Annual Follow-up Record of Calls

FORM CODE: ARC
VERSION B 10/12/05

PARTICIPANT ID NUMBER: | | | | | | | | CONTACT YEAR: | |

LAST NAME: | | | | | | | | | | | | | INITIALS: | |

DATE OF BASELINE VISIT: | | | / | | | / | | | | |
m m d d y y y y

EARLIEST DATE OF CONTACT: | | | / | | | / | | | | |
m m d d y y y y

TARGET CONTACT DATE: | | | / | | | / | | | | |
m m d d y y y y

LATEST CONTACT DATE: | | | / | | | / | | | | |
m m d d y y y y

INSTRUCTIONS: Use this form to record every call to the participant. Complete as indicated, including appropriate Result Codes.

A. RECORD OF CALLS

	A. Day of Week	B. Date mm/dd/yyyy	C. D. Time	E. Int. ID	F. Result Code *	G. Notes
1.	S M T W H F A	/ /	A P			
2.	S M T W H F A	/ /	A P			
3.	S M T W H F A	/ /	A P			
4.	S M T W H F A	/ /	A P			
5.	S M T W H F A	/ /	A P			
6.	S M T W H F A	/ /	A P			

* RESULT CODES [ENTER AND CIRCLE THE FINAL SCREENING RESULT CODE IN ITEM 15.f] (Continue on next page)

A AFU letter sent
B No action taken
C No answer
D Busy signal
E Answering machine
F Privacy block
G Disconnected/ Non-working number
H Recording / # Change rescheduled
I Participant does not live here/ unknown
J Participant lived here, but moved permanently
K Tracing
L Physically/mentally incompetent
M Language barrier
N Contacted, interview complete
O Contacted, interview partially complete or
P Contacted, interview refused
Q Reported alive, will continue to attempt to contact this year
R Reported alive, contact not possible this year
S Reported deceased
T Unknown
U Does not want further contact
V Other
W ARIC AFU
X Exam scheduled
Y Clinic exam not scheduled, pending
Z Clinic exam not scheduled, refused

[ENTER COMMENTS IN NOTES ABOVE FOR CODES H, J, K, L, M, N, O, R, U, V, Z]

B. THE SOURCE OF INFORMATION FOR ARC RESULT CODES L, Q, R and S

Source's Name

Number/Street/RFD

n n n – n n n – n n n n
Telephone Number

City

State

Zip Code

RECORD OF CALLS (cont'd)

	A. Day of Week	B. Date mm/dd/yyyy	C. D. Time	E. Int. ID	F. Result Code *	G. Notes
7.	S M T W H F A	/ /	A P			
8.	S M T W H F A	/ /	A P			
9.	S M T W H F A	/ /	A P			
10.	S M T W H F A	/ /	A P			
11.	S M T W H F A	/ /	A P			
12.	S M T W H F A	/ /	A P			
13.	S M T W H F A	/ /	A P			
14.	S M T W H F A	/ /	A P			
15.	FINAL CODE OFFICE USE ONLY					

* RESULT CODES [ENTER AND CIRCLE THE FINAL SCREENING RESULT CODE IN ITEM 15.f]

A AFU letter sent
B No action taken
C No answer
D Busy signal
E Answering machine
F Privacy block
G Disconnected/ Non-working number
H Recording / # Change
I Participant does not live here/ unknown
J Participant lived here, but moved permanently
K Tracing
L Physically/mentally incompetent
M Language barrier
N Contacted, interview complete
O Contacted, interview partially complete or Rescheduled
P Contacted, interview refused
Q Reported alive, will continue to attempt to contact this year
R Reported alive, contact not possible this year
S Reported deceased
T Unknown
U Does not want further contact
V Other
W ARIC AFU
X Clinic exam schedule
Y Clinic exam not scheduled, pending
Z Clinic exam not scheduled, refused

[ENTER COMMENTS IN NOTES ABOVE FOR CODES H, I, K, L, M, N, P, Q, R, U, V, Z]

16. Does participant live within official JHS boundaries? ..... Yes 1
No 2
Unknown 3

Body Composition Form

FORM CODE: BCF
VERSION A 10/17/2005

ID NUMBER: | | | | | | | | CONTACT: | 0 | 6 |

LAST NAME: | | | | | | | | | | | | | INITIALS: | | |

INSTRUCTIONS: This form is to be completed during the participant's clinic 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 using a paper form 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 correct code corresponding to the most appropriate response. If a number is circled incorrectly, mark through it with an "X" and circle the correct response.

A. PRELIMINARY INFORMATION

1. When was the last time you had anything to drink including water?..... TIME | | | | |
h h m m

2. If you drink alcohol, have you had any alcoholic beverages in the last 48 hours? .....

Don't drink alcohol	1
Yes	2
No	3
Don't Know	7
Refused	8
Missing	9

3. Have you engaged in any moderate or vigorous physical activity within the past 12 hours? .....

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

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 COMPARABBILITY 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:

Balance beam/wall only (Complete Section C **ONLY**)	1
Tanita body composition only (Complete Section D **ONLY**)	2
Both (Complete Section C **AND** D)	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/m^2
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) ..... [ ][ ][ ].[ ] %

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: ..... | | | |

Fasting Form

FORM CODE: FTR
VERSION B 10/07/2005

ID NUMBER: | | | | | | | | CONTACT YEAR: | 0 | 6 |

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.

1. Date of clinic visit: ..... | | | / | | | / | | | | |
m m d d y y y y

2. Date of fasting determination: ..... | | | / | | | / | | | | |
m m d d y y y y

3a. Time: ..... | | | | |
h h m m

4. When was the last time you ate or drank anything except water?

4a. Day last consumed: .....

Today	1
Yesterday	2
Before Yesterday	3
Don't Know	7
Refused	8
Missing	9

4b. Time last consumed: ..... | | | | |
h h m m

5. Computed fasting time: ..... | | | | | h h m m

6. Have you given blood within the last 7 days? ..... Yes 1

No 2

Don't Know 7

Refused 8

Missing 9

7. Method of data collection: ..... Computer 1

Paper form 2

8. Data Collected: ..... In house 1

Off Site 2

9. Code number of person completing this form: ..... | | |

Finger Stick

FORM CODE: FST
VERSION A 10/07/2005

ID NUMBER: | | | | | | | | CONTACT YEAR | 0 | 6 |

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: ..... ☐☐☐

Health History Form

FORM CODE: HHX
VERSION A 08/16/2005

ID NUMBER: | | | | | | | | CONTACT YEAR: | 0 | 6 |

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 | | pounds 3b | | ounces

Don't know	77
Refused	88
Missing	99

4a. Were you breast fed? ..... Yes 1

No 2

Don't Know 7

Refused 8

Missing 9

→ Go to Item 5a

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

Don't Know 7

Refused 8

Missing 9

→ Go to Item 6

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 → Go to Item 9a

Refused 8

Missing 9

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 → Go to Item 10a

Refused 8

Missing 9

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 → Go to Item 11a

Refused 8

Missing 9

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 → Go to Item 12a

Refused 8

Missing 9

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 — Go to Item 13a

Refused 8

Missing 9

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 — Go to Item 14a

Refused 8

Missing 9

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

Don't know 7

Refused 8

Missing 9

→ Go to Item 15a

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

Don't know 7

Refused 8

Missing 9

→ Go to Item 16a

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

Don't know 3

Refused 8

Missing 9

→ Go to Item 17a

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 → Go to Item 18a

Refused 8

Missing 9

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

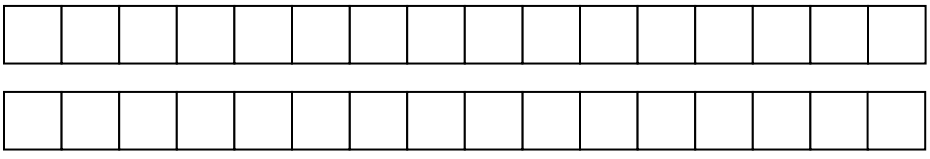
No 2

Don't know 7 → Go to Item 19

Refused 8

Missing 9

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	Go to Item 23
Refused	8	
Missing	9	

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 → Go to Item 24

Refused 8

Missing 9

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 REPONSE 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

ADMINISTRATIVE INFORMATION

28. Date of data collection: …….. | | | / | | | / | | | | |
m m d d y y y y

29. Method of data collection: ..... Computer 1

Paper 2

30. Data Collected ..... In-Clinic 1

Off – Site 2

31. Code number of person completing this form: ..... | | | |

Medical History Form

FORM CODE: MHX
VERSION B 08/13/2005

ID NUMBER: | | | | | | | | CONTACT: | 0 | 6 |

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. SLEEP

"The following questions are about your medical history. First I'd like to ask about your sleep. Using this response card **[RC #1]**, please tell me which response best describes your sleep behavior."

	Never	Seldom	Some-times	Often	Almost Always
1. You are told that you snore loudly and bother others	1	2	3	4	5
2. You are told that you stop breathing ("hold your breath") in sleep	1	2	3	4	5
3. You fall asleep during the day, particularly when not busy	1	2	3	4	5
4. You are tired after sleeping	1	2	3	4	5
5. You feel sleepy or fall asleep while driving	1	2	3	4	5

"The next two questions are about your usual sleep habits during the past month only. We are interested in the majority of days and nights in the past month."

6. During the past month, how would you rate your sleep quality overall? Would you say it was excellent, very good, good, fair, or poor?

Excellent	1
Very good	2
Good	3
Fair	4
Poor	5

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

No 2

Go to Item 32 — Don't Know 7

Refused 8

Missing 9

9. Do you get it when you walk uphill or hurry?..... Yes 1

Go to Item 29 — 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

No 2

Go to Item 29 — 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

Go to Item 29 — Don't Know 7

Refused 8

Missing 9

13. How soon? ..... 10 minutes or less 1

More than 10 minutes 2

Go to Item 29 — Don't Know 7

Refused 8

Missing 9

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

	Yes	No	Don't Know	Refused	Missing
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

Go to Item 15

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

Go to Item 18 — Don't know 7

Refused 8

Missing 9

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

Go to Item 22 — 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
Go to Item 26 — 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
Go to Item 32 — 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

Go to Item 35 → 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

Go to Item 37 → 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

Go to Item 46 — 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

Go to Item 46 — 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 you 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
Go to Item 52c — Don't know 7
Refused 8
Missing 9

52b2. Specify:

52c. Carotid endarterectomy: ..... Yes 1
Go to Item 52e1 — No 2
Don't know 7
Refused 8
Missing 9

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.

	Yes	No	Don't Know	Refused	Missing
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: 0 6

LAST NAME: | | | | | | | | | | | |

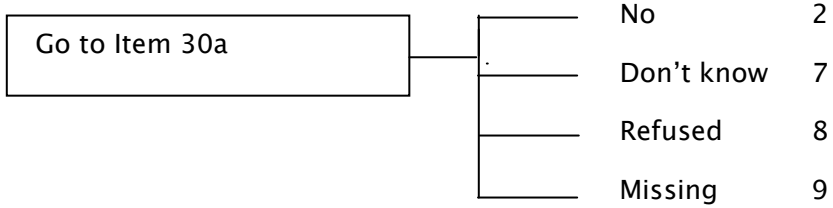
INITIALS: | | |

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



2. Did you bring all the medications you used in the past two weeks, or their containers? This includes all prescription medications, all over-the-counter medications, all vitamins, minerals, herbs and dietary supplements? .....

Go to Item 4: Begin transcription while participant proceeds with clinic visit.

- Yes, all 1
- Some of them 2
- None (forgot/unable) 3
- Don't Know 7
- Refused 8
- Missing 9

Go to Item 3a to determine follow up options for medications they did not bring.

Go to Item 4 and transcribe those medications which were brought at this time.

"That's alright. Since the information on medications is so important, we would still like to ask you about it during the interview."

3a. Could we follow up on this after the visit so that we can get the information from the (other) medication labels? **[EXPLAIN FOLLOW-UP OPTIONS]** ..... Yes 1

ATTEMPT TO CONVERT REFUSALS; INDICATE ON ITINERARY FORM

Go to Item29a

- No (don't want a follow-up) 2
- Insist to list by memory 3
- Don't know 7
- Refused 8
- Missing 9

3b. Describe method of follow-up to be used:

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.

	INITIAL VISIT – 1 OR FOLLOW-UP – 2	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.	B CONCENTRATION	C INSTRUCTIONS FOR ADMINISTRATION	D "DID YOU TAKE THIS MEDICATION IN PAST 24 HOURS?" 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
					1 2 7 8 9	1 2 7 8 9
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

	INITIAL VISIT – 1 OR FOLLOW–UP – 2	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.	B CONCENTRATION	C INSTRUCTIONS FOR ADMINISTRATION	D "DID YOU TAKE THIS MEDICATION IN PAST 24 HOURS?" 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 1

Some medications taken in the past 2 weeks 2

None of the medications taken in the past 2 weeks 3

Don't know 7

Refused 8

Missing 9

27h. What is the reason that information on all medications was not provided .....

Can't find the container(s), bottle 1

Can't read the label(s) 2

Don't Know 7

Refused 8

Missing 9

27i. Other: Specify:

27j. Code number of person completing follow-up .....

27k. Date of follow-up.....

m m / d d / y y y y

END HERE FOR FOLLOW-UP CONTACT

28a Code Number of medication coder: .....

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.]

	Yes	No	Don't Know	Refused	Missing
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."

	Reason Indicated	Not a Reason	Don't Know	Refused	Missing

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

Go to Item 34a

No 2
Don't know 7
Refused 8
Missing 9

"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

Go to Item 34a

No 2
Don't know 7
Refused 8
Missing 9

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

No 2 → Go to Item 35a

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?

36a. Epsom Salts? ....Yes 1

Go to Item 37a — No 2

Don't know 7

Refused 8

Missing 9

36b. How many days during the past 2 weeks? .... [ ][ ] Days

36c. For what purpose?

37a. Lemon juice or lemon? .... Yes 1

Go to Item 38a — No 2

Don't Know 7

Refused 8

Missing 9

37b. How many days during the past 2 weeks? .... [ ][ ] Days

37c. For what purpose?

38a. Garlic? .... Yes 1

[Go to Item 39a] — No 2 / Don't Know 7 / Refused 8 / Missing 9

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

38b. How many days during the past 2 weeks? .... [ ][ ] Days

38c. For what purpose?

[ ]

39a. Teas? .... Yes 1

[Go to Item 40a] — No 2 / Don't Know 7 / Refused 8 / Missing 8

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

39b. How many days during the past 2 weeks? .... [ ][ ] Days

39c. For what purpose?

[ ]

39d. Specify type:

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

40a. Roots? ..... Yes 1

Go to Item 41a — No 2

Don't Know 7

Refused 8

Missing 9

40b. How many days during the past 2 weeks? ..... Days

40c. For what purpose?

40d. Specify type:

41a. Have you taken any other home remedies, teas, roots or herbs in the last 2 weeks? ..... Yes 1

Go to Item 42a — No 2

Don't Know 7

Refused 8

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
Go to Item 43	Don't Know	7
Go to Item 43	Refused	8
Go to Item 43	Missing	9

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

Heart	1	Go to Item 42d
Other	2	
Don't Know	7	
Refused	8	

Missing 9

42c. For what other 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: .....

		/			/				
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: ..... | | | |

Medication Survey Follow-Up Form

FORM CODE: FUP
VERSION A 08/09/2005

ID NUMBER: | | | | | | | |

CONTACT YEAR: 0 6

LAST NAME: | | | | | | | | | | | | |

INITIALS: | | |

INSTRUCTIONS: This form is completed during a follow up telephone call to the participant (or walk in visit to the clinic) to obtain information on medications that were not brought to the clinic visit, or to clarify information (e.g. medication with an 888 or 999 data entry code on the MSR form). This follow up form should be completed immediately after the clinic visit, but under no circumstances should it be completed more than three months follwoing the participant's clinic visit. It is to be completed by appropriately trained persons at the workstations. 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.

Instruct the participant to obtain all of her or his medications taken during the past 2 weeks. 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. MEDICATION TRANSCRIPTION

Ask if the participant has all of her/ his medications available. Remind the participant that we are interested in ALL medications including *prescription medications, over the counter medications, cold or allergy pills, herbals, vitamins, and other remedies.* Ask the participant to take one medication bottle at a time and respond to each question as you ask it. Transcribe the NAME followed by the CONCENTRATION and INSTRUCTIONS FOR ADMINISTRATION of each medication in the spaces below. Ask the respondent to read the complete list of ingredients for nutritional supplements and list each one (continue on the second line if needed). If the participant brings medications to the clinic, make a copy of the bottle and label it with the participant's JID. Before ending, ask *Are there any other medications that you took during the past two weeks, that is, any other prescription medications, over the counter medications, cold or allergy pills, herbals, vitamins, or anything else?*

	A MEDICATION NAME ENTER NAME EXACTLY AS PRINTED ON LABEL. ENTER "888" …. IF UNCLEAR…INCLUDE YOUR BEST EFFORT AT TRANSCRIBING "999' IF MEDICATION CANNOT BE TRANSCRIBED AND NOTE REASON IN NOTES.	B CONCENTRATION	C INSTRUCTIONS FOR ADMINISTRATION	D "DID YOU TAKE THIS MEDICATION IN PAST 24 HOURS?" 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
1.	_____	_____	_____	1 2 7 8 9	_____ 7 8 9
2.	_____	_____	_____	1 2 7 8 9	_____ 7 8 9
3.	_____	_____	_____	1 2 7 8 9	_____ 7 8 9
4.	_____	_____	_____	1 2 7 8 9	_____ 7 8 9
22	_____	_____	_____		

23. Participant has provided information on:

All medications taken in past 2 weeks ..... 1 → Go to Item 24

Some medications taken in past 2 weeks 2

None of the medications taken in the past 2 weeks 3

Don't know 7

Refused 8

Missing 9

23a. What is the reason that information on all medications was not provided?

Can't find the container(s), bottle(s 1

Can't read the label(s 2

None of the medications taken in the past 2 weeks 3

Don't know 7

Refused 8

Missing 9

23b. Specify:

B. 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.]

		Yes	No	Don't Know	Refused	Missing
24a.	High blood pressure?	1	2	7	8	9
24b.	High blood cholesterol?	1	2	7	8	9
24c	Angina or chest pain?	1	2	7	8	9
24d.	Control of heart rhythm?	1	2	7	8	9
24e.	Heart failure or fluid on the lungs?	1	2	7	8	9
24f.	Blood thinning?	1	2	7	8	9
24g.	Diabetes or high blood sugar?	1	2	7	8	9
24h.	Stroke?	1	2	7	8	9
24i.	Leg pain when walking?	1	2	7	8	9

C. ADMINISTRATIVE INFORMATION

25. Date of data collection: ..... | | | / | | | / | | | | |
m m d d y y y y

26. Method of data collection: ..... In clinic 1
By phone 2
Off site 3

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

28. Code number of person completing this form: ..... | | | |

29. Code number of medication coder..... | | | |

PARTICIPANT EVALUATION OF CLINIC VISIT

FORM CODE: PEC
VERSION B 8/15/2005

CONTACT YEAR: | | |

Date of Data Collection: | | | / | | | / | | | | |
m m d d y y y y

Interviewer ID: | | | |

1. On a scale of 1-10 with 1 being the worst possible experience and 10 being the best possible experience, how would you rate your clinic examination visit today? .....

2. What was the best part of the clinic examination visit?

3. What was the worst part of the clinic examination visits?

4. What changes would you like to see made so that you and others have the best possible clinic examination visit?

5. Other comments:

6. Do you have access to a computer: Yes 1

No 2

7. Have you accessed the internet information for JHS participants, including the scheduling system?

Yes 1

No 2

7a. IF YES—do you have any comments on how we can improve the web site to make it most usable for participants?

JHS Participant Itinerary Form – Exam 2

FORM CODE: PIT
VERSION B 09/28/2005

ID NUMBER: | | | | | | | | DATE: _____/___/_____ CONTACT: | 0 | 6 |

NAME: | | | | | | | | | | | | | | | | | | | |

VISIT TYPE: ___I Initial ___R Re-scheduled (If re-scheduled, go to procedure(s)/interview(s) being done at this visit)

DATE OF BIRTH _____ / _____ / _____ GENDER: ___1 Male ___2 Female TIME OF CHECK-IN: _____ : _____

1. ANY MAJOR MEDICAL PROBLEMS WE SHOULD KNOW ABOUT?

_____ Diabetes _____ Recent blackouts _____ Heart Troubles
_____ Seizure disorders _____ Surgery in past six weeks _____ Hx Aneurysms
Specify :

2. SUB/ANCILLARY STUDY PARTICIPANT? ____ YES ____ NO **3. FS PARTICIPANT?** ___ YES _____ NO

[USE THE FOLLOWING CODES FOR ALL ITEMS: **IF COMPLETE, ENTER 1** **IF INCOMPLETE, ENTER 2** **IF RESCHEDULED, ENTER 3** **IF REFUSED, ENTER 8** **IF MISSING, ENTER 9**

	4. CLINIC PRODEDURES	**Start Time**	**End Time**	**Tech Code**
_____	Reception (ICF, CON, FTR, Medications collected)	_____:_____	_____:_____	____ ____ ____
	Comment: _____			
_____	SBP..... Cuff Size _____	_____:_____	_____:_____	____ ____ ____
	Comment: _____			
_____	Body Composition	_____:_____	_____:_____	____ ____ ____
	Comment: _____			
_____	Venipuncture ..... Fast Time _____	_____:_____	_____:_____	____ ____ ____
	Comment: _____			
_____	Urine	_____:_____	_____:_____	____ ____ ____
	Comment: _____			
_____	Snack	_____:_____	_____:_____	____ ____ ____
	Comment: _____			
_____	SMBP.....	_____:_____	_____:_____	____ ____ ____
	Comment: _____			
-------	Imaging Procedures	_____:_____	_____:_____	_____ ____ _____
	CT.....	.....: .....: .....: .....:.....	....	
	Comment: _____			
	MRI.....	.....: .....: .....: .....:.....:	....	
	Comment _____			

5. INTERVIEWS

_____	Medication Survey (Comment: ……)	_____:_____	_____:_____	____	____ ____
_____	Medical History (Comment: ……)	_____:_____	_____:_____	____	____ ____
_____	Health History (Comment: ……)	_____:_____	_____:_____	____	____ ____
_____	Stroke Symptoms (Comment: ……)	_____:_____	_____:_____	____	____ ____
_____	Renal Disease (Comment ……)	_____:_____	_____:_____	____	____ ____

6. MEDICAL DATA REVIEW

_____	Medical Data Review (Comment: ……)	_____:_____	_____:_____	____	____ ____
_____	Social Work Exit Interview/Satisfaction Survey Comment: ……	_____:_____	_____:_____	____	____ ____

7. IF EXAM PROCEDURE OR INTERVIEW RESCHEDULED, PLEASE NOTE DATE AND TIME

7a. Date: _____/_____/_____ 7b. : _____:_____

INSTRUCTIONS

PART 1. USE THE FOLLOWING CODES FOR MAJOR MEDICAL PROBLEMS:

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

PART 4. IF ANY CLINIC PROCEDURE IS NOT COMPLETED, PROVIDE A COMMENT WITH THE PRIMARY REASON FOR NOT COMPLETING THE PROCEDURE USING ONE OF THE FOLLOWING CODES:

1: Computer/Equipment Malfunction
2: Overall Time Constraint
3: Participant Uncomfortable with Assessment
4: Participant has to leave due to unforeseen circumstances
5: Other

PART 5 & 6. IF ANY INTERVIEW OR MEDICAL DATA REVIEW IS NOT COMPLETED, PROVIDE A COMMENT WITH THE PRIMARY REASON FOR NOT COMPLETING IT USING ONE OF THE FOLLOWING CODES:

1: Overall Time Constraint
2: Questionnaire is too long
3: Questions are too sensitive
4: Participant has to leave due to unforeseen circumstances
5: Computer Malfunction
6: Other

Quality Control Phantom Participant & Non-Participant ID Form

FORM CODE: PNP
VERSION C 07-26-2006

ID NUMBER: | | | | | | | | CONTACT YEAR: | 0 | 6 |

LAST NAME: | | | | | | | | | | | | | INITIALS: | | |

INSTRUCTIONS: 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. ID ASSIGNMENT

1. This form is being filled out for: .....
   - A quality control (QC) phantom participant — 1
   - A non-participant — 2

2. The ID in the header of this form is the JHS ID assigned to the phantom (or non-participant). Is a laboratory ID also required for this phantom (or non-participant)? .....Yes — 1
   - Go to Item 4 — No — 2
   - Don't Know — 7
   - Refused — 8
   - Missing — 9

3. Laboratory ID assigned to phantom (or non-participant): ..... | | | | | | | | |

4. Date ID(s) assigned: ..... | | | / | | | / | | | | |
   m m d d y y y y

5. Code number of person assigning ID(s):..... | | | |

FOR NON-PARTICIPANTS, STOP HERE
FOR QC PHANTOMS, CONTINUE WITH LOGS ON PAGES 2 & 3 OF THIS FORM

B. LOG: BODY COMPOSITION (BCF) FORM ITEMS

	Item	a. Matching (real JHS ID	b. Date of Measurement (mm/dd/yyyy)	c. Tech Code
6.	Height	J	/ /	
7.	Weight	J	/ /	
8.	Waist Girth	J	/ /	
9.	Hip Girth	J	/ /	
10	Body Fat %	J	/ /	

C. LOG: SITTING BLOOD PRESSURE (SBP) FORM ITEMS

	Item	a. Matching (real) JHS ID	b. Date of Measurement (mm/dd/yyyy)	c. Tech Code
11.	Heart Rate, 1st & 2nd BP	J	/ /	

D. LOG: VENIPUNCTURE & URINE

	a. Tubes	b. Matching (real) JHS ID	c. Date of Measurement (mm/dd/yyyy)	D. Tech Code
12.	1	J	/ /	
13.	2	J	/ /	
14.	3	J	/ /	
15.	Urine	J	/ /	

E. LOG: IMAGING PROCEDURES

	a. Procedure	b. Matching (real) JHS ID	c. Date of Measurement (mm/dd/yyyy)	d. Tech Code
16.	CT	J	/ /	
17.	MRI	J	/ /	

Renal Disease Form

FORM CODE: RDF
VERSION A 08/13/2005

ID NUMBER: | | | | | | | | CONTACT YEAR: 0 6

LAST NAME: | | | | | | | | | | | | | INITIALS: | |

INSTRUCTIONS: This form should be completed during the interview portion of 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.

1. "The following are possible warning signs for kidney or urinary tract disease. Can you tell me if you experience any of these on a regular basis, that is, multiple times in the course of a week?

		Yes	No	Don't Know	Refused	Missing
1a.	Burning or difficulty urinating	1	2	7	8	9
1b.	Urgency of urination, that is, you can't hold it	1	2	7	8	9
1c.	Uncontrolled, or constant urination	1	2	7	8	9
1d.	More frequent urination, particularly at night (when you are NOT taking a diuretic or water pill)	1	2	7	8	9
1e.	Foam in the toilet after urination	1	2	7	8	9
1f.	Puffiness around your eyes or swelling of both hands and feet	1	2	7	8	9
1g.	Pain in the small of your back just below the ribs (not caused by movement)	1	2	7	8	9
1h.	Difficulty emptying your bladder	1	2	7	8	9

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

		Yes	No	Don't Know	Refused	Missing
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

Go to Item 5

4. Were you or have you ever been on kidney dialysis for more than one month? ..... Yes 1

Go to Item 5

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: 0 6

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	Go to Item 8
Don't Know	7	
Refused	8	
Missing	9	

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 {>41cm}	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:..... ☐☐

+ 3 0

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

26. Diastolic:..... | | | mm/hg

J. SECOND OMRON BLOOD PRESSURE MEASUREMENT

27. Systolic ..... | | | mm/hg

28. Diastolic..... | | | 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: .....

Self Monitored Blood Pressure Form

FORM CODE: SMP
VERSION A 10/07/2005

ID NUMBER: | | | | | | | | CONTACT YEAR: | 0 | 6 |

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. SMBP MONITOR AND INSTRUCTION

1. Was the SMBP instruction sheet given to the participant? .....

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

2. Did the technician explain the SMBP procedure to the participant? .....

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

3. Did the participant verbally agree to use the SMBP? .....

Yes	1
No → Go to Item 12a	2
Don't know	7
Refused	8
Missing	9

4a. Does the participant agree to a follow up call for SMBP? .....

Yes	1
No → Go to Item 5	2

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	→ Go to Item 13
No	2	
Don't know	7	
Refused	8	
Missing	9	

12a. Unable to use SMBP: .....

Exceeded maximum cuff size	1	→ Go to Item 17

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: ..... | | | |

Stroke Symptoms Form

FORM CODE: SSF
VERSION B 07/29/2005

ID NUMBER: | | | | | | | | CONTACT YEAR: | 0 | 6 |

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. STROKE HISTORY

1. Since your last Jackson Heart Study exam in (mm/dd /yyyy), have you been told by a physician that you had a stroke? ..... Yes 1

   Go to Item 3 — No 2

   Don't know 7

   Refused 8

   Missing 9

2. When did this stroke occur? ..... | | | / | | | | | (m m / y y y y)

B. SUDDEN LOSS OR CHANGE OF SPEECH

3. In the past 5 years, since your last Jackson Heart Study exams, have you had any sudden loss or changes in speech lasting 24 hours or longer? .... Yes 1

   No 2

   Go to Item 7 —

   Don't know 7

   Refused 8

   Missing 9

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]

	Yes	No	Don't Know	Refused	Missing
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

Go to Item 6c — 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

Go to Item 6e — 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
	Go to Item 7	No	2
		Don't know	7
		Refused	8
		Missing	9

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

No 2

Go to Item 11a

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

Go to Item 10a

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

Go to Item 10d — 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

Go to Item 10f — 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

No 2

Go to Item 14

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 [READ ALL CHOICES]	The right side only	1
	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

Go to Item 20

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 — 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]

	Yes	No	Don't Know	Refused	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

Go to Item 19d — No 2

Don't know 7

Refused 8

Missing 9

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
Go to Item 20	No	2
	Don't know	7
	Refused	8
	Missing	9

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

Go to Item 25	No	2
	Don't know	7
	Refused	8
	Missing	9

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]

	Yes	No	Don't Know	Refused	Missing
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: ..... [READ ALL CHOICES]

The right side only 1

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
	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

Go to Item 29

No	2
Don't know	7
Refused	8
Missing	9

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

Yes	1	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	
No	2	Go to Item 27d
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: ..... [READ ALL CHOICES]	The right side only	1
		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
Go to Item 28	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

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: ..... | | | |

Spot Urine Collection Form

FORM CODE: SUC
VERSION C 02-26-2009

ID NUMBER: | | | | | | | | CONTACT YEAR: | 0 | 9 |

LAST NAME: | | | | | | | | | | | | | INITIALS: | | |

INSTRUCTIONS: This form should be completed during participant's visit (or at the initiation of the procedure). 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.

1. Lab ID: …….. | | | | | | | | |

2 Date of Specimen collection: …….. | | | / | | | / | | | | |
m m d d y y y y

Unable to Collect 8

Refused 9

STUDY INITIATION

3. Did the participant verbally agree to complete the urine collection? ……..Yes 1

No 2

Don't Know 7

Refused 8

Missing 9

B. ADMINISTRATIVE INFORMATION

4. Method of data collection: …….. Computer 1

Paper Form 2

5. Data Collected: ..... In house 1

Off site 2

6. Code number of person completing this form: …….. | | | |

Venipuncture

FORM CODE: VEN
VERSION B 7/12/2006

ID NUMBER: | | | | | | | | CONTACT YEAR: | 0 | 6 |

LAST NAME: | | | | | | | | | | | | | INITIALS: | | |

INSTRUCTIONS: This form should be completed on paper during the participant's clinic visit. Verify the participant's Name and ID Number before beginning the interview or procedure. If a number or response is entered incorrectly, mark through the incorrect entry with an "X". Code the correct entry clearly above the incorrect entry.

A. BLOOD DRAWING

1. Lab ID (label): ..... | | | | | | | | |

2. Do you have any bleeding disorders? ..... Yes 1

No 2

Don't know 7

Refused 8

Missing 9

[IF YES, REVIEW SPECIAL PRECAUTIONS AND SPECIFY IN ITEM 15.]

3a. Date of blood draw: ..... | | | / | | | / | | | | |
m m d d y y y y

3b. Time of blood draw: | | | | |
h h m m

4. Number of venipuncture attempts: ..... | |

[THIS ITEM IS COMPLETED TO DOCUMENT PROBLEMS WITH THE VENIPUNCTURE. PLACE AN "X" IN BOXES CORRESPONDING TO THE TUBES IN WHICH BLOOD DRAWING PROBLEMS OCCURRED. IF A PROBLEM OTHER THAN THOSE LISTED OCCURRED, USE ITEM 5f.]

Blood Drawing Incidents:		Tubes			
		1	2	3	4
5a.	Samples not drawn				
5b.	Partial sample drawn				
5c.	Tourniquet reapplied				
5d.	Fist clenching				
5e.	Needle movement				

5f. Other problems in blood drawing:

6. Phlebotomist technician code: ..... | | | |

B. CENTRIFUGING

7a. Were tubes 1(red/gray) and 2 (lavender) drawn? .....

	Yes, both	1
Go to Item 8 ←	No	2
	Yes, tube 1 only	3
	Don't Know	7
	Refused	8
	Missing	9

7b. Time at which tubes 1 and/or 2 were centrifuged ..... | | | | |

h h m m

8. Was tube 3 (lavender) drawn? ..... Yes, 1

No 2

Don't Know 7

Refused 8

Missing 9

9. Was tube 4 (black/blue) drawn? .....

Yes, 1

No 2

Don't Know 7

Refused 8

Missing 9

C. PREPARING MICROVIALS

10. How many micro vials were prepared from tube 1? ..... ☐

11. How many micro vials were prepared from tube 2? ..... ☐

D. FREEZING

12. Time at which specimens from tubes 1 and 2 were placed into -70°C freezer? ..... ☐☐☐☐

h h m m

13. Processing technician code: ..... ☐☐☐

[THIS ITEM IS COMPLETED TO DOCUMENT PROBLEMS PROCESSING THE SPECIMENS. PLACE AN "X" IN BOXES CORRESPONDING TO THE TUBES IN WHICH PROCESSING PROBLEMS OCCURRED. IF A PROBLEM OTHER THAN THOSE LISTED OCCURRED, USE ITEM 14f.]

Blood Processing Incidents:		Tubes			
		1	2	3	4
14a.	Broken tube				
14b.	Clotted				
14c.	Hemolyzed				
14d.	Lipemic				
14e.	Other contamination				

14f. Other problems in blood processing:

15. Comments on blood drawing/processing:

F. ADMINISTRATIVE INFORMATION

16. Method of data collection: ..... Computer 1

Paper form 2

17. Data Collected . .....In house 1

Offsite 2

O.M.B: 0925-0491
exp.08/31/2010

Physician Questionnaire Form

ID NUMBER: | | | | | | | | | CONTACT YEAR: | | |

FORM CODE: PHQ
VERSION C: 05/22/2007

LAST NAME: | | | | | | | | | | | | | INITIALS: | |

Decedent's Name: _____ Age: | |

Date of Birth: | | / | | / | | | | |
month / day / year

Date of Death: | | / | | / | | | | |
month / day / year

Event ID: | | | | | | | | Sequence Number: | |

Physician's name: _____

Please complete the following and return in the enclosed envelope.

A. Medical History

1. Are you familiar with the decedent's medical history?

Yes ☐

If No, Skip to Item 5 on Page 3 —— No ☐

2. When did you last see the decedent?

| | / | | | | |
month / year

3. Did the decedent have a history of any of the following?

	Yes	No	Uncertain
a. Angina pectoris or coronary insufficiency.....	☐	☐	☐
b. Valvular disease or cardiomyopathy.....	☐	☐	☐
c. Coronary bypass surgery.....	☐	☐	☐
d. Coronary angioplasty.....	☐	☐	☐
e. Hypertension.....	☐	☐	☐
f. Myocardial infarction.....	☐	☐	☐

If MI **yes,** date of most recent event: ☐☐ / ☐☐☐☐
month year

h. Other chronic ischemic heart disease.....	☐	☐	☐
i. Stroke (CVA).....	☐	☐	☐

j. **If yes**, date of most recent event: ☐☐ / ☐☐☐☐
month year

	Yes	No	Uncertain
k. Any non-cardiac condition that might have contributed to this death.....	☐	☐	☐

If yes, specify: _____

	Yes	No	Uncertain
l. Diabetes.....	☐	☐	☐
m. Cigarette smoking.....	☐	☐	☐

4. Was the decedent taking any of the following medications within four weeks prior to death?

	Yes	No	Uncertain
a. Nitrates.....	☐	☐	☐
b. Calcium channel blockers.....	☐	☐	☐
c. Digitalis.....	☐	☐	☐
d. Beta-blockers.....	☐	☐	☐
d.1. Aspirin.....	☐	☐	☐
d.2. ACE or Angiotensin II inhibitors.....	☐	☐	☐
e. Other cardiovascular drugs.....	☐	☐	☐

If yes, specify: _____

B. Details of Death

5. Are you familiar with the events surrounding the decedent's death?

Yes ☐ No ☐

If you answered **No** to both 5 and 6 skip to Item 14. Otherwise, continue with Item 7.

6. Did you witness the death?

Yes ☐ No ☐

7. Was there any pain in the chest, left arm, shoulder or jaw within 72 hours of death?

Yes ☐ No ☐ Uncertain ☐

If **No** or **Uncertain** go to item 8.

b. Did the pain include the chest?

Yes ☐ No ☐ Uncertain ☐

c. Did you think this pain was of a cardiac origin?

Yes ☐ No ☐ Uncertain ☐

If No, specify what you think was the cause:

_____

8. Did the decedent take (or was he/she given) nitrates at the time of the acute episode?

Yes ☐ No ☐ Uncertain ☐

9. Was coronary reperfusion (intravenous or intracoronary streptokinase or TPA, angioplasty, etc.) attempted during the acute episode?

Yes ☐ No ☐ Uncertain ☐

10. Was CPR and/or cardioversion performed within 24 hours of death?

Yes ☐ No ☐ Uncertain ☐

11. Please give time between onset of acute symptoms to death. (We are defining death as the point where spontaneous breathing ceased and the patient never recovered)

- ☐ More than 3 days (A)
- ☐ 2-3 days (B)
- ☐ 1 day (C)
- ☐ At least 12 hours, but less than 24 hours (D)
- ☐ At least 4 hours, but less than 12 hours (E)
- ☐ At least 1 hour, (F) but less than 4 hours
- ☐ Less than 1 hour (G)
- ☐ Death instantaneous, (H) no symptoms
- ☐ Unknown (I)

12. Would you classify the decedent's cause of death as due to CHD?

Yes	No	Uncertain
☐	☐	☐

13. **If no**, what do you believe to be the cause of death?

	Yes	No	Uncertain
13a. Pulmonary embolism.....	☐	☐	☐
13b. Acute pulmonary edema.....	☐	☐	☐
13c. Stroke.....	☐	☐	☐
13d. Pneumonia.....	☐	☐	☐
13e. Congestive Heart Failure	☐	☐	☐
13f. Other.....	☐	☐	☐

13g. **Specify:** _____

C. Signature

14. Form completed by: _____
Signature

15. Date: ☐☐ / ☐☐ / ☐☐☐☐
month day year

Thank you very much for your help. Please return this questionnaire in the enclosed self-addressed envelope.

Office use only: 23. Self (A)_____ Interview(B)_____ ER. records(C)_____

OMB 0925-0491
08/31/2010

Surveillance Event Inventory/Linkage Form

FORM CODE: SXI
VERSION B: 10/20/2003

ID NUMBER: | | | | | | | | |

CONTACT YEAR: | | |

INITIALS: | | |

LAST NAME: | | | | | | | | | | | | |

INSTRUCTIONS: The SXI form is used for inventory, tracking, and linkage of information on Surveillance Event. It should be completed and entered into ASDES only when the field investigation for this ID number is considered closed. The Q x Q Instructions must be followed when completing this form. If new linkages are discovered subsequently, these must be reported by using ASDES to make the appropriate changes to the existing SXI Form for the Linked events.

SURVEILLANCE EVENT INVENTORY AND LINKAGE FORM

A. Inventory of Materials

1. Inventory of forms completed and keyed:

		Yes	No
a.	CEL	Y	N
b.	DTN	Y	N
c.	IFI-1	Y	N
d.	IFI-2	Y	N
e.	IFI-3	Y	N
f.	PHQ-1	Y	N
g.	PHQ-2	Y	N
h.	COR	Y	N
i.	HRA	Y	N
j.	Stroke records sent to Minnesota	Y	N
k.	Autopsy report sent to the CSCC	y	N

2. a. Is this a hospitalization — Yes Y / No N

Go to Item 3

b. Were duplicated material sent to the Minneapolis ECG Reading Center?

	Yes	No
1. First ECG	Y	N
2. Last ECG	Y	N
3. Third ECG	Y	N

B. Event Determination

3. Type of event for this ID — Out of Hospital O / In-Hospital Death I / Non-fatal Hospitalization N

Go to Item 3

3. b. Date of discharge

M M	/	D D	/	Y Y Y Y

4. Date of this event:

M M	/	D D	/	Y Y Y Y

C. Linkage Information

5. Have you identified any other ID(s) belonging to this same person? Yes Y / No N

Go to item 12.

Please enter all linkage within the last 12 months. If none, enter the most recent:

		Surveillance ID	Date of Events
6.	a.	_____	_____
7.	a.	_____	_____
8.	a	_____	_____
9.	a	_____	_____
10.	a	_____	_____
11.	a.	_____	_____

D. Administrative Information

12. Date of Collection:

13. Code number of person completing this form:

/

Clinic Appointment Form

FORM CODE: CLA
VERSION B 07/29/2005

ID NUMBER: | | | | | | | | CONTACT YEAR: 0 6

LAST NAME: | | | | | | | | | | | | | INITIALS: | |

[IF RESPONDENT IS NOT PLANNING TO COME TO THE CLINIC, GO TO ITEM 14]

"There are several points we would like to cover to make your clinic visits easier.

For your visit we ask that you fast, that is not eating or drinking anything by mouth but water and medication for 12 hours before your appointment. This means take all routine medication during this time with water only – no coke, no tea, no coffee – just water. It also means not to chew any gum, eat mints or other foods. You will be given a snack shortly after your arrival, after getting your finger stick blood sample."

1. Some medicines, such as insulin for diabetes, cannot be taken while fasting. Do you take insulin for diabetes?..... Yes 1 — "Continue to take insulin the way you normally do. You should not fast before you come to the clinic." (Go to Item 6)
   No 2

2. Do you have any medical reason why you must not fast for 12 hours? ..... Yes 1
   Go to Item 4 — No 2

   Specify: _____

   _____

3. Is it possible for you to arrange with your doctor a way to fast before you come to the clinic? ..... Yes 1 — "Good. Please do so."
   "Then it will be okay for you to eat before the visit as you normally do." [Go to Item 6] — No 2

4. Some medications can be taken fasting or delayed until the snack at the clinic. Do you have a medicine you must take for which you must not fast for 12 hours? ..... Yes 1

Go to Item 6 — No 2

Specify: _____

_____

5. Is it possible for you to arrange with your doctor a way to take this medicine and still fast, or to fast for a shorter time before you come to the clinic? ..... Yes 1 — "Good. Please do so."

"Then it will be okay for you to eat before the visit as you normally do." — No 2

6. Do you have any special diet we should consider for the clinic snack? ..... Yes 1

Go to Item 7 — No 2

Specify: _____

_____

7. Will you need any assistance getting around the clinic? ..... Yes 1

Go to Item 8a — No 2

Specify: _____

_____

8a. Will you need to have transportation provided by Jackson Heart Study in order to get your clinic appointment? ..... Yes 1

Go to Item 9 — No 2

Specify: _____

_____

8b. May we call a taxi or would you like to have a Jackson Heart Study volunteer call to arrange transportation, or shall we call a taxi? ..... JHS Volunteer 1

Taxi 2

Other 3

Specify: _____

_____

9. Will you need to have child (or adult) care provided at the Jackson Heart Study clinic while you attend your clinic appointment?..... Yes 1

Go to Item 10 — No 2

Specify: _____

_____

10. Will you need any assistance (reading/writing) with completing the paperwork? ..... Yes 1

Go to Item 11 — No 2

Specify: _____

_____

11. Do you have any other special needs for the clinic visit that we should know about? ..... Yes 1

Go to Scheduling Script — No 2

Specify: _____

_____

IF INTERVIEW PLANNED WITH ANOTHER HOUSEHOLD MEMBER, READ:
"Now I would like to interview (Name of Respondent), then we will make the appointment for your clinic examinations together."]

IF INTERVIEWS COMPLETED FOR THIS VISIT, READ:
"Now I would like to set your appointment for the clinic examination at the Jackson Medical Mall. Let me call to schedule a good time for you." [CALL (CLINIC TELEPHONE NUMBER) FOR APPOINTMENT INFORMATION AND RECORD BELOW.] **[If participant unable to make appointment, inform her/him that you will be sending instructions to schedule via internet or calling the clinic.]**

12a. APPOINTMENT STATUS: ..... Set 1

Go To Item 13a — Pending 2

Go To Item 14 — Refused 8

12b. Day of appointment: ..... Sunday 1

Monday 2

Tuesday 3

Wednesday 4

Thursday 5

Friday 6

Saturday 7

12c. Date of appointment: ..... | | | / | | | / | | | | |

m m d d y y y y

12d. Time of appointment: ..... | | | : | | |

h h m m

[REVIEW APPOINTMENT SCHEDULE, PROCEDURES.
IF RESPONDENT IS UNABLE TO SCHEDULE APPOINTMENT AT THIS TIME, SPECIFY]:

13a. Reason:

13b. Recontact Procedures:

14a. **[RECORD REASON RESPONDENT IS NOT COMING TO THE CLINIC:]**

Go to Item 15

Language barrier	1
Physically unable to attend clinic	2
Doesn't want blood drawn	3
Doesn't want to take time off work	4
Other refusal	5
Other	6

Specify other refusal/reason: _____

_____

ADMINISTRATIVE INFORMATION

15. Date of data collection: ..... | | | / | | | / | | | | |
m m d d y y y y

16. Code number of person completing this form: ..... | | | |

IF APPOINTMENT SCHEDULED, GO TO MEDICATIONS INSTRUCTIONS NEXT PAGE

Medication Instructions Information

PLEASE BRING WITH YOU TO THE CENTER...

- Prescription Drugs from your physician or health care provider
- Prescription Drugs you have been given by a friend or relative
- Non-prescription Drugs (over the counter that you obtained from a drugstore, supermarket, or by mail, such as aspirin, cold remedies, vitamins, herbals or "natural" medicines, or the likes.

THAT YOU HAVE TAKEN FROM _____ TO _____

In order to be sure you have included everything, think about the past few weeks when you may have seen a health care provider who gave you medications or you may have talked with a friend or family member who remembered you use a medicine, herb, or root for any problem you might have. For your convenience, a list of reasons why many people take medication and some possible medications is presented below to help you remember any medications you need to bring with you.

Medical conditions

Allergies
Arthritis, joint pain, for example, cortisone -type medicine, anti-inflammatory drugs
Cancer
Constipation or improve regularity
Coughs and Colds
Diabetes – for example, insulin or pills
Fever
Flu, pneumonia
Headaches
Heart problems, chest pain or angina, for example, digitalis, nitroglycerin
High Blood Pressure
Hot flashes
Infection, for example, penicillin, sulfas, other antibiotics
Pain, for example, codeine, Darvon, Percodan, Demerol, Tylenol #3/#4
Lung problems - such as asthma, lung disease, emphysema, shortness of breath, wheezing
Menstrual problems
Mood (anxiety or depression or nerves)
Nausea
Seizures
Skin problems
Sleep
Ulcers, stomach, digestion
Vascular problems, blood thinning, for example, dicumarol, coumadin
Weight reduction

Medications

Antacids –liquids or tablets
Antianxiety or antidepressants
Antihistamines
Appetite suppressants
Birth control pills
Blood thinners
Calcium supplements
Cholesterol lowering medicines
Cold remedies
Cough medicines
Decongestants
Diet pills
Digestive aids
Eye, ear or nose drops, ointments or sprays
Fish oil
Hemorrhoidals or suppositories
Herbs or folk remedies
Hormones
Iron or anemia medicines (don't forget Geritol)
Laxatives
Mineral supplements
Muscle relaxants
Sleeping pills
Steroid, cortisone
Shots or pills to lose water from your body
Thyroid
Tranquilizers
Vitamins or mineral supplements

ALL INFORMATION COLLECTED FOR THIS STUDY IS HELD IN CONFIDENCE AND USED ONLY FOR STATISTICAL RESEARCH PURPOSES

Participant Information, Exam 2

Thank you for taking part in the Jackson Heart Study Exam 2. We look forward to seeing you on your appointment date:

DAY _____ DATE _____ TIME _____ A.M.

Please come to 350 West Woodrow Wilson, Jackson Medical Mall, Jackson Heart Study Clinic. A map and parking directions are attached. Please read the following instructions carefully.

- FASTING:
  You should **NOT** eat or drink anything except water and your medications for 12 hours before your appointment time. This includes chewing gum, mints or any other food. A snack will be provided during your visit. **Except for medications that must be taken with food** (such as insulin), remember to take **ALL** your regular medicines with water before coming to the clinic. **If you are taking medicine for your blood pressure, be sure to take it as usual before you come to the Jackson Heart Study clinic.**

- SMOKING AND PHYSICAL ACTIVITY:
  Please **DO NOT** smoke or do vigorous physical activity for at least one hour before your appointment.

- CLOTHING:
  Please be prepared to change into a hospital gown after your arrival and bring or wear comfortable shoes or slippers that are easy to get on and off. Please wear loose fitting underwear and leave necklaces at home.

- MEDICATIONS:
  Please be sure to bring **ALL** your medications including prescriptions, over the counter vitamins, or herbals in their original containers. You should put these containers in the Jackson Heart Study medications bag. You may refer to the Medications Information Listing to remind you of all the possible medicines you might be taking. If you are taking insulin, bring both your insulin and syringes to the clinic so you can take it before your snack.

- GLASSES:
  If you normally use glasses for reading, please bring them with you to the clinic.

- PHYSICIAN CONTACT:
  Please complete the attached card providing the name and address of your health care provider and bring it with you to the clinic.

It is most important that you be on time for your appointment. Here is a schedule of activities for your clinic visit with average times for each activity:

Welcome and Consent	15 minutes
Height, Weight, Blood Pressure, Body Composition	20 minutes
Finger Stick Blood Drawing for glucose and cholesterol (blood lipids)	5 minutes
Medical History	50 minutes
Receive Home Blood Pressure Monitor and Instruction	30 minutes

You will also be given a light heart healthy snack after your finger stick blood tests are complete. The total exam time will be 2 hours or less.

If you have any questions or a problem with your appointment, please call the clinic at 815-5050 between 7:30 a.m. and 4:30 p.m. Tuesday through Saturday.

We look forward to seeing you.

Mary Crump, RN, MSN
Clinic Manager

and the Jackson Heart Study Staff

Request for Contact Information Form

FORM CODE: REQ PC
VERSION B 08/20/2005

ID NUMBER: | | | | | | | | CONTACT YEAR: | 0 | 6 |

LAST NAME: | | | | | | | | | | | | | INITIALS: | | |

We will provide your doctor or health care provider with the results of your tests if you would like us to. Will you please fill out the information below and **BRING IT WITH YOU TO THE CLINIC** so that we will not have to take time during the clinic visits to look up the information?

YOUR DOCTOR'S NAME: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE NUMBER: (_____) _____

Since we will be contacting you for several more years, we would like to update our information to help us locate you in the future. Remember that all information is confidential and that anyone we might contact will be told only that we are trying to locate you for a health study.Please complete the name, address, telephone number(s), and email address of three close friends or relatives who you are likely to keep in touch with (**BUT DO NOT LIVE WITH YOU),** and who are not planning to move anytime soon.

CONTACT PERSON 1

NAME: _____

STREET ADDRESS _____

CITY: _____STATE _____ ZIP CODE_____

TELEPHONE:(_____)_____CELL PHONE_(_____)_____EMAIL_____

CONTACT PERSON 2

NAME: _____

STREET ADDRESS _____

CITY: _____STATE _____ ZIP CODE_____

TELEPHONE:(_____)_____CELL PHONE_(_____)_____EMAIL_____

CONTACT PERSON 3

NAME: _____

STREET ADDRESS _____

CITY: _____STATE _____ ZIP CODE_____

TELEPHONE:(_____)_____CELL PHONE_(_____)_____EMAIL_____

Change to Statement of Participation For Exam 1

FORM CODE: SOP
VERSION A 03-26-2007

ID NUMBER: | | | | | | | | | CONTACT YEAR: | | |

LAST NAME: | | | | | | | | | | | | | INITIALS: | | |

I have reviewed my responses from Exam 1 and wish to change the following.

		Yes	No
1.	I agree to participate in the clinic and annual interviews, clinic examinations and record review.	☐	☐
2.	I agree to participate in the 24-hour blood pressure, physical activity and urine tests.	☐	☐
3.	I agree to participate in the genetic (inheritance/DNA) studies, and to provide a blood sample from which DNA will be extracted.	☐	☐
4.	If selected for participation in the Family study, will allow a living tissue sample (cell line) to be taken from a blood sample for future genetic or inheritance/DNA studies.	☐	☐
5.	I give my permission for JHS investigations to review a copy of my birth certificate.	☐	☐
6.	I give permission for JHS investigators to review a copy of my medical records.	☐	☐
7.	I would like to receive JHS results from the clinic examinations.	☐	☐
8.	I would like my health care provider to receive JHS results from the clinic examinations.	☐	☐

I agree to allow my study data to be tested by scientists studying the disease listed below.

9.	Blood pressure, heart or other cardiovascular disease, obesity, diabetes, kidney disease, or lung disease and risk factors for these diseases.	☐	☐

10. Any other major diseases or health conditions, such as arthritis. ☐ ☐

I agree to allow my genetic/DNA samples to be released, for research purposes, to

11. Other researchers not collaborating with the JHS investigators who meet JHS standards and procedures. ☐ ☐

12. Researchers from private or non-profit organizations who wish to develop diagnostic laboratory tests medications or other therapies that could benefit many people. (Note: Neither you nor your heirs will benefit financially from this, and your cell line or DNA will not be sold to anyone for profit). ☐ ☐

ADMINISTRATIVE INFORMATION

14. Social Security ..... ☐☐☐_☐☐_☐☐☐☐

15. Date of data collection: ..... ☐☐/☐☐/☐☐☐☐
m m d d y y y y

16. Code number of person completing this form: ..... ☐☐☐

_____
Names of Participant

_____ _____
Participant's Signature: Date:

Termination Form

FORM CODE: TERA
VERSION A 05/04/2007

ID NUMBER: | | | | | | | | CONTACT YEAR: 0 6

LAST NAME: | | | | | | | | | | | | | INITIALS: | |

INSTRUCTIONS: This form should be completed with the participant is discontinued from the study. 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

1. Last know date the participant was contacted | | | / | | | / | | | | |
m m d d y y y y

2. Was the participant prematurely discontinued from the study?
Yes 1
No 2

3. Principal Reason
Protocol Criteria 1
Non-Compliance 2
No Consent 3
Moved 4
Died 5

4a. If reason was death, date of death | | | / | | | / | | | | |
m m d d y y y y

Specify: | | | | | | | | | | | | | | | | | | |

5. Did the investigator sign?
Yes 1
No 2

6. Date Signed | | | / | | | / | | | | |
m m d d y y y y

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. Code number of person completing this form: ..... | | | |