**Singapore Consortium of Cohort Studies (SCCS) -- Multiethnic Cohort (MEC)**

**Health Screening Form**

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| **Appt Time:** | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | **Visit ID**  **2nd Ref. Number** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |
| **Date Registered:** | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |
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| **Not for Data Entry** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Time Registered:** | | | | | | | | | |  | | | | | | |  | | | | | | | | | |  | | | | | | | | |  | | | | | | | | | | | |  | | | | | |  | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Participants:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| A | | | Have you had a fever for the last 14 days? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | □ No | | | | | | | | | □ Yes; **do not proceed** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| B | | | For ladies, are you pregnant? □ N.A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | □ No | | | | | | | | | □ Yes; **do not proceed** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| C | | | Have you eaten/drink for the last 8 hours? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | □ No | | | | | | | | | □ Yes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| D | | | Have you been taking any medications? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | □ No | | | | | | | | | □ Yes; please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **For Data Entry :** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1 | | | Date Of Birth : | | | | |  | | | | |  | | | | | |  | | | | | | | | | | | |  | | | | | |  | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | |  | | |  | | | | | | Gender:  Male  Female | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 2 | | | Have you taken any painkillers / antibiotics in the | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | □ No | | | | | | | | | □ Yes; do not collect urine | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | last 7 days / (for women) having menses currently? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 3 | | | For women, are you still having periods? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | □ Yes | | | | | | | | | □ No (menopausal) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | □ N.A (male) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 4 | | | Do you have any known medical history? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | □ No | | | | | | | | | □ Yes; \*\* High Cholesterol / Hypertension / Diabetes / | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | *\*\*Please circle* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | Kidney failure / Heart failure / Heart attack / Stroke / Cancer | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 5 | | | Are you on high dose steroids? # | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | □ No | | | | | | | | | □ Yes; specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 6 | | | Do you have a metallic implant in your body? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | |
| 7 | | | Have you ever had a hip/disc replacement surgery? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | |
| 8 | | | Have you ever had a fracture in your spine/hip? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | |
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| **I certify the above information given by me is correct.**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  *Participant‘s signature:* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | *# High dose: >10 mg prednisolone per day (or equivalent) for >1 week in the past 1 year. Not applicable to topical (applied to the skin) or inhaled (for asthma etc) applications.*  **Omit DXA and CT Ca if kidney failure/ heart failure/ heart attack/ stroke/ cancer/ on high dose steroids.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Stations** | | | | | | | | | | | | | | | | | | | | | **Results** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **For Data Entry**  **Investigator Code** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1 | | Height (cm) | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | **.** | | | | |  | | | | | | | | |  | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | | | |
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| 5 | | Blood pressure (mmHg) | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | □ Dinamap | | | | | | | | | | | | | | | | | | | **Systolic / Diastolic** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | |  | | | | | |
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|  | | | | □ Manual | | | | | | | | | | | | | | | | | | 2nd | | | | | | | | | | | | | | | | / | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | |  | | | | | |
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| 6 | | | | CASP | | | | | | | | | | | | | | | | | | □ CASPRO **A** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Ref:\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | Refuse | | | | | | | | | | | | | | | | Unable | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | |  | | | | | |
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| **Station II** | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Refuse | | | | | | | | | | | | | | | | Unable | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | |  | | | | | |
| 1 | | | | ECG | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | □ Taken | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | □ | | | | | | | | | | | | | | | | □ | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | |  | | | | | |
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| **Station III** | | | | | | | | | | | | | | | | | | | | | | No. of sensory points felt | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1 | | | | Monofilament 5.07 | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | **R** | | | | | | | | | | | **5** | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | |  | | | | | |
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| 2 | | | | Neurothesiometer | | | | | | | | | | | | | | | | | |  | | | | | | | Apex 1st | | | | | | | | | | | | | | | | | R | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | L | | | | | |  | | | | | | | | | |  | | | | | | | | |  | | | Staff initial/Date | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | Reading (Mv) | | | | | | | | | | | | | | | | | |  | | | | | | | Med Mal. | | | | | | | | | | | | | | | | | R | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | L | | | | | |  | | | | | | | | | |  | | | | | | | | |  | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 3 | | | | Brachial BP (mmHg) | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | 1 | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | | | | Arm used | | | | | | | | | | | | | | | | | | | | | | | | | □ Left □ Right | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | | | | Is this the dominant arm? | | | | | | | | | | | | | | | | | | | | | | | | | □ Yes □ No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 4 | | | | Ankle BP (mmHg) | | | | | | | | | | | | | | | | | | R1 | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | L1 | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | |  | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | (systolic reading by Doppler) | | | | | | | | | | | | | | | | | | R2 | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | L2 | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | |  | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | | | | **ABI** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | **ABI** | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Station IV** | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1 | | | | Blood sample | | | | | | | | | | | | | | | | | | | | | | | | □ Random □ Fasting | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | |  | | | | | |
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|  | | | | | Return copy of consent form to participant | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Discharge Voucher \_ [I ] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
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| **Remarks ( For data entry)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Additional Notes ( For site use only; not for data entry)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Station V -** Skinfolds (mm) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 3 | | | | | Sub-scapula1 | | | | | |  | | | | |  | | | | | | | | | | **.** | | | | | | | | |  | | | | | | | | | | 4 | | | | | | | | | | | | | | | | | | | Supra-iliac1 | | | | | | | | | | | | | | | | | | |  | | | | |  | | | | | | | | | | | **.** | | |  | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
|  | | | | | Sub-scapula2 | | | | | |  | | | | |  | | | | | | | | | | **.** | | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | Supra-iliac2 | | | | | | | | | | | | | | | | | | |  | | | | |  | | | | | | | | | | | **.** | | |  | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
|  | | | | | Sub-scapula3 | | | | | |  | | | | |  | | | | | | | | | | **.** | | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | Supra-iliac3 | | | | | | | | | | | | | | | | | | |  | | | | |  | | | | | | | | | | | **.** | | |  | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
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| 5 | | | | | Para-umbilicus1 | | | | | |  | | | | |  | | | | | | | | | | **.** | | | | | | | | |  | | | | | | | | | | 6 | | | | | | | | | | | | | | | | | | | Thigh1 | | | | | | | | | | | | | | | | | | |  | | | | |  | | | | | | | | | | | **.** | | |  | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
|  | | | | | Para-umbilicus2 | | | | | |  | | | | |  | | | | | | | | | | **.** | | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | Thigh2 | | | | | | | | | | | | | | | | | | |  | | | | |  | | | | | | | | | | | **.** | | |  | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
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| 7 | | | | | Calf1 | | | | | |  | | | | |  | | | | | | | | | | **.** | | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | | | | |  | | | | | | | | | | |  | | |  | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
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| For female participant only  I certify that I am not pregnant or suspected to be pregnant | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *Participant‘s signature and Date* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
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| 3 | | | | | CT Ca | | | | | | | | | | | | | | | □ Taken | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | □ | | | | | | | | | | | | □ | | | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | |
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|  | | | | | Time of Discharge |\_\_\_|\_\_\_|\_\_\_|\_\_\_| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | **Not for Data Entry** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | |
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|  | | | | | Return copy of consent form to participant | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
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