



Annual Follow-Up Form

FORM CODE: AFU
VERSION: F 01/05/2015

ID NUMBER:

CONTACT YEAR:

LAST NAME:

INITIALS:

ADMINISTRATIVE INFORMATION

0a. Completion Date: / / 0b. Staff ID:
Month Day Year

Instructions: This form should be completed during the interview portion of the participant's follow-up. The Date is the day the contact was made or is the date the status determination was made. Special missing values are allowed for cases where the response "Don't know", "Refused", "Unknown", or "N/A" is not listed as an option.

INTRODUCTION SCRIPT: "Hello, this is [your name] from the JHS Study. May I please speak with [name of contact]?"

"Hello [name of respondent]. My name is [your name] and I am from the JHS Study. May I have a few minutes of your time to ask about your recent health?"

A. STATUS

1. Result of contact for the interview (select one)

- a. Participant contacted, agreed to be interviewed... → **GO TO QUESTION 17**
- b. Participant contacted, refused to be interviewed... → **GO TO QUESTION 71**
- c. Proxy/Informant contacted
- d. Other person contacted
- e. Contact pending; continue to attempt to contact... → **SAVE AND CLOSE FORM**
- f. Window closed; unable to contact → **SAVE AND CLOSE FORM**

2. Is the participant deceased?

Yes
No → **GO TO QUESTION 28**

B. DEATH INFORMATION

3. Death reported by: (select one)

- Relative/Spouse/Acquaintance
- Surveillance
- Other (e.g., Obituary, Social Security Administration)

4. Date of death: / /
Month Day Year

5. Location of death:

a. City: _____

c. State:

b. County: _____

6. Are you able to answer some questions about any hospitalizations that occurred since our last contact with [name] on [mm/dd/yyyy]?

Yes **GO TO QUESTION 7**

No

6a. Is there someone else who could answer these questions?

Yes - person located.....

Yes - reschedule remainder of interview.....

No

GO TO QUESTION 71

GO TO QUESTION 71

HOSPITALIZATIONS FOR HEART ATTACK / CONDITION / STROKE (for deceased participants)

7. Was [name] hospitalized for a heart attack, or heart condition, or stroke since our last contact on [mm/dd/yyyy]?

Yes

No **GO TO QUESTION 10**

8a. Hospital Name, City, State: ▼

8a1. Specify hospital name, city, and state if not in drop down list: _____

8b. Approximate date of hospitalization: /
Month Year

Second hospitalization, if applicable

9a. Hospital Name, City, State: ▼

9a1. Specify hospital name, city, and state if not in drop down list: _____

9b. Approximate date of hospitalization /
Month Year

OTHER HOSPITALIZATIONS (for deceased participants)

10. Was [name] hospitalized or did [name] stay in a hospital observation unit for any other reason since our last contact?

Yes No **GO TO QUESTION 14**

11a. Hospitalization Reason: _____

11b. Hospital Name, City, State: ▼

11b1. Specify hospital name, city, and state if not in drop down list: _____

11c. Approximate date of hospitalization / /
 Month Year

Second hospitalization, if applicable

12a. Hospitalization Reason: _____

12b. Hospital Name, City, State: ▼

12b1. Specify hospital name, city, and state if not in drop down list: _____

12c. Approximate date of hospitalization / / Month Year

Third hospitalization, if applicable

13a. Hospitalization Reason:

13b. Hospital Name, City, State: ▼

13b1. Specify hospital name, city, and state if not in drop down list:

13c. Approximate date of hospitalization / /
 Month Year

OUTPATIENT TREATMENT (for deceased participants)

14. Was [name] seen at an emergency room or a medical facility for outpatient treatment since our last contact?

Yes..... No .. **GO TO QUESTION 71**

15. Was this related to a heart problem or difficulty breathing?

Yes No **GO TO QUESTION 71**

16a. ER/Facility Name, City, State: ▼

16a1. Specify ER/facility name, city, and state if not in drop down list: _____

16b. Approximate date: / → **GO TO QUESTION 71**

C. GENERAL HEALTH

17. Now I will ask you some questions about your health. Over the past year, compared to other people your age, would you say that your health has been excellent, good, fair or poor?

Excellent	<input type="checkbox"/>
Good.....	<input type="checkbox"/>
Fair	<input type="checkbox"/>
Poor	<input type="checkbox"/>

[QUESTIONS 18-20 MOVED TO MCU FORM]

21a. Are there times when you wake up at night because of difficulty breathing?

Yes.....
No.....

21b. Do you have trouble breathing or shortness of breath when hurrying on a level surface?

Yes
No
Unable to Walk  **GO TO QUESTION 22**

21c. Do you have trouble breathing or shortness of breath when walking at ordinary pace on a level surface?

Yes.....
No.....

21d. Do you stop for breath when walking at your own pace?

Yes.....
No.....

21e. Do you stop for breath after walking 100 yards on a level surface?

Yes.....
No.....

21f. Do you have to walk slower than people of your own age on a level surface because of shortness of breath?

Yes.....
No.....

22. Do you have difficulty breathing when you are not walking or active?

Yes
No

23. Do you usually have some cough or wheezing?

Yes
No

[QUESTIONS 24-25 MOVED TO MCU FORM]

26. Do you have pain in your legs caused by a blockage of the arteries?

Yes
No

27. Do you often have swelling in your feet or ankles at the end of the day?

Yes
No → **GO TO QUESTION 28**

27a. Is the swelling in your feet or ankles gone in the morning?

Yes
No

28. Since we last contacted you [name], has a doctor said you [name] had cancer?

Yes
No IF QUESTION 1 is 'a. Participant contacted, agreed to be interviewed',
GO TO QUESTION 36;
IF QUESTION 1 is 'c. Proxy/Informant contacted'
or 'd. Other person contacted', GO TO QUESTION 29



28a. Can you tell me in what part of the body the [name's] most recently diagnosed cancer was located?

28b. What is the approximate date the cancer was diagnosed?

/
Month Year

DOCTOR INFORMATION FOR CANCER

"Please provide the contact information of the doctor you [name] most recently visited for your [his/her] cancer."

28c. Contact information of the doctor you [name] last saw for your [his/her] cancer:

28c1. Doctor Name: _____

28c2. Clinic or Institution Name: _____

28c3. Address: _____

28c4. City: _____

28c5. State:

28c6. Approximate date: /
Month Year

If speaking to the participant: “**The JHS study would like to ask your health care providers to tell us more about your cancer diagnosis and treatment. If you agree to do this, I will send you a form that tells your providers that you authorize the JHS study to get this information from them. Once you sign that form and mail it back to me, I will contact your health care providers.**”

If speaking to the proxy/informant/other: “**The JHS study would like to ask [name’s] health care providers to tell us more about his/her cancer diagnosis and treatment. If you agree to do this, I will send [name] a form that tells his/her providers that [name] authorizes the JHS study to get this information from them. Once [name] signs that form and mails it back to me, I will contact the office of the health care providers.**”

28d. May I send you this release form and an addressed envelope for you to mail it back?

Yes No

**IF QUESTION 1 is ‘a. Participants contacted, agreed to be interviewed’
GO TO QUESTION 36;
IF QUESTION 1 is ‘c. Proxy/Informant contacted’
or ‘d. Other person contacted’, GO TO QUESTION 29**

D. CARDIOVASCULAR EVENTS

29. May I ask you some more questions about [name’s] health?

Yes No

29a. Is there someone else we can ask?

Yes, person located..... Yes, reschedule remainder of interview..... No

GO TO QUESTION 36

GO TO QUESTION 71

GO TO QUESTION 71

RECENT HEART FAILURE DIAGNOSIS

[QUESTIONS 30-35 MOVED TO MCU FORM]

36. Since we last contacted you [name] on [mm/dd/yyyy], has a doctor said you [name] had a heart attack?

Yes No

GO TO QUESTION 40

37. Were you (Was [name]) hospitalized at that time?

Yes No

GO TO QUESTION 40

HOSPITAL INFORMATION FOR HEART ATTACK

38a. Hospital Name, City, State: ▼

38a1. Specify hospital name, city, and state if not in drop down list: _____

38b. Approximate date of hospitalization /
Month Year

Second hospitalization, if applicable

39a. Hospital Name, City, State: ▼

39a1. Specify hospital name, city, and state if not in drop down list: _____

39b. Approximate date of hospitalization /
Month Year

40. Since we last contacted you [name], has a doctor said you [name] had angina, angina pectoris or chest pain due to heart disease?

Yes
No

[QUESTION 41 MOVED TO MCU FORM]

42. Since we last contacted you [name], has a doctor said that you [name] had a blood clot in a leg or deep vein thrombosis?

Yes
No ➔ **GO TO QUESTION 45**

43. At that time, were you (was [name]) hospitalized or did you [name] stay in a hospital observation unit for a blood clot in a leg or deep vein thrombosis?

Yes
No ➔ **GO TO QUESTION 45**

HOSPITALIZATION FOR BLOOD CLOT IN LEG

44a. Hospital Name, City, State: ▼

44a1. Specify hospital name, city, and state if not in drop down list: _____

44b. Approximate date of hospitalization /
Month Year

45. Since we last contacted you [name], has a doctor said that you [name] had a blood clot in your lungs or a pulmonary embolus?

Yes
No ➔ **GO TO QUESTION 48**

46. Were you (was [name]) hospitalized for a blood clot in your lungs or a pulmonary embolus at that time?

Yes

No **GO TO QUESTION 48**

HOSPITALIZATION FOR BLOOD CLOT IN LUNGS

47a. Hospital Name, City, State: ▼

47a1. Specify hospital name, city, and state if not in drop down list: _____

47b. Approximate date of hospitalization /
Month Year

48. Since we last contacted you [name], has a doctor said that you [name] had a stroke, slight stroke, transient ischemic attack, or TIA?

Yes

No **GO TO QUESTION 51**

49. Were you (was [name]) hospitalized for this stroke, slight stroke, transient ischemic attack, or TIA?

Yes

No **GO TO QUESTION 51**

HOSPITALIZATION FOR STROKE OR TIA

50a. Hospital Name, City, State: ▼

50a1. Specify hospital name, city, and state if not in drop down list: _____

50b. Approximate date of hospitalization /
Month Year

E. ADMISSIONS

51. Since our last contact, were you (was [name]) hospitalized or did you [name] stay in a hospital observation unit for any reason that you have not yet mentioned?

Yes

No **GO TO QUESTION 57**

HOSPITALIZATION FOR OTHER REASON

52a. Hospitalization Reason: _____

52b. Hospital Name, City, State: ▼

52b1. Specify hospital name, city, and state if not in drop down list: _____

52c. Approximate date of hospitalization /
Month Year

HOSPITALIZATION FOR OTHER REASON

53a. Hospitalization Reason: _____

53b. Hospital Name, City, State: ▼

53b1. Specify hospital name, city, and state if not in drop down list: _____

53c. Approximate date of hospitalization /
Month Year

HOSPITALIZATION FOR OTHER REASON

54a. Hospitalization Reason: _____

54b. Hospital Name, City, State: ▼

54b1. Specify hospital name, city, and state if not in drop down list: _____

54c. Approximate date of hospitalization /
Month Year

HOSPITALIZATION FOR OTHER REASON

55a. Hospitalization Reason: _____

55b. Hospital Name, City, State: ▼

55b1. Specify hospital name, city, and state if not in drop down list: _____

55c. Approximate date of hospitalization /
Month Year

HOSPITALIZATION FOR OTHER REASON

56a. Hospitalization Reason: _____

56b. Hospital Name, City, State: ▼

56b1. Specify hospital name, city, and state if not in drop down list: _____

56c. Approximate date of hospitalization /
Month Year

EMERGENCY ROOM/MEDICAL FACILITY INFORMATION

57. Were you (Was [name]) seen at an emergency room or a medical facility for outpatient treatment since our last contact on [mm/dd/yyyy]?

Yes No  **GO TO QUESTION 60**

58. Was this related to a heart problem or difficulty breathing?

Yes No  **GO TO QUESTION 60**

59a. ER/Facility Name, City, State: ▼

59a1. Specify ER/Facility name, city, and state if not in drop down list: _____

59b. Approximate date /
Month Year

60. Since our last contact, have you (has [name]) stayed overnight as a patient in a nursing home?

Yes No

61. Are you (Is [name]) currently a resident of a nursing home or long-term care facility?

Yes No

F. INVASIVE PROCEDURES

Next I am going to ask about various types of surgery and medical procedures. We are interested in those that occurred in the hospital, or as an outpatient.

62. Since we last contacted you [name] on [mm/dd/yyyy], have you (has [name]) had any surgery on your [name's] heart, or the arteries of your [name's] neck or legs, not counting surgery for varicose veins?

Yes No  **GO TO QUESTION 64**

63. Did you [name] have:

a. Coronary bypass?

Yes No

b. Other heart procedure?

Yes No  **Specify:** _____

c. Carotid endarterectomy?

Yes

No ➔ **GO TO QUESTION 63e**

d. Site:

Right

Left

Both

e. Other arterial revascularization?

Yes ➔ **Specify:** _____

No

f. Any other type of surgery on your heart or the arteries of your [name's] neck or legs?

Yes

No

64. Since we last contacted you [name] on [mm/dd/yyyy], have you (has [name]) had a balloon angioplasty or stent on the arteries of your [name's] heart, neck, or legs?

Yes

No ➔ **Go to Question 65**

Did you [name] have:

a. Angioplasty or stent of the coronary arteries of your [name's] heart:

Yes

No

b. Angioplasty or stent in the arteries of your [name's] neck:

Yes

No

c. Angioplasty or stent of the lower extremity arteries:

Yes

No

Angioplasty or stent facility information

d. Facility Name, City, State: ▼

e. Specify Facility name, city, and state if not in drop down list: _____

f. Approximate date / /
Month Year

G. INTERVIEW

Now I would like to ask about medication use during the past four weeks.

65. Did you [name] take any prescription medications in the past 4 weeks?

Yes
No  **Go to Question 66**

Did you [name] take any prescribed medications for:

a. High blood pressure or hypertension?

a. Yes
b. No

b. High blood cholesterol?

a. Yes
b. No

c. Diabetes or high blood sugar?

a. Yes
b. No

d. Heart failure?

a. Yes
b. No

e. Asthma?

a. Yes
b. No

f. Chronic bronchitis or emphysema?

a. Yes
b. No

g. Chest pain or angina?

a. Yes
b. No

h. Abnormal heart rhythm?

a. Yes
b. No

i. Blood thinning?

a. Yes
b. No

j. Stroke?

- a. Yes
b. No

k. Mini-stroke or TIA?

- a. Yes
b. No

l. Leg pain while walking or claudication?

- a. Yes
b. No

m. Depression?

- a. Yes
b. No

Next I would like to ask you about your regular use of aspirin. This includes aspirin alone or in a combination with another drug, such as aspirin in a cold medicine. By regular use, I mean taking aspirin at least once a week for several months.

66. Do you (Does [name]) regularly take any aspirin or aspirin-containing products including Alka-Seltzer, cold and allergy medication or headache powder? This does not include Tylenol, Advil, Motrin, Nuprin, Midol, or Ibuprofen among others.

- Yes
No

66a. Do you (Does [name]) regularly take medicine for pain or inflammation that does NOT contain aspirin? This would include Tylenol, Advil, Motrin, Nuprin, Midol, or Ibuprofen among others.

- Yes
No

[Questions 67-68 deleted]

Next, I have a few miscellaneous questions.

69. Do you (Does [name]) now smoke cigarettes?

- Yes
No

70. Please tell me which of the following describes your [name's] current marital status:

- Married
Widowed
Divorced
Separated
Never Married

H. ADMINISTRATIVE INFORMATION

71. AFU Completion Status:

- a. Complete
- b. Partially complete; contact again within window (interruptions) ...
- c. Partially complete; unable to complete within window (done)

CLOSURE SCRIPT:

If participant deceased: "We may need to contact a family member later. When would be a good time to call in that case?"