MOSAAIC

Health Conditions and Procedures

The following questions ask about new health conditions that a healthcare provider has said you had since the date of your in-person MOSAAIC exam:

__ __ / __ __ / __ __ __ __ (MM/DD/YYYY)

1. Since the date of your in-person MOSAAIC exam, has a health care provider said that you had any of the following health conditions? *(Select all that apply)*

   ☐1 Heart attack (also called "myocardial infarction") → **Complete Myocardial Infarction Form on page 2**

   ☐2 Coronary artery disease or angina → **Complete CAD Form on page 3**

   ☐3 Heart Failure → **Complete Heart Failure Form on page 4**

   ☐4 Atrial fibrillation or atrial flutter → **Complete Atrial Fibrillation Form on page 5**

   ☐5 Stroke → **Complete Stroke Form on page 6**

   ☐6 Mini-stroke or transient ischemic attack → **Complete TIA Form on page 7**

   ☐7 Blood clot in your leg or vein that should be treated with blood thinning medicine → **Complete PE/DVT Procedure Form on page 8**

   ☐8 None of the above

2. Since the date of your in-person MOSAAIC exam, have you had any of the following procedures? *(Select all that apply)*

   ☐1 Procedure to improve blood flow to the heart (a coronary artery bypass surgery (CABG) or placing a stent in the heart arteries) → **Complete Heart Procedure Form on page 9**

   ☐2 Procedure to improve blood flow to the brain → **Complete Brain Procedure Form on page 10**

   ☐3 Procedure to improve blood flow to the legs → **Complete Vascular Procedure Form on page 11**

   ☐4 None of the above

MOSAAIC

Myocardial Infarction Form

You answered that you had a heart attack or myocardial infarction since the date of your in-person MOSAAIC exam. We have some follow-up questions.

1. Were you hospitalized due to this condition?

☐$_1$ Yes

☐$_0$ No → Date of Diagnosis: ___ ___ / ___ ___ / ___ ___ ___ ___ (MM/DD/YYYY)

2. What was the name of the hospital? _____

3. What was the location of the hospital?

   a. City: _____

   b. State: _____

4. What was the date you entered the hospital?
   ___ ___ / ___ ___ / ___ ___ ___ ___ (MM/DD/YYYY)

5. How many times were you hospitalized for this condition since your in-person MOSAAIC exam?

   ___ ___ times

Provide details for additional hospitalizations on the Additional Hospitalizations Form on page 14.

MOSAAIC

CAD Form

You answered that you had coronary artery disease (CAD) or angina since the date of your in-person MOSAAIC exam. We have some follow-up questions.

1. Were you hospitalized due to this condition?

☐$_1$ Yes

☐$_0$ No → Date of Diagnosis: ___ ___ / ___ ___ / ___ ___ ___ ___ (MM/DD/YYYY)

2. What was the name of the hospital? _____

3. What was the location of the hospital?

   a. City: _____

   b. State: _____

4. What was the date you entered the hospital?
   ___ ___ / ___ ___ / ___ ___ ___ ___ (MM/DD/YYYY)

5. How many times were you hospitalized for this condition since your in-person MOSAAIC exam?

   ___ ___ times

Provide details for additional hospitalizations on the Additional Hospitalizations Form on page 14.

MOSAAIC

Heart Failure Form

You answered that you had heart failure since the date of your in-person MOSAAIC exam. We have some follow-up questions.

1. Were you diagnosed in a clinic (not during a hospitalization)?

☐$_1$ Yes

☐$_0$ No → **Go to question 5**

2. What was the name of the hospital/clinic that provided the diagnosis?

_____

3. What was the location of the hospital/clinic?

   a. City: _____

   b. State: _____

4. What was the date of your appointment?

   ___ ___ / ___ ___ / ___ ___ ___ ___ (MM/DD/YYYY)

5. Were you hospitalized for this condition?

☐$_1$ Yes

☐$_0$ No → **Thank you for completing this form.**

6. What was the name of the hospital? _____

7. What was the location of the hospital?

   a. City: _____

   b. State: _____

8. What was the date you entered the hospital?

   ___ ___ / ___ ___ / ___ ___ ___ ___ (MM/DD/YYYY)

9. How many times were you hospitalized for this condition since your in-person MOSAAIC exam?

   ___ ___ times

Provide details for additional hospitalizations on the Additional Hospitalizations Form on page 14.

MOSAAIC

Atrial Fibrillation

You answered that you had atrial fibrillation since the date of your in-person MOSAAIC exam. We have some follow-up questions.

1. Were you diagnosed in a clinic (not during a hospitalization)?

☐$_1$ Yes

☐$_0$ No → **Go to question 5**

2. What was the name of the hospital/clinic that provided the diagnosis?

_____

3. What was the location of the hospital/clinic?

   a. City: _____

   b. State: _____

4. What was the date of your appointment?

   ___ ___ / ___ ___ / ___ ___ ___ ___ (MM/DD/YYYY)

5. Were you hospitalized for this condition?

☐$_1$ Yes

☐$_0$ No → **Thank you for completing this form.**

6. What was the name of the hospital? _____

7. What was the location of the hospital?

   a. City: _____

   b. State: _____

8. What was the date you entered the hospital?

   ___ ___ / ___ ___ / ___ ___ ___ ___ (MM/DD/YYYY)

9. How many times were you hospitalized for this condition since your in-person MOSAAIC exam?

   ___ ___ times

Provide details for additional hospitalizations on the Additional Hospitalizations Form on page 14.

MOSAAIC

Stroke Form

You answered that you had a stroke since the date of your in-person MOSAAIC exam. We have some follow-up questions.

1. Were you hospitalized due to this condition?

☐$_1$ Yes

☐$_0$ No → Date of Diagnosis: ___ ___ / ___ ___ / ___ ___ ___ ___ (MM/DD/YYYY)

2. What was the name of the hospital? _____

3. What was the location of the hospital?

   a. City: _____

   b. State: _____

4. What was the date you entered the hospital?
   ___ ___ / ___ ___ / ___ ___ ___ ___ (MM/DD/YYYY)

5. How many times were you hospitalized for this condition since your in-person MOSAAIC exam?

   ___ ___ times

Provide details for additional hospitalizations on the Additional Hospitalizations Form on page 14.

MOSAAIC

TIA Form

You answered that you had a mini-stroke or transient ischemic attack (TIA) since the date of your in-person MOSAAIC exam. We have some follow-up questions.

1. Were you hospitalized due to this condition?

☐$_1$ Yes

☐$_0$ No → Date of Diagnosis: ___ ___ / ___ ___ / ___ ___ ___ ___ (MM/DD/YYYY)

2. What was the name of the hospital? _____

3. What was the location of the hospital?

   a. City: _____

   b. State: _____

4. What was the date you entered the hospital?
   ___ ___ / ___ ___ / ___ ___ ___ ___ (MM/DD/YYYY)

5. How many times were you hospitalized for this condition since your in-person MOSAAIC exam?

   ___ ___ times

Provide details for additional hospitalizations on the Additional Hospitalizations Form on page 14.

MOSAAIC

PE/DVT Procedure Form

You answered that you had a pulmonary embolism/DVT (deep vein thrombosis) since the date of your in-person MOSAAIC exam. We have some follow-up questions.

1. Since the date of your in-person MOSAAIC exam, has a healthcare provider said that you have a blood clot in your leg vein or lung requiring blood thinning medicine?

   ☐$_1$ Yes, legs

   ☐$_2$ Yes, lungs

   ☐$_3$ Yes, both legs and lungs

   ☐$_4$ Yes, but unsure

2. Are you taking blood thinning medication?

   ☐$_1$ Yes ☐$_0$ No

3. What was the name of the hospital/clinic that provided the procedure?

   _____

4. What was the location of the hospital/clinic?

   a. City: _____

   b. State: _____

5. What was the date of your appointment?

   __ __ / __ __ / __ __ __ __ (MM/DD/YYYY)

6. What was the last name of the doctor who performed the procedure?

   _____

MOSAAIC

Heart Procedure Form

You answered that you had a procedure to increase blood flow to your heart (e.g., CABG, and stent) since the date of your in-person MOSAAIC exam. We have some follow-up questions.

1. What was the name of the hospital/clinic that provided the procedure?

   _____

2. What was the location of the hospital/clinic?

   a. City: _____

   b. State: _____

3. What was the date of your appointment?

   __ __ / __ __ / __ __ __ __ (MM/DD/YYYY)

4. What was the last name of the doctor who performed the procedure?

   _____

MOSAAIC

Brain Procedure Form

You answered that you had a procedure to increase blood flow to your brain since the date of your in-person MOSAAIC exam. We have some follow-up questions.

1. What was the name of the hospital/clinic that provided the procedure?

   _____

2. What was the location of the hospital/clinic?

   a. City: _____

   b. State: _____

3. What was the date of your appointment?

   ___ ___ / ___ ___ / ___ ___ ___ ___ (MM/DD/YYYY)

4. What was the last name of the doctor who performed the procedure?

   _____

MOSAAIC

Vascular Procedure Form

You answered that you had a procedure to increase blood flow to the legs since the date of your in-person MOSAAIC exam. We have some follow-up questions.

1. What was the name of the hospital/clinic that provided the procedure?

   _____

2. What was the location of the hospital/clinic?

   a. City: _____

   b. State: _____

3. What was the date of your appointment?

   ___ ___ / ___ ___ / ___ ___ ___ ___ (MM/DD/YYYY)

4. What was the last name of the doctor who performed the procedure?

   _____

MOSAAIC

Other Hospitalization Form

1. Besides the conditions and procedures asked above, were you hospitalized due to any other condition or procedure?

   ☐$_1$ Yes

   ☐$_0$ No → **Go to page 15**

2. What was the name of the hospital? _____

3. What was the location of the hospital?

   a. City: _____

   b. State: _____

4. What was the date you entered the hospital? 11/11/1111 (MM/DD/YYYY)

5. What was the diagnosis? _____

6. Were you hospitalized more than once?

   ☐$_1$ Yes

   ☐$_0$ No → **Go to page 15**

7. What was the name of the hospital? _____

8. What was the location of the hospital?

   a. City: _____

   b. State: _____

9. What was the date you entered the hospital? 22/22/2222 (MM/DD/YYYY)

10. What was the diagnosis? _____

11. Were you hospitalized more than once?

    ☐$_1$ Yes

    ☐$_0$ No → **Go to page 15**

MOSAAIC

12. What was the name of the hospital? _____

13. What was the location of the hospital?

    a. City: _____

    b. State: _____

14. What was the date you entered the hospital?
    __ __ / __ __ / __ __ __ __ (MM/DD/YYYY)

15. What was the diagnosis? _____

16. Were you hospitalized more than once?

    ☐$_1$ Yes

    ☐$_0$ No → **Go to page 15**

MOSAAIC

Additional Hospitalizations Form

Hospitalization 1:

What was the name of the hospital?

_____

What was the location of the hospital?

a. City: _____

b. State: _____

What was the date you entered the hospital?

__ __ / __ __ / __ __ __ __

(MM/DD/YYYY)

What was the main condition were you hospitalized for?

_____

Hospitalization 2:

What was the name of the hospital?

_____

What was the location of the hospital?

a. City: _____

b. State: _____

What was the date you entered the hospital?

__ __ / __ __ / __ __ __ __

(MM/DD/YYYY)

What was the main condition were you hospitalized for?

_____

Hospitalization 3:

What was the name of the hospital?

_____

What was the location of the hospital?

a. City: _____

b. State: _____

What was the date you entered the hospital?

__ __ / __ __ / __ __ __ __

(MM/DD/YYYY)

What was the main condition were you hospitalized for?

_____

Hospitalization 4:

What was the name of the hospital?

_____

What was the location of the hospital?

a. City: _____

b. State: _____

What was the date you entered the hospital?

__ __ / __ __ / __ __ __ __

(MM/DD/YYYY)

What was the main condition were you hospitalized for?

_____

MOSAAIC

MOSAAIC Health Conditions and Procedures – Part 2

The next questions ask whether you have ever had any of the following health conditions.

1. Has a healthcare provider ever said that you have high blood pressure or hypertension?

☐$_1$ Yes ☐$_0$ No → **Go to question 2**

1a. Did it occur during pregnancy?

☐$_1$ Yes ☐$_0$ No → **Go to question 1c**

1b. Did a doctor ever tell you that you still had hypertension more than 3 months after your pregnancy ended?

☐$_1$ Yes ☐$_0$ No ☐$_2$ Pregnancy has not ended

1c. Are you currently taking medication for hypertension?

☐$_0$ Yes ☐$_1$ No

2. Has a healthcare provider ever said that you have high cholesterol?

☐$_1$ Yes ☐$_0$ No → **Go to question 3**

2a. Are you taking medication for cholesterol levels?

☐$_1$ Yes ☐$_0$ No

3. Has a healthcare provider ever said that you have diabetes (high sugar in blood or urine)?

☐$_1$ Yes ☐$_0$ No → **Go to question 5**

3a. Did it occur during pregnancy (sometimes called “gestational diabetes”)?

☐$_1$ Yes ☐$_0$ No → **Go to question 3c**

3b. Did a doctor tell you that you still had diabetes more than 3 months after your pregnancy ended?

☐$_1$ Yes ☐$_0$ No ☐$_2$ Pregnancy has not ended

MOSAAIC

3c. Are you being treated with insulin or other diabetes medications? (*Select all that apply*)

☐$_0$ No

☐$_1$ Insulin

☐$_2$ Other diabetes medications

4. Has a healthcare provider said that you have peripheral arterial disease (problems with circulation, blocked arteries to the legs)?

☐$_1$ Yes ☐$_0$ No

5. Are you currently receiving dialysis (either hemodialysis or peritoneal dialysis)?

☐$_1$ Yes ☐$_0$ No

6. Has a healthcare provider ever said that you have COPD (chronic obstructive pulmonary disease) or emphysema?

☐$_1$ Yes ☐$_0$ No → **Go to question 7**

6a. Are you receiving medical treatment, taking medications or using an inhaler for COPD or emphysema?

☐$_1$ Yes ☐$_0$ No

7. Has a healthcare provider ever said that you have asthma?

☐$_1$ Yes ☐$_0$ No → **Go to question 8**

7a. Are you receiving medical treatment, taking medications or using an inhaler for asthma?

☐$_1$ Yes ☐$_0$ No

8. Has a healthcare provider ever said that you have depression?

☐$_1$ Yes ☐$_0$ No

MOSAAIC

The following question asks about cancer diagnoses that a healthcare provider has said you had since the date of your in-person MOSAAIC exam:

___ ___ / ___ ___ / ___ ___ ___ ___ (MM/DD/YYYY)

9. Since the date of your in-person MOSAAIC exam, has a healthcare provider said that you have a new cancer or malignant tumor that had not been previously diagnosed?

☐$_1$ Yes ☐$_0$ No → **Go to page 18**

9a. What type of cancer or malignant tumor? (*Select all that apply*)

☐$_1$ Lung
☐$_2$ Breast
☐$_3$ Cervical
☐$_4$ Blood/Lymph Glands
☐$_5$ Testes/Scrotum
☐$_6$ Bone
☐$_7$ Melanoma
☐$_8$ Skin (not Melanoma)
☐$_9$ Brain
☐$_{10}$ Stomach
☐$_{11}$ Colon
☐$_{12}$ Uterine
☐$_{13}$ Prostate
☐$_{14}$ Liver
☐$_{15}$ Pancreatic
☐$_{16}$ Ovarian
☐$_{17}$ Endometrial
☐$_{18}$ Other (specify): _____
☐$_{99}$ Don't know/I prefer not to answer

9b. Are you currently receiving active treatment (i.e., chemotherapy, radiation, immunotherapy) for cancer or a tumor?

☐$_1$ Yes ☐$_0$ No

9c. Are you currently receiving hormonal therapy for cancer or a tumor?

☐$_1$ Yes ☐$_0$ No

If you are aged 50 or older, please answer questions 10, 11, and 12 before completing the Hospitalization Form.

10. In the past year, has a healthcare provider said that you have dementia or Alzheimer's disease?

    ☐$_1$ Yes ☐$_0$ No

11. In the past year, have you had a fall and landed on the ground? Do not include falls due to sports.

    ☐$_1$ 0 falls → **Go to END OF SURVEY**

    ☐$_2$ 1 fall

    ☐$_3$ 2 or more falls

12. In the past year, were you injured as a result of any of these falls?

    ☐$_1$ 0 falls

    ☐$_2$ 1 fall

    ☐$_3$ 2 or more falls