

Initials and code number of person performing Fecal Occult Blood Test readings in question 9.

a. Initials _____

b.

7. 1
 2

7. Was blood seen for complete blood count?

1) No.....

2) Yes.....

II. URINALYSIS

Check the one appropriate result for each test.

	Neg.	Trace	30 mg or +	100 mg or ++	300 mg or +++	1000 mg or ++++
8.1 Protein	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3	<input type="text"/> 4	<input type="text"/> 5	<input type="text"/> 6
8.2 Glucose	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3	<input type="text"/> 4	<input type="text"/> 5	<input type="text"/> 6
8.3 Occult Blood	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3	<input type="text"/> 4	<input type="text"/> 5	<input type="text"/> 6

III. FECAL OCCULT BLOOD TEST

TEST RESULTS	Test #	Date (Month/Day/Year)	Results	
			Neg.	Pos.
9.1	1	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> 1	<input type="text"/> 2
9.2	2	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> 1	<input type="text"/> 2
9.3	3	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> 1	<input type="text"/> 2
9.4	4	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> 1	<input type="text"/> 2
9.5	5	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> 1	<input type="text"/> 2
9.6	6	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> 1	<input type="text"/> 2

HEMATOLOGY DATA FORM

CBCA

Subject ID Number:

Contact Year:

Instructions: This form is to be completed each annual visit where blood was drawn. See General Instructions, Section III.A for numeric information.

1. Date of Visit: / /
Month Day Year

2. Last Name:

Initials:
1st 2nd

3. White Blood Count, $\times 10^3$ /cmm.....

3. .

4. Red Blood Count, $\times 10^6$ /cmm.....

4. .

5. Hemoglobin, g/100 ml.....

5. .

6. Hematocrit (%).....

6.

7. Initials and code number of person completing this form.

a. Initials: _____

7. Code Number

b.

DEFINITIVE EVENT CODING FORM

DECA (1-4)

Subject ID Number: (5-13)

Contact Year: (14-15)

Event Identifier: (16-17) M.F.#

For CPR Use Only (18-23)

Instructions: This form must be sent to the CPR within 60 days of sending the Provisional Event Notification form. A copy of the hospital record must be obtained and kept in the participant's clinic file. Another copy of the hospital record must be sent to the CPR with a Cover Sheet for a hospital record. Use this form to document all events. The event identifier number and event date must match those on the Linking Form (SEL).

1. Today's Date: / / (24-29)
Month Day Year

2. Last Name: (30-41)

Initials: (42-43)

3. Date of Event: / / (44-49)
Month Day Year

I. HOSPITALIZATION INFORMATION

4. Dates of Hospitalization: 1) From: / / (50-55)
Month Day Year

2) To: / / (56-61)
Month Day Year

Code "00-00-00" as ending date of hospitalization for subjects who are still hospitalized; from and to date can be the same. If not hospitalized draw a line through both dates.

Comments:

II. DIAGNOSES

5. FATAL EVENTS (Check appropriate box)

- 1) Cardiovascular death..... 1
- 2) Cancer death..... 2
- 3) Other death..... 3 (62)

If Q5.3, specify cause:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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(63-92)

6. NON-FATAL EVENTS

Enter the diagnoses listed on face sheet of the hospital record. If the face sheet is not obtainable, enter the discharge diagnosis. Additional diagnoses should be entered as required. Do not enter historical diagnoses.

6.1 Primary Diagnosis
Specify: _____

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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(93-96)

6.2 Additional Diagnoses

1) Specify: _____

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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(97-100)

2) Specify: _____

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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(101-104)

6. CPR USE ONLY

6. NON-FATAL EVENTS (continued)

6.2 3) Specify: _____

4) Specify: _____

5) Specify: _____

6.2 CPR USE ONLY

3)

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 (105-108)

4)

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 (109-112)

5)

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 (113-116)

III. OPERATIVE PROCEDURES

Enter below the procedures listed on the face sheet of the subject's hospital record. If a face sheet is not obtainable, list the operative procedures performed as indicated in the hospital record.

7. Procedures

1) Specify: _____

2) Specify: _____

3) Specify: _____

4) Specify: _____

7. CPR USE ONLY

1)

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 (117-119)

2)

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 (120-122)

3)

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 (123-125)

4)

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 (126-128)

8. Source of Diagnoses:

Code LRC criteria if LRC event has occurred and face sheet diagnosis is different.

1) Face Sheet..... 1

2) Discharge Diagnoses..... 2

3) LRC Criteria..... 3

4) Death Certificate..... 4 (129)

9. Initials and code number of person completing this form.

1) Initials: _____ 1)

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 (130-131)

10.

1) Initials of CPR coder: 1)

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 (132-133)

2) Initials of CPR reviewer: 2)

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 (134-135)

13. Are you presently taking any of the following drugs to lower cholesterol?

- 1) No.....
- 2) Yes.....

If "Yes", check the appropriate box(es) of the lipid lowering drug(s) presently being taken and enter the number of times per day each drug is being taken.

Medication	Taken	Time/Day
13.1 colestipol Colestid	<input type="checkbox"/> 1	<input type="checkbox"/>
13.2 cholestyramine Questran	<input type="checkbox"/> 2	<input type="checkbox"/>
13.3 clofibrate Atromid-S	<input type="checkbox"/> 3	<input type="checkbox"/>
13.4 nicotinic acid (niacin) Nicobid, Nico-Span, etc.	<input type="checkbox"/> 4	<input type="checkbox"/>
13.5 siosterols Cytellin	<input type="checkbox"/> 5	<input type="checkbox"/>
13.6 probucol Lorelco	<input type="checkbox"/> 6	<input type="checkbox"/>
13.7 dextrothyroxine Choloxin	<input type="checkbox"/> 7	<input type="checkbox"/>
13.8 gemfibrozil Lopid	<input type="checkbox"/> 8	<input type="checkbox"/>
13.9 mevinolin	<input type="checkbox"/> 9	<input type="checkbox"/>
13.10 Other	<input type="checkbox"/> 0	<input type="checkbox"/>

Name of drug: _____

14. Are you presently taking any other prescription drugs?

- 1) No.....
 - 2) Yes.....
- If "Yes", please specify: _____

Please give name of drug(s) and dosage(s) for clinic staff.

FOOD ITEM

	(1) More than once/day	(2) Once/day	(3) 3-6 times/week	(4) Once or twice/week	(5) Once/month or less	(6) Never
10.24 Non-dairy sour cream.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.25 Stick margarine.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.26 Tub (soft) margarine.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.27 Cheese (American, processed, Swiss, and other).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.28 Pies, cakes, cookies.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.29 Sweet rolls, buns, coffee cake, waffle, doughnut.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.30 Snack type crackers, potato chips.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.31 French fries.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.32 Ready to serve mixed dishes or meals, i.e., TV dinners.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. Are you currently on a cholesterol-lowering diet?

- 1) No.....
- 2) Yes.....

12. Are you currently on any other type of diet?

- 1) No.....
 - 2) Yes.....
- If "Yes", please specify: _____

15. Are you presently taking any non-prescription drugs?

1) No..... 1 2

2) Yes..... 1 2

If "Yes", please specify: _____

Please have name of drug(s) and dosage(s) for clinic staff.

16. In the past year year, have you been involved in any other clinical studies?

1) No..... 1 2

2) Yes..... 1 2

If "Yes", please specify: _____

17. How many aspirin tablets do you consume in an average week?.....

In the past year, have you experienced any of the following symptoms?

18.1 Pain or discomfort in your chest..... 1 2

18.2 Pressure or heaviness in your chest..... 1 2

18.3 A change in bowel habits..... 1 2

18.4 Bleeding from rectum or urinary bladder..... 1 2

18.5 A persistent cough..... 1 2

18.6 A sore on your skin or in your mouth which has not healed..... 1 2

18.7 Pain in either leg on walking..... 1 2

18.8 Abdominal pain..... 1 2

18.9 Unexplained weight loss..... 1 2

18.10 Difficulty swallowing..... 1 2

18.11 Heartburn..... 1 2

In the past year, have you been hospitalized or diagnosed as having any of the following illnesses?

19.1 Heart attack..... 1 2

19.2 Other heart disease..... 1 2

19.3 Stroke..... 1 2

19.4 Malignant tumor or growth (cancer)..... 1 2

19.5 Benign tumor or growth..... 1 2

19.6 Leukemia..... 1 2

19.7 High blood pressure..... 1 2

19.8 Active peptic ulcer..... 1 2

19.9 Other diseases of the stomach or intestines..... 1 2

19.10 Gallbladder disease..... 1 2

19.11 Back trouble (Lumbar and Disk disease)..... 1 2

19.12 Other Specify: _____ 1 2

<p>In the past year, have you had the following surgery performed?</p> <p>20.1 Coronary bypass.....</p> <p>20.2 Coronary angioplasty.....</p> <p>20.3 Other Specify operations: _____</p> <p>_____</p> <p>_____</p>	<p>No Yes</p> <p><input type="checkbox"/> 1 <input type="checkbox"/> 2</p> <p><input type="checkbox"/> 1 <input type="checkbox"/> 2</p> <p><input type="checkbox"/> 1 <input type="checkbox"/> 2</p>
<p>In the past year, have you had any of the following procedures performed?</p> <p>21.1 Endoscopic examination of the colon and rectum.....</p> <p>21.2 Endoscopic examination of the esophagus, stomach and/or duodenum.....</p> <p>21.3 X-ray of the gastrointestinal tract.....</p> <p>21.4 Coronary angiography.....</p> <p>21.5 Biopsy.....</p> <p>21.6 Other Specify procedures: _____</p> <p>_____</p> <p>_____</p>	<p>No Yes</p> <p><input type="checkbox"/> 1 <input type="checkbox"/> 2</p> <p><input type="checkbox"/> 1 <input type="checkbox"/> 2</p> <p><input type="checkbox"/> 1 <input type="checkbox"/> 2</p> <p><input type="checkbox"/> 1 <input type="checkbox"/> 2</p> <p><input type="checkbox"/> 1 <input type="checkbox"/> 2</p> <p><input type="checkbox"/> 1 <input type="checkbox"/> 2</p>