Following Activities?
Coding: 0=No help needed, independent, 1=Uses device,independent,
2=Human assistance needed, minimally dependent, 3=Dependent, 4=Do not do during a normal day, 9=Unknown

|__|	**Dressing** (undressing and redressing)
|__|	**Bathing** (including getting in and out of tub or shower)
|__|	**Eating**
|__|	**Transferring** (getting in and out of a chair)
|__|	**Toileting Activities** (using bathroom facilities and handle clothing)
|__|	**Bladder Continence** (ask if person has "accidents") (code=5 if use special products)
|__|	**Bowel Continence** (ask if person has "accidents") (code=5 if use special products)
|__|	**Walking on Level Surface about 50 Yards** (length of Thurber St.)
|__|	**Walking up and down One Flight Stairs**
|__|	**Using a Telephone**
|__|	**Taking Own Medications** (code as above, and 8=takes no medications regularly)

EXAM 6 [_____] ID type/ID [_____]Last Name, First Name
(HOME 2) VERSION 02/28/91

Activities Questions- Part A

|6|0|0|0|5| FORM NUMBER

|__|__|	**Nurse Examiner's Number**

Use of Nursing and Community Services

|__| **if yes, continue☞ and below**

In the past two years, have you been admitted to a nursing home, been visited by a nursing service, or used community programs (0=No, 1=Yes, 9=Unknown)

|__| Been admitted to nursing home (or skilled facility) in past two years (0=No, 1=Yes, 9=Unknown)

Past month only	**Past two years**	
|__| |__| Home health aides
|__| |__| Homemaker visits
|__| |__| Visiting Nurses
|__| |__| Rehabilitation services (such as physical therapy, occupational therapy, speech therapy)
|__| |__| Meals on Wheels
|__| |__| Community Day Programs
|__| |__| Other (specify_____)

0=None
1=< 1 per month
2=1-5 times per month
3=6-15 times per month
4=15 to 30 times per month
9=unknown

Rosow-Breslau Questions

|__| **Are you able to do heavy work around the house, like shovel snow or wash windows, walls or floors without help?** (0=No, 1=Yes, 9=Unknown)

|__| **Are you able to walk up and down stairs to the second floor without any help?** (0=No, 1=Yes, 9=Unknown)

|__| **Are you able to walk half a mile without help?** (About 4 to 6 blocks) (0=No, 1=Yes, 9=Unknown)

|__| **Have you driven a car in the past ?** (0=No, 1=Yes, 9=Don't Know)

|__| **if no then☞** **Do you drive now?** (0=No, 1=Yes, 9=Don't Know)

|__| **Reason for not driving now** (1=Health, 2=Other non-health reason, 3=never drove a car 9=Unknown

EXAM 6 [_____] ID type/ID [_____]Last Name, First Name

(HOME 3 VERSION 02/28/91

Activities Questions - Part B

|6|0|0|0|6| FORM NUMBER

|__|__|	**Nurse Examiner's Number**

Nagi Questions

For each thing tell me whether you have
(0) No Difficulty
(1) A Little Difficulty
(2) Some Difficulty
(3) A Lot Of Difficulty
(4) Unable To Do
(5) Don't Do On MD Orders
(9) Unknown

|__|	Pulling or pushing large objects like a living room chair.
|__|	Either stooping, crouching, or kneeling
|__|	Reaching or extending arms below shoulder level
|__|	Reaching or extending arms above shoulder level
|__|	Either writing, or handling, or fingering small objects.
|__|	Standing in one place for long periods, say 15 minutes
|__|	Sitting for long periods, say 1 hour
|__|	Lifting or carrying weights under 10 pounds (like a bag of potatoes)
|__|	Lifting or carrying weights over 10 pounds (like a very heavy bag of groceries)
|__|	Getting in and out of car
|__|	Putting on socks or stockings

EXAM 6 [_____] ID type/ID [_____]Last Name, First Name
INTERVIEW

Activities Questions Part C

|6|0|0|0|7| FORM NUMBER

|__|__|	**Nurse Examiner's Number**
	| __ |	**In the past year have you accidentally fallen and hit the floor or ground?**
if yes, fill ☞	(code as no if during sports activity) (0=No, 1=Yes, 2=Maybe, 9=Unk)
	|__|__| How many times did you fall in the past year? (99=Unknown)

Fractures

|__| **Since Your Last Clinic Visit Have You Broken Any Bones?**
(Code: 0=No, 1=Yes, 2=Unsure, 3=Under age 30, 9=Unknown)

If 0,3,9 then skip rest of table

If 1,2, fill ☞

Left	Right	Location
19|__|__|	19|__|__|	**Upper arm (humerus) or elbow**
19|__|__|	19|__|__|	**Forearm or wrist**
19|__|__|		**Back** (If disc disease only, code as no)
19|__|__|		**Pelvis**
19|__|__|	19|__|__|	**Hip**
19|__|__|		**Other** (specify)_____

EXAM 6 [_____] ID type/ID [_____]Last Name, First Name

CES-D Scale

|6|0|0|0|8 FORM NUMBER

|__|__|	**Nurse Examiner's Number**

The questions below ask about your feelings during the past week. For each of the following statements, please say if you felt that way much of the time during the past week.

Questions to be answered Circle best answer for each question	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or moderate amount of time (3-4 days)	Most or all of the time (5-7 days)	Unknown
1. I was bothered by things that usually don't bother me.	0	1	2	3	9
2. I did not feel like eating; my appetite was poor.	0	1	2	3	9
3. I felt that I could not shake off the blues, even with help from my family and friends.	0	1	2	3	9
4. I felt that I was just as good as other people.	0	1	2	3	9
5. I had trouble keeping my mind on what I was doing.	0	1	2	3	9
6.I felt depressed.	0	1	2	3	9
7. I felt that everything I did was an effort.	0	1	2	3	9
8. I felt hopeful about the future.	0	1	2	3	9
9. I thought my life had been a failure.	0	1	2	3	9
10. I felt fearful.	0	1	2	3	9
11. My sleep was restless.	0	1	2	3	9
12. I was happy.	0	1	2	3	9
13. I talked less than usual.	0	1	2	3	9
14. I felt lonely.	0	1	2	3	9
15. People were unfriendly.	0	1	2	3	9
16. I enjoyed life.	0	1	2	3	9
17. I had crying spells.	0	1	2	3	9
18. I felt sad.	0	1	2	3	9
19. I felt that people disliked me.	0	1	2	3	9
20. I could not "get going"	0	1	2	3	9

EXAM 6 [_____] ID type/ID [_____]Last Name, First Name

Medical History--Hospitalizations

(SCREEN 1) VERSION 09/30/92

OFFSPRING EXAM 6 DATE _____

|6|0|3|0|1| FORM NUMBER

Basic Background and Health Care	
|__|	**Sex of Patient** (1=Male, 2=Female)
|__|__|__|	**1st Examiner ID** _____ 1st Examiner Name
|__|	**Hospitalization (not just E.R.) in Interim** (0=No; 1=yes, hospitalization, 2=yes, more than 1 hospitalization, 9=Unknown)
|__|	**E.R. Visit in Interim** (0=No; 1=Yes, 1 or more Emergency Room visit, 9=Unknown)
|__|	**Day Surgery** (0=No, 1=Yes, 9=Unknown)
|__|	**Illness with visit to doctor** (0=No, 1=Yes,1 visit; 2=Yes,more than 1 visit; 9=Unk)
|__|	**Check up** in interim by doctor (0=No, 1=Yes, 9=Unknown)
_____ MM DD YY	**Date** of this FHS exam (Today's date - See above)

Medical Encounter	Month/Year (of last visit)	Site of Hospital or Office	Doctor

EXAM 6 [_____] ID type/ID [_____]Last Name, First Name

Medical History--Cardiovascular Medications

|6|0|3|0|2| FORM NUMBER (SCREEN 2)

|__| If yes, fill☞	**Take aspirin regularly** (0=No, 1=Yes, 9=Unk)
	|__|__|	**Number aspirins taken regularly** (99=Unknown)
	|__|	**Aspirin frequency**- number taken regularly (0=Never, 1=Day, 2=Week ,3=Month, 4=Year, 9=Unk)
	|__|__|__|	**Usual aspirin dose for above** 081=baby,160=half dose, 325=nl, 500=extra or larger,999=unk
|__|	**Currently receiving medication for the treatment of hypertension?** (0=No,1=Yes,9=Unk)
|__| If yes,continue	**Any of the cardiovascular medications below on this page?** (0=No, 1=Yes, 9=Unk)
|__|	**Cardiac Glycosides**
|__|	**Nitroglycerine**
|__|	**Longer acting nitrates** (Isordil, Cardilate, etc.)
|__|	**Calcium Channel Blockers** (Nifedipine, Verapamil, Diltiazem)
|__|	**Beta Blockers** (Specify_____ (0=No, 1=Yes, 9=Unk)
	|__|	**Beta Blocker Group** (Propranolol=01 Timolol =02 Nadolol=03 Atenolol=04 Metoprolol=05 Pindolol =06 Acebutolol=07 Labetalol=08 Other=09)
	|__|__|__|	**Dose** (mg/day) of Beta Blocker (999=unknown)
|__|	**Loop Diuretics** (Lasix, etc.)
|__|	**Thiazide/K-sparing diuretics**(Dyazide, Maxide, etc.)
|__|	**Thiazide diuretics**
|__|	**K-sparing diuretics** (Aldactone, Triamterene)
|__|	**Potassium supplements**
|__|	**Reserpine** derivatives
|__|	**Methyldopa** (Aldomet)
|__|	**Alpha-1 agonist** (Clonidine, Wytensin, Guanabenz)
|__|	**Alpha-2 blockers** (Prazosin, Terazosin, Doxazosin)
|__|	**Renin-angiotensin blocking drugs (ACE)** (Captopril, Enalapril, Lisinopril)
|__|	**Peripheral vasodilators** (Hydralazine, Minoxidil, etc)
|__|	**Other anti-hypertensives**(Specify)_____
|__|	**Antiarrhythmics** (Quinidine, Procainamide, Norpace,Disopyramide,etc)
|__|	**Antiplatelet** (Anturane, Persantine, etc.)
|__|	**Anticoagulants** (Coumadin, Warfarin, etc.)
|__|	**Other cardiac medication** (Specify)_____

CODE
0=No;
1=Yes,now;
2=Yes,not now
3=Maybe,
9=Unknown)

CODING FOR REST OF PAGE
0=No;
1=Yes,now;2=Yes,not now
3=Maybe,9=Unknown)

All Medicines-- Scratch Sheet

_____

_____

_____

_____

_____

_____

EXAM 6 [_____] ID type/ID [_____]Last Name, First Name

Medical History-- Other Medications

|6|0|3|0|3| FORM NUMBER (SCREEN 3)

|__|	Anti cholesterol drugs (Resins--e.g. Questran, Colestid)
|__|	Anti cholesterol drugs (Niacin or Nicotinic Acid)
|__|	Anti cholesterol drugs (Fibrates--e.g. Gemfibrozil)
|__|	Anti cholesterol drugs (Statins--e.g.Lovastatin,Pravastatin)
|__|	Anti cholesterol drugs (Other--Specify_____)
|__|	Antigout--uric acid lowering (Allopurinol, Probenecid etc)
|__|	Antigout--(Colchicine)
|__|	Thyroid extract (Dessicated Thyroid)
|__|	Thyroxine (Synthroid etc.)
|__| **if yes fill in dose** ☞	Insulin 0=No, 1=Yes,now 2=Yes,not now 3=Maybe 9=Unknown |__|__|__| Total units of insulin a day
|__|	Oral hypoglycemics (Specify brand_____)
|__|	Oral/patch estrogen (for women users also see estrogen section)
|__|	Oral glucocorticoids (Prednisone, Cortisone,etc)
|__|	Non-steroidal anti-inflammatory agents (NSAIDS) (Motrin,Ibuprofen, Naprosyn, Indocin, Clinoril)
|__|	Analgesic-narcotics (Demerol, Codeine, Dilaudid, etc.)
|__|	Analgesic-non-narcotics (Acetaminophen etc.)
|__|	Antihistamines
|__|	Antiulcer (Tagamet, Ranitidine, Probanthine, H ion inhibitors)
|__|	Anti-anxiety, Sedative/Hypnotics etc. (Librium, Valium etc.)
|__|	Sleeping pills
|__|	Anti-depressants
|__|	Eyedrops
|__|	Antibiotics
|__|	Anti-parkinson drugs (Sinemet, L-Dopa, Symmetrel, Cogentin, etc)
|__|	Anticonvulsants (Dilantin, Phenobarbital, Tegretol, Mysoline etc)
|__|	Bronchodilators **and aerosols**
|__|	Others Specify:_____

CODING FOR REST OF PAGE

0=No

1=Yes,now

2=Yes,not now

3=Maybe

9=Unknown

EXAM 6 [_____] ID type/ID [_____]Last Name, First Name

Medical History-- Female Genitourinary Disease

|6|0|3|0|4| FORM NUMBER (SCREEN 4)

|__|	**Menstrual periods have stopped one year or more** (0=No, 1=Yes, 8=Man, 9=Unknown)
If yes ☞	|__|__|	Age when periods stopped (Years) (00=Not stopped, 88=Man, 99=Unk)
	|__|	Cause of cessation of menses (0=Not stopped, 1=Natural, 2=Surgery, 3=Other,8=Man, 9=Unk)
If no or unsure fill ☞	|__|	Did you have one or more menstrual periods in last 2 months? (0=No, 1=Yes, 2=Unsure, 8=Man, 9=Unknown)
	|__|__|	Number of days since last period ended? (00=currently having menstrual period, acceptable range 01-60; (88=not applicable, man; 99=unsure or unknown)
|__|__|	**Age at hysterectomy** (years) (00=No, 88=Man,99=Unknown)
|__|	**Ovary or ovaries removed** (0=No; 1=Yes,one; 2=Yes,two; 8=Man, 9=Unknown)
|__|__|	**Number of live births** (88=Not Applicable-man, 88=Man, 99=Unknown)
|__|__|	**Age at tubal ligation** (00=No, 88=Man, 99=Unknown)
|__|	**Oral contraceptives in interim** (0=No, 1=Yes,now; 2=Yes,not now, 8=Man, 9=Unk)
		_____ Name of oral contraceptive last used (e.g. Demulen 1/50) (only list if agent used since last exam)
|__|	**Estrogen replacement in interim** (e.g. Premarin) (0=No, 1=Yes,now; 2=Yes,not now, 8=Man, 9=Unk)
If yes, fill all to ☞	|__|	**Dose/day of premarin conjugated Estrogens, or other oral estrogen** (0=No, 1=0.3 mg, 2=0.625 mg, 3=1.25 mg, 4=2.5mg,, (pick nearest dose) 5=other_____ 9=Unk) (write in)
	|__|	**Patch dose of estrogen** (0=No, 1=0.5 mg/wk, 2=other _____, 9=Unk) (write in)
	|__|__|	**Number of days a month taking estrogens** (99=Unknown)
|__|	**Estrogen cream use interim** (0=No ; 1=Yes,now; 2=Yes,not now; 8=man; 9=Unknown)
|__|	**Progesterone use interim**
|__|	**Urinary disease in interim** (0=No,1=Yes,2=Maybe 8=man; ,9=Unknown)
|__|	**Kidney disease in interim**
|__|	**Kidney stones in interim**

EXAM 6 [_____] ID type/ID [_____]Last Name, First Name

Medical History-- Male Genitourinary Disease

|6|0|3|0|5| FORM NUMBER (SCREEN 5)

|__| **Urinary disease in interim**	Coding: 0=No, 1=Yes, 2=Maybe, 8=Woman 9=Unknown
|__| **Kidney disease in interim**	
|__| **Kidney stones in interim**	
|__| **Prostate trouble in interim**	
|__| **Prostate surgery in interim**	
|__| **Vasectomy history** (0=No, 1=Yes, in interim, 2=Yes, not in interim, 8=Woman 9=Unknown)	
if yes, ☞	|__|__| Age at vasectomy (years 99=unknown)	

EXAM 6 [_____] ID type/ID [_____]Last Name, First Name

Medical History-- Thyroid, Gastrointestinal, Beverages

|6|0|3|0|6| FORM NUMBER (SCREEN 6)

Thyroid and Gastrointestinal

|__| Interim diagnosis of a **thyroid** condition?(0=No,1=Yes,9=Unknown)

Comments_____

|__| Interim **ulcer** condition? (e.g., stomach, duodenum, peptic)(0=No,1=Yes, 9=Unknown)

|__| Interim **hiatal hernia**? (0=No,1=Yes,9=Unknown)

|__| Have you ever had **gallbladder disease**? (0=No, 1=Yes, 9=Unknown)

If yes,☞ |__|__| **Gallbladder procedure**
1=Surgical removal, 2=Lithotropsy, 3=Diagnosis only, 9=Unknown)

Comments_____

Daily intake over past year

Caffeinated Beverages				Decaffeinated Beverages			
	Unit	# per day	Method§		Unit	# per day	Method§
Coffee	cup	|__|__|	|__|	**Coffee**	cup	|__|__|	|__|
Tea	cup	|__|__|		**Tea**	cup	|__|__|	
Cola	12 oz	|__|__|		**Cola**	12 oz	|__|__|	

§ Method used predominantly: 0=Non drinker, 1=Filter, 2=Perc, 3=Boil, 4=Instant, 8=Other, 9=Unknown

Alcohol Consumption

Beverage	Unit	Average Number of drinks per week over course of year	Number days drink per week	On Average, Limit for number of drinks at one period of time
		Code 00=never, 01=1 or less, 99=unknown	Code 0-7 9=Unknown	Code number 99=Unknown
Beer	bottle,can,glass (12 oz)	|__|__|	|__|	|__|__|
White Wine (or Rosé)	glass (4 oz)	|__|__|	|__|	|__|__|
Red Wine	glass (4 oz)	|__|__|	|__|	|__|__|
Liquor	cocktail,highball	|__|__|	|__|	|__|__|

EXAM 6 [_____] ID type/ID [_____]Last Name, First Name

Medical History--Smoking

|6|0|3|0|7| FORM NUMBER (SCREEN 7)

|__| **if yes fill rest of this table**

Smoked cigarettes regularly in the last year? (0=No, 1=Yes, 9=Unkown)

|__|__| How many cigarettes do/did you smoke a day?
(01=one or less, 99=unknown)

|__| Do you inhale? (0=No,1=Yes,9=Unknown)

Cigarette Brand	Strength	Type	Filter	Length
Code the first eight letters	Code 1=Normal 2=Lite 3=Ultralite 8=N/A 9=Unknown	Code 1=Regular 2=Menthol 8=N/A 9=Unknown	Code 1=Nonfilter 2=Filter 8=N/A 9=Unknown	Code 1=Regular 2=King 3=100 mm 4=120 mm 8=N/A 9=Unknown
|__|__|__|__|__|__|__|__|	|__|	|__|	|__|	|__|

|__|__| How many hours since last cigarette?
(01=1 hour or less, 24=24 or more hours,)
(88=currently non-smoker, 99=Unknown)

Cigars and Pipes

|__| **Do you now smoke cigars?** (0=no, 1=yes,inhale, 2=yes, no inhale 9=unk)

|__| **Do you now smoke pipes?**

Passive Smoking

|__| **Does your spouse smoke now?** (0=no, 1=yes, 2=not married, 9=unknown)

If yes, ☞

Location	Cigarettes/day	Pipes/day	Cigars/day
Total	|__|__|	|__|__|	|__|__|
At home	|__|__|	|__|__|	|__|__|

|__|__| **Excluding you and your spouse, *how many other smokers* live in your household?**

(Cigarette, cigar or pipe smokers)

(0=none, 98=nursing home resident, 99=unknown)

EXAM 6 [_____] ID type/ID [_____]Last Name, First Name

Medical History-- Respiratory

|6|0|3|0|8| FORM NUMBER (SCREEN 8)

Respiratory Symptoms	
|__|	**Chronic cough in interim** (at least 3 months/year) (0=No; 1=Yes, productive; 2=Yes, non-productive; 9=Unknown)
if yes, ☞	|__| Type of Cough (0=None, 1=New in interim, 2=Old, 8=N/A, 9=Unknown)
|__|	**Wheezing or asthma** (0=No, 1=Yes, 9=Unknown)
|__|	**Dyspnea on exertion** (0=No) (1=Climbing stairs or vigorous exertion) (2=Rapid walking or moderate exertion) (3=Any slight exertion) (9=Unknown)
|__|	**Dyspnea has increased over the past two years** (0=No, 1=Yes, 9=Unknown)
|__|	**Orthopnea**
|__|	**Paroxysmal nocturnal dyspnea**
|__|	**Ankle edema bilaterally**

(0=No, 1=Yes-new in interim, 2=Yes-old complaint, 9=Unknown)

Respiratory First Opinions		
|__|	**1st Examiner believes CHF**	(0=No, 1=Yes, 2=Maybe, 9=Unknown)
|__|	**1st Examiner believes Chronic Bronchitis** (Cough that produces sputum at least 3 months in past 12 months) No second opinion needed for bronchitis	

Respiratory Comments _____

_____

_____

_____

_____

EXAM 6 [_____] ID type/ID [_____]Last Name, First Name

Medical History-- Heart Part I

6|0|3|0|9| FORM NUMBER (SCREEN 9)

	__	**Any chest discomfort since last exam**	**(0=No, 1=Yes,2=Maybe,9=Unknown)**
if yes, fill☞ and below	|__| Chest discomfort with exertion or excitement	(0=No, 1=Yes,2=Maybe,9=Unknown)
	|__| Chest discomfort when quiet or resting	
	Chest Discomfort Characteristics (must have checked box at top of table)	
	|__|__|*|__|__| Date of onset	mo/yr,99/99=Unknown)
	|__|__|__| Usual duration	(minutes, 999=Unknown)
	|__|__|__| Longest duration	(minutes: 1=1 min or less, 900=15 hrs or more, 999=Unknown)
	|__| Location	(0=No, 1=Central sternum and upper chest, 2=L Up Quadrant, 3=L Lower ribcage, 4=R Chest, 5=Other, 6=Combination, 9=Unknown)
	|__| Radiation	(0=No, 1=Left shoulder or L arm, 2=Neck, 3=R shoulder or arm, 4=Back, 5=Abdomen, 6=Other, 7=Combination, 9=Unknown)
	|__|__|__| Frequency (number in past month)	999=Unknown
	|__|__|__| Frequency (number in past year)	999=Unknown
	|__| Type	(1=Pressure,heavy,vise; 2=Sharp; 3=Dull; 4=Other; 9=Unk)
	|__| Relief by Nitroglycerine in <15 minutes	0=No
	|__| Relief by Rest in <15 minutes	1=Yes,
	|__| Relief Spontaneously in <15 minutes	8=Not tried
	|__| Relief by Other cause in <15 minutes	9=Unknown

CHD First Opinions		
|__| **Angina pectoris in interim**	(0=No, 1=Yes, 2=Maybe, 9=Unknown)
|__| **Angina pectoris since revascularization procedure**	
|__| **Coronary insufficiency in interim**	
|__| **Myocardial infarct in interim**	

Comments_____

_____

_____

EXAM 6 [_____] ID type/ID [_____]Last Name, First Name

Medical History-- Syncope

|6|0|3|1|0| FORM NUMBER Version 3/26/95 (SCREEN 10)

|__| **Have you fainted or lost consciousness in the interim?** (If due to stroke skip to screen 11) If event immediately preceded by head injury or accident code 0=No)		Code: 0=No, 1=Yes, 2=Maybe, 9=Unknown
if yes, fill all☞	|__|__|__|	Number of episodes in the past two years	(999=Unknown)
	|__|__|*|__|__|	Date of first episode	(mo/yr, 99/99=Unknown)
	|__|__|__|	Usual duration of loss of consciousness	(minutes, 999=Unkn)
if yes, fill all ☞	|__|__|	**Usual Activity Preceding Event** (00=None, 01=Exertion,0 2=Rest, 03=Defecation/Micturition/Cough, 04=Emotional upset, 05=Alcohol consumption, 06=Turning neck (e.g. shaving), 07=Postural change (e.g. lying to standing), 0 8=Recent medication change or ingestion, 09=Other, or combination (specify)_____, 10=Pain, 11 illness, specify_____99=Unknown)	

	Symptoms noted before event(s) (0=No, 1=Yes, 2=Maybe, 9=Unkn)		**Symptoms noted after event(s)** (0=No, 1=Yes, 2=Maybe, 9=Unkn)	
if yes, fill both columns to☞	|__|	Nausea/vomiting	|__|	Urinary/fecal incontinence
	|__|	Warning signs (e.g. Aura)	|__|	Confusion
	|__|	Chest discomfort	|__|	Focal weakness (e.g. arm,leg)
	|__|	Shortness of breath	|__|	Other (specify)_____
	|__|	Palpitations		_____
	|__|	Other		

|__| Did you have any injury caused by the event? (0=No, 1=Yes, 2=Maybe, 9=Unkn)

if yes, fill☞

|__| Was event observed? (0=No, 1=Yes, 2=Maybe, 9=Unkn)
Who observed event?_____

|__| ER/hospitalized or saw M.D. (0=No, 1=Hosp., 2=Saw M.D., 9=Unkn)
Hospitalized at: _____

M.D. seen: _____

Syncope First Opinions

|__| **Syncope** (0=No, 1=Yes, 2=Maybe, 3=Presyncope, 9=Unknown) needs second opinion

(0=No,1=Yes,2=Maybe,9=Unknown)

- |__| **Cardiac syncope**
- |__| **Vasovagal syncope**
- |__| **Other-- Specify:_____**

|__| **Seizure Disorder** (0=No, 1=Yes, 2=Maybe, 9=Unknown)

Comments _____

EXAM 6 [_____] ID type/ID [_____]Last Name, First Name

Medical History--Cerebrovascular

|6|0|3|1|1| FORM NUMBER (SCREEN 11)

Cerebrovascular Episodes in Interim

Code: 0=No, 1=Yes, 2=Maybe, 9=Unknown

|__| **Sudden muscular weakness**

|__| **Sudden speech difficulty**

|__| **Sudden visual defect**

|__| **Double vision**

|__| **Loss of vision in one eye**

|__| **Unconsciousness**

|__| **Numbness, tingling**

if yes, fill ☞ |__| Numbness and tingling is positional

|__| **CT or MRI scan (head) since last exam** (date/place_____)

|__| **Seen by neurologist since last exam** (write in who and when below)
_____

Details for "Serious" Cerebrovascular Event in Interim

|__| **Examiner's opinion that "serious" or "significant" cerebrovascular event took place in interim** (0=No, 1=Yes, 2=Maybe, 9=Unknown)

if yes or maybe

fill all to ☞

|__|__|*|__|__| **Date** (mo/yr,99/99=Unkn
Observed by_____

|__| **Onset time**
(1=Active, 2=During sleep, 3=While arising, 9=Unkn)

|__|__|*|__|__| **Exact/approximate time** (use 24-hour military time, 99.99=unkn)

|__|__|*|__|__|*|__|__| **Duration** (use format days/hours/mins, 99/99/99=Unknown)

|__| **Hospitalized or saw M.D**.
0=No,1=Hosp.2=Saw M.D,9=Unk

|__|__| **Number of days stayed at**
_____

Stroke/TIA First Opinions

(0=No,1=Yes,2=Maybe,9=Unknown)

|__| **Stroke in Interim**

|__| **Transient Ischemic Attack in Interim (TIA)**

|__| **Other-- Specify:_____**

Neurology Comments_____

_____

EXAM 6 [_____] ID type/ID [_____]Last Name, First Name

Medical History--Peripheral Arterial and Venous

|6|0|3|1|2| FORM NUMBER (SCREEN 12)

0= Able	1=Needs help	9=Unkn	**Can you walk 50 feet without help?** (e.g. no cane, walker, wheelchair) (0=Able to walk 50 feet without help,1=Needs help, 9=Unk)
0= No	**1=Yes**	**9=Unkn**	**Do you have lower limb discomfort while walking?** (0=No, 1=Yes, 9=Unkn)

if yes fill in below

Left	Right	**Vascular symptoms (0=No, 1=Yes, 9=Unkn)**
|__|	|__|	Discomfort in calf while walking
|__|	|__|	Discomfort in lower extremity (not calf) while walking
|__|		Occurs with first steps
|__|		After walking a while
|__|		Related to rapidity of walking or steepness
|__|		Forced to stop walking
|__|		Time for discomfort to be relieved by stopping (minutes) (00=No relief with stopping, 88=Not Applicable)
|__|__|		Number of days/month of lower limb discomfort (00=No, 88=N/A, 99=Unknown)

|__|	**Is one foot colder than the other? (0=No, 1=Yes, 9=Unknown)**

Venous Disease

Left	Right		
|__|	|__|	**Phlebitis**	Code: 0=No, 1=Yes, 9=Unknown
|__|	|__|	**Leg ulcers**	
|__|	|__|	**Treatment for varicose veins**	

PVD and Venous Disease First Opinions

|__|	**Intermittent Claudication**	(0=No, 1=Yes, 2=Maybe, 9=Unknown)
|__|	**Venous Insufficiency**	

Comments Peripheral Vascular Disease_____

_____

EXAM 6 [_____] ID type/ID [_____]Last Name, First Name

Medical History-- Raynaud's and Heart Surgery

|6|0|3|1|3| FORM NUMBER (SCREEN 13)

Raynaud's Questions

|___| Are either your fingertips or toes unusually sensitive to the cold? (0=no, 1=yes, 9=unknown)

|__| **Do your fingers ever show unusual color changes?** (0=no, 1=yes, 9=unknown)

|__|__| At what age did this begin? (99=unkn)

If yes fill☞

|__| Do they become white? (0=no, 1=yes, 9=unknown)

|__| Do they become blue?

|__| Do they become red?

|__| Have you consulted a doctor for color changes or sensitivity in fingers?

|__| **Have you ever used vibrating power tools?** (0=no, 1=yes, 9=unk)

If yes fill☞

|__| Used vibrating power tools at home (0=no, 1=yes, 9=unk)

|__| Used vibrating power tools at work

History of Heart Surgery (Not Coronary Surgery)

If unsure, please write in comments for later coding

Valve Procedure	Aortic	Mitral	Tricuspid	Pulmonic
0 =No or none 1 =Mechanical (Bjork, Starr Edwards 2 =Bioprosthesis (Pig, homograft) 3 =Commissurotomy, Balloon valvuloplasty 4 =Repair (NOT A commusurotomy 5 =Other-Specify _____ 9 =Unknown	|__|	|__|	|__|	|__|
Year Performed	19|__|__|	19|__|__|	19|__|__|	19|__|__|

Comments_____

_____

_____

EXAM 6 [_____] ID type/ID [_____]Last Name, First Name

Medical History-- CHD and Complications

|6|0|3|1|4| FORM NUMBER (SCREEN 14)

Coding: 0=No, 1=Yes 2=Maybe, 9=Unkn	Cardiovascular Procedure
|__| **if yes fill☞**	**Exercise Tolerance Test (most recent only)**
	19|__|__| Year done Location_____
|__| **if yes fill ☞**	**Coronary arteriogram (most recent only)**
	19|__|__|Year done (99=unknown)
|__| **if yes fill☞**	**Coronary artery angioplasty**
	19|__|__| Year first done (99=unknown)
	|__| Type of procedure (0=none, 1=balloon, 2=other_____ 9=unkn),
|__| **if yes fill☞**	**Coronary bypass surgery**
	19|__|__| Year first done (99=unknown)
|__| **if yes fill ☞**	**Permanent pacemaker insertion**
	19|__|__| Year first done (99=unknown)
|__| **if yes fill ☞**	**Carotid artery surgery**
	19|__|__| Year first done (99=unknown)
|__| **if yes fill ☞**	**Thoracic aorta surgery**
	19|__|__| Year first done (99=unknown)
|__| **if yes fill ☞**	**Abdominal aorta surgery**
	19|__|__| Year first done (99=unknown)
|__| **if yes fill ☞**	**Femoral or lower extremity surgery**
	19|__|__| Year first done (99=unknown)
|__| **if yes fill ☞**	**Lower extremity amputation**
	19|__|__| Year first done (99=unknown)

Cardiovascular Procedures Summary
Please list all subsequent cardiovascular procedures

Date	Hospital	Type of Procedure
___/___/____		
___/___/____		
___/___/____		
___/___/____		

EXAM 6 [_____] ID type/ID [_____]Last Name, First Name

Cancer Site or Type

|6|0|3|1|5| FORM NUMBER (SCREEN 15)

|__| **Have you ever had cancer or a tumor? (0=No and skip to next screen, If 1=Yes, 2=Maybe, 9=Unknown please continue)**

Code for table: 0=No, 1=Yes, Cancerous, 2=Maybe, Possible Cancer, 3=Benign, 9=Unknown

Code	Site of Cancer or Tumor	Year First Diagnosed	Name Diagnosing M.D.	City of M.D.
|__|	**Esophagus**			
|__|	**Stomach**			
|__|	**Colon**			
|__|	**Rectum**			
|__|	**Pancreas**			
|__|	**Larynx**			
|__|	**Trachea/Bronchus/Lung**			
|__|	**Leukemia**			
|__|	**Skin**			
|__|	**Breast**			
|__|	**Cervix/Uterus**			
|__|	**Ovary**			
|__|	**Prostate**			
|__|	**Bladder**			
|__|	**Kidney**			
|__|	**Brain**			
|__|	**Lymphoma**			
|__|	**Other/Unknown** _____			

Comment (If participant has more details concerning tissue diagnosis, other hospitalization, procedures, treatments)

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EXAM 6 [_____] ID type/ID [_____]Last Name, First Name

Physical Exam--Head, Neck and Respiratory

|6|0|3|1|6| FORM NUMBER (SCREEN 16)

Physician Blood Pressure (first reading)	Systolic	Diastolic
	|__|__|__| to nearest 2 mm Hg	|__|__|__| to nearest 2 mm Hg

Eyes and Xanthomata

|__|	**Corneal arcus** (0=No, 1=Slight, 2=Moderate, 3=Marked, 9=Unknown)		
|__|	**Xanthelasma** (0=No, 1=Yes, 2=Maybe, 9=Unknown)		
|__|	**Xanthomata** (0=No, 1=Yes, 2=Maybe, 9=Unknown)		
If yes, fill ☞	|__|	Achilles tendon xanthomata	(0=No, 1=Yes, 2=Maybe, 9=Unknown)
	|__|	Palmar xanthomata	
	|__|	Tuberous xanthomata	

Thyroid

|__|	**Thyroid abnormality** (0=No, 1=Yes, 2=Maybe, 9=Unknown)		
If yes, fill ☞	|__|	Scar	0=No, 1=Yes, 2=Maybe, 9=Unknown
	|__|	Other	
	|__|	Diffuse enlargement	
	|__|	Single Nodule	
	|__|	Multiple Nodules	

Comments about Thyroid_____

_____

Respiratory

|__|	**Increased anterior-posterior diameter**	(0=No, 1=Yes, 2=Maybe, 9=Unknown)
|__|	**Fixed thorax**	
|__|	**Other**	
|__|	**Wheezing on auscultation**	
|__|	**Rales**	
|__|	**Other abnormal breath sounds**	

Comments about Respiratory_____

_____

EXAM 6 [_____] ID type/ID [_____]Last Name, First Name

Physical Exam--Heart

|6|0|3|1|7| FORM NUMBER (SCREEN 17)

Heart		
|__|	**Left Heart Enlargement**	This section (0=No, 1=Yes, 9=Unknown)
|__|	**Right Heart Enlargement**	
|__|	**S3Gallop**	
|__|	**S4 Gallop**	
|__|	**Systolic Click**	This section (0=No, 1=Yes,2=Maybe, 9=Unknown)
|__|	**Diastolic Click**	
|__|	**Abnormally split S2**	
|__|	**Diminished A2**	
|__|	**Neck vein distention at 45 degrees**	
|__|	**Other--Specify _____**	

|__| **if yes, fill out below**	**Systolic murmur(s)** (0=No, 1=Yes, 2=Maybe, 9=Unknown)				
Murmur Location	**Grade** 0=No sound 1 to 6 for grade of sound heard)	**Type** 0=None, 1=Ejection, 2=Regurgitant 3=Other 9=Unknown)	**Radiation** 0=None, 1=Axilla, 2=Neck, 3=Back, 4=Rt chest, 9=Unknown	**Valsalva** 0=Nochange, 1=Increase 2=Decrease 9=Unknown)	**Origin** 0=None,indet. 1=Mitral 2=Aortic 3=Tricuspid 4=Pulm 9=Unknown)
Apex	|__|	|__|	|__|	|__|	|__|
Left Sternum	|__|	|__|	|__|	|__|	|__|
Base	|__|	|__|	|__|	|__|	|__|

|__|	**Diastolic murmur(s)** (0=No, 1=Yes, 2=Maybe, 9=Unknown)
if yes, fill ☞	|__| Valve of origin for diastolic murmur(s) (0=No, 1=Mitral, 2=Aortic, 3=Both, 4=Other, 8=N/A, 9=Unk)

Comments_____

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EXAM 6 [_____] ID type/ID [_____]Last Name, First Name

Physical Exam--Breasts and Abdomen

|6|0|3|1|8| FORM NUMBER (SCREEN 18)

	Breast Abnormality **(complete for men and women)**
|__|	**Breast Abnormality** (0=No, 1=Yes, 9=Unknown)
if Yes, fill☞	|__| **Localized mass** |__| **Axillary nodes**

Breast Surgery **(complete for men and women)**		
|__|	**Breast Surgery** (0=No, 1=Yes, 9=Unknown)	
if Yes, fill☞	**Left**	**Right**
	|__|	|__| **Procedure** Use lowest code: (0=No, 1=Radical mastectomy, 2=Simple mastectomy, 3=Biopsy, 4=Lump removal, 5=Cosmetic, 9=Unknown)

Comments about abnormality:_____

_____

Abdominal Abnormalities		
|__|	**Liver enlarged**	(0=No, 1=Yes, 2=Maybe, 9=Unknown)
|__|	**Surgical scar**	
|__|	**Abdominal aneurysm**	
|__|	**Bruit**	
|__|	**Surgical gallbladder scar**	
|__|	**Other abdominal abnormality:** (0=No, 1=Yes, 2=Maybe, 9=Unknown)	

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EXAM 6 [_____] ID type/ID [_____]Last Name, First Name

Physical Exam--Peripheral Vessels--Part I

|6|0|3|1|9| FORM NUMBER (SCREEN 19)

Left	Right	Varicosities	
|__|	|__|	**Stem**	0=No abnormality 1=Uncomplicated 2=With skin changes 3=With ulcer 9=Unknown
|__|	|__|	**Reticular**	
|__|	|__|	**Spider**	

Left	Right	Lower Extremity Abnormalitiess	
|__|	|__|	**Ankle edema**	(0=No, 1=Yes, 2=Maybe, 8=absent due to amputation 9=Unknown)
|__|	|__|	**Foot cold**	
|__|	|__|	**Amputation**	
|__|	|__|	**Amputation level**	(0=No, 1=Toes only, 2=Ankle, 3=Knee,4=Hip, 8=Not applicable, 9=Unknown)

Comments_____

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EXAM 6 [_____] ID type/ID [_____]Last Name, First Name

Physical Exam--Peripheral Vessels--Part II

|6|0|3|2|0| FORM NUMBER **(SCREEN 20)**

Artery	Pulse		Bruit	
	(0=Normal, 1=Abnormal, 9=Unknown)		(0=Normal, 1=Abnormal, 9=Unknown)	
	Left	Right	Left	Right
Radial	|__|	|__|		
Femoral	|__|	|__|	|__|	|__|
Mid-Thigh			|__|	|__|
Popliteal			|__|	|__|
Post Tibial	|__|	|__|		
Dorsalis Pedis	|__|	|__|		

(For intermittent claudication and chronic venous insufficiency - See history questions)

Comments_____

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EXAM 6 [_____] ID type/ID [_____]Last Name, First Name

Physical Exam--Neurological and Final Blood Pressure

|6|0|3|2|1| FORM NUMBER **(SCREEN 21)**

Neurological Exam			
Left	**Right**		
|__|	|__|	**Carotid Bruit**	
|__|		**Speech disturbance**	**Coding entire section (0=No, 1=Yes, 2=Maybe, 9=Unknown)**
|__|		**Disturbance in gait**	
|__|		**Localized muscle weakness**	
|__|		**Visual disturbance**	
|__|		**Abnormal reflexes**	
|__|		**Cranial nerve abnormality**	
|__|		**Cerebellar signs**	
|__|		**Sensory impairment**	

Stroke and Parkinson's Disease Physical Exam Opinions		
|__|	**1st Examiner believes residual of stroke**	**(0=No,1=Yes,2=Maybe,9=Unknown)**
|__|	**1st Examiner believes Parkinson's Disease**	

Comments about Neurological findings_____

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Physician Blood Pressure (second reading)	Systolic	Diastolic
	|__|__|__| to nearest 2 mm Hg	|__|__|__| to nearest 2 mm Hg

EXAM 6 [_____] ID type/ID [_____]Last Name, First Name

Electrocardiograph--Part I

|6|0|3|2|2| FORM NUMBER **(SCREEN 22)**

|__| **if Yes, fill out rest of form**	**ECG done (0=No, 1=Yes)**
	Rates and Intervals
|__|__|__|	**Ventricular rate per minute** (999=Unknown)
|__|__|	**P-R Interval (hundreths of a second)** (99=FullyPaced, Atrial Fib, or Unknown)
|__|__|	**QRS interval (hundreths of second)** (99=Fully Paced, Unknown)
|__|__|	**Q-T interval (hundreths of second)** (99=Fully Paced, Unknown)
|__|__|__|__|	**QRS angle (put plus or minus as needed) (e.g. -045 for minus 45 degrees, +090 for plus 90, 9999=Fully paced or Unknown)**
	Rhythm
|__|	**0 or 1 = Normal sinus,(including s.tach, s.brady, s arrhy, 1 degree AV block)** **3 = 2nd degree AV block, Mobitz I (Wenckebach)** **4 = 2nd degree AV block, Mobitz II** **5 = 3rd degree AV block / AV dissociation** **6 = Atrial fibrillation / atrial flutter** **7 = Nodal** **8 = Paced** **9 = Other or combination of above (list)_____**
	Ventricular conduction abnormalities
|__|	**IV Block** (0=No, 1=Yes, 9=Fully paced or Unknown)
if yes, fill to right	**|__| Pattern** (1=Left, 2=Right, 3=Indeterminate)
	|__| Complete (QRS interval=.12 sec or greater)(0=No, 1=Yes, 9=Unknown)
	|__| Incomplete (QRS interval = .10 or .11 sec) (0=No, 1=Yes, 9=Unknown)
|__|	**Hemiblock** (0=No, 1=Left Ant, 2=Left Post, 9=Fully paced or Unknown)
|__|	**WPW Syndrome** (0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unknown)
	Arrhythmias
|__|	**Atrial premature beats** (0=No, 1=Atr, 2=Atr Aber, 9=Unknown)
|__|	**Ventricular premature beats** (0=No, 1=Simple, 2=Multifoc, 3=Pairs, 4=Run, 5=R on T, 9=Unk)
|__|__|	**Number of ventricular premature beats in 10 seconds** (see 10 second rhythm strip)

EXAM 6 [_____] ID type/ID [_____]Last Name, First Name

Electrocardiograph-Part II

|6|0|3|2|3| FORM NUMBER **(SCREEN 23)**

	Myocardial Infarction Location	
|__| **Anterior**	**(0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unknown)**
|__| **Inferior**	
|__| **True Posterior**	
	Left Ventricular Hypertrophy Criteria	
|__| **R > 20mm in any limb lead**	**(0=No, 1=Yes, 9=Fully paced, Complete LBBB or Unk)**
|__| **R > 11mm in AVL**	
|__| **R in lead I plus S ≥ 25mm in lead III**	
	Measured Voltage	
*|__|__|	**R AVL in mm (at 1 mv = 10 mm standard) Be sure to code these voltages**	
*|__|__|	**S V3 in mm (at 1 mv = 10 mm standard) Be sure to code these voltages**	
	R in V5 or V6-----S in V1 or V2	
|__| **R≥ 25mm**	**(0=No, 1=Yes, 9=Fully paced, Complete LBBB or Unk)**
|__| **S≥= 25mm**	
|__| **R or S ≥ 30mm**	
|__| **R + S ≥ 35mm**	
|__| **Intrinsicoid deflection ≥ .05 sec**	
|__| **ST depression**	
	Hypertrophy, enlargement, and other ECG Diagnoses	
|__| **Nonspecific S-T segment abnormality**	**(0=No, 1=Yes, 2=Maybe, 9=Paced or Unk)**
|__| **Nonspecific T-wave abnormality**	
|__| **U-wave present**	
|__| **Atrial enlargement (0=None, 1=Left, 2=Right, 3=Both, 9=Atrial fib. or Unknown)**	
|__| **RVH (0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unknown; If complete RBBB present, RVH=9)**	
|__| **LVH (0=No, 1=LVH with strain, 2=LVH with mild S-T Segment Abn, 3=LVH by voltage only, 9=Fully paced or Unkn, If complete LBBB present, LVH=9)**	

Comments and Diagnosis_____

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EXAM 6 [_____] ID type/ID [_____]Last Name, First Name

Clinical Diagnostic Impression--Part I

|6|0|3|2|4| FORM NUMBER **(SCREEN 24)**

Coronary Heart Disease First Examiner Opinions		
|__|	**Angina Pectoris**	**0=No, 1=Yes, 2=Maybe, 9=Unknown**
|__|	**Coronary Insufficiency**	
|__|	**Myocardial Infarct**	

Other Heart Diagnoses First Examiner Opinions		
|__|	**Rheumatic Heart Disease**	**0=No, 1=Yes, 2=Maybe, 9=Unknown**
|__|	**Aortic Valve Disease**	
|__|	**Mitral Valve Disease**	
|__|	**Other Heart Disease (includes congenital)**	
|__|	**Congestive Heart Failure**	
|__|	**Arrhythmia**	
|__|	**Functional Class-New York Heart Assoc. Classification** 0=None 1=Ordinary physical activity, does not cause symptoms 2=Ordinary physical activity, results in symptoms 3=Less than ordinary physical activity results in symptoms 4=Any physical activity results in symptoms	

Comments CDI Heart

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EXAM 6 [_____] ID type/ID [_____]Last Name, First Name

Clinical Diagnostic Impression--Part II

|6|0|3|2|5| FORM NUMBER **(SCREEN 25)**

Peripheral Vascular Disease First Examiner Opinions		
|__|	**Intermittent Claudication**	
|__|	**Other Peripheral Vascular Disease**	**0=No, 1=Yes, 2=Maybe, 9=Unknown**
|__|	**Stem Varicose Veins**	
|__|	**Phlebitis**	
|__|	**Other Vascular Diagnosis**	
		(Specify)_____	

Cerebrovascular Disease First Examiner Opinions		
|__|	**Stroke**	
|__|	**Transient Ischemic Attack (TIA)**	**0=No, 1=Yes, 2=Maybe, 9=Unknown**
|__|	**Dementia**	
|__|	**Parkinson's Disease**	
|__|	**Other Neurological Disease**	
		(Specify)_____	

Comments CDI
Neurological_____

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EXAM 6 [_____] ID type/ID [_____]Last Name, First Name

Clinical Diagnostic Impression--Part III

|6|0|3|2|6| FORM NUMBER **(SCREEN 26)**

Non Cardiovascular Diagnoses First Examiner Opinions		
|__|	**Diabetes Mellitus**	
|__|	**Urinary Tract Disease**	
|__|	**Prostate Disease**	**0=No, 1=Yes, 2=Maybe, 9=Unknown**
|__|	**Renal Disease**	
|__|	**Emphysema**	
|__|	**Chronic Bronchitis**	
|__|	**Pneumonia**	
|__|	**Asthma**	
|__|	**Other Pulmonary Disease**	
|__|	**Gout**	
|__|	**Degerative joint disease**	
|__|	**Rheumatoid arthritis**	
|__|	**Gallbladder disease**	
|__|	**Other non C-V diagnosis (for cancer, see special screen)**	

Comments CDI Other Diagnoses_____

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EXAM 6 [_____] ID type/ID [_____]Last Name, First Name

Second Examiner Opinions in Interim

|6|0|3|2|7| FORM NUMBER **(SCREEN 27)**

|__|__|__| **2nd Examiner ID Number**	_____**2nd Examiner Last Name**

Coronary Heart Disease Second Examiner Opinions		
|__|	Congestive Heart Failure	0=No, 1=Yes, 2=Maybe, 9=Unknown
|__|	Cardiac Syncope	
|__|	Angina Pectoris	
|__|	Coronary Insufficiency	
|__|	Myocardial Infarct	

Comments about chest and heart disease

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Intermittent Claudication Second Examiner Opinions		
|__|	Intermittent Claudication	0=No, 1=Yes, 2=Maybe, 9=Unknown

Comments about peripheral vascular disease

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Cerebrovascular Disease Second Examiner Opinions		
|__|	Stroke	0=No,1=Yes, 2=Maybe, 9=Unknown
|__|	TIA	

Comments about possible Cerebrovascular Disease

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