

Attach ID Label Here

- -
 Month Day Year

FORM 10 (1-3) AUG 86

BIRTHDATE

6. Date of Birth: - -
Month Day Year

Participant is ineligible if age < 45 or > 69 years as of today's date.

7. Do you plan to change your permanent residence more than 50 miles away from this area during the next year? 1 ☐ yes 2 ☐ no
8. Will you travel so extensively or move from the area for such long periods of time each year that it would make study participation difficult? 1 ☐ yes 2 ☐ no
9. Do you take medicine prescribed by a doctor for diabetes? 1 ☐ yes 2 ☐ no
10. Have you ever been hospitalized for a week or more for a heart attack? 1 ☐ yes 2 ☐ no
11. Have you ever been hospitalized for a week or more for a stroke? 1 ☐ yes 2 ☐ no

12. Blood Pressure Measurements (Standard Sphygmomanometer):

Arm circumference: _____ cm

Cuff size (check one): ___ pediatric (<24.5 cm) ___ regular adult (24.5-33 cm) ___ large adult (>33 cm)

Pulse obliteration _____ + 30 = _____ Peak inflation level

After applying the appropriate cuff, the participant must be seated without legs crossed for 5 minutes before taking the 2 readings. Wait 30 seconds after the 1st reading before taking the 2nd reading.

Reading	Systolic	Diastolic (5th Phase)
1st	<input type="text"/> <input type="text"/> <input type="text"/> mm Hg	<input type="text"/> <input type="text"/> <input type="text"/> mm Hg
2nd	<input type="text"/> <input type="text"/> <input type="text"/> mm Hg	<input type="text"/> <input type="text"/> <input type="text"/> mm Hg
Average	<input type="text"/> <input type="text"/> <input type="text"/> mm Hg	<input type="text"/> <input type="text"/> <input type="text"/> mm Hg
Blood pressure observer's code: <input type="text"/> <input type="text"/>		

13. Are you currently taking blood pressure medication?

1 ☐ yes

2 ☐ no

14. When did you first begin taking blood pressure medication?

-
Month Year

15. Are you currently taking more than one class of blood pressure medication?

1 ☐ yes 2 ☐ no

One class of blood pressure medication is defined as taking one blood pressure drug or taking a pill/capsule medication which is a combination of two drugs of the same type, e.g. dyazide.

16. Is the participant's average DBP (item 12) \geq 95 mmHg?

1 ☐ yes 2 ☐ no

CONTINUE WITH ITEM 18.

17. Is the participant's average DBP (item 12) < 90 or > 99 mmHg?

1 ☐ yes 2 ☐ no

21. Have you been troubled in the **past three months** with any of the following specific conditions? (If a participant has been troubled, ask him/her to indicate the severity of the condition (mild, moderate, severe). For those conditions volunteered by the participant which are not listed below, please write them in item 22.)

Definitions of severity:

Mild - bothersome, but does not interfere with usual daily activities

Moderate - interferes with usual daily activities

Severe - so bad that you cannot perform usual daily activities

		No, not troubled	Yes, mildly	Yes, moderately	Yes, severely
a. Fever?		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
b. Unexpected sweating?		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
c. Drowsiness or sleepiness?	SEBL_1	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
d. Tiredness or fatigue?	SEBL_2	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
e. Weakness?		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
f. Faintness or dizziness when arising in the morning, or on hot days or after exercise?	SEBL_3	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
g. Blacking out or losing consciousness?		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
h. Faintness or lightheadedness when you stand up quickly?		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
i. Hair loss?		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
j. Abnormal hair growth?		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
k. Flushed face?		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
l. Itchy skin (urticaria, hives)?	SEBL_4	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
m. Skin rash?	SEBL_5	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
n. Unusual bruises?		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
o. Abnormal bleeding?		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
p. Headaches?	SEBL_6	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
q. Ringing in the ears?	SEBL_7	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
r. Stuffy nose?	SEBL_8	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
s. Change in taste perception?		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
t. Blurring of vision?		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
u. Excessive thirst?		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
v. Dry mouth?	SEBL_9	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

	No, not troubled	Yes, mildly	Yes, moderately	Yes, severely
w. Wheezing?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
x. Cough? SEBL_10	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
y. Shortness of breath?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
z. Heart beating unusually fast or skipping beats? SEBL_11	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
aa. Episodes of chest pain, pressure or heaviness in the chest? SEBL_12	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
bb. Swelling or tenderness of the breasts?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
cc. Lack of appetite?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
dd. Diarrhea?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
ee. Constipation?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
ff. Abdominal pain?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
gg. Nausea or vomiting?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
hh. Black or tarry stools?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
ii. Bright red blood in stools?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
jj. Incoordination or unsteadiness when standing?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
kk. Pain in any joint? SEBL_13	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
ll. Coldness or blanching of fingers or toes?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
mm. Swelling of feet or ankles? SEBL_14	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
nn. Muscle pain or cramps? SEBL_15	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
oo. Muscle tremors?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
pp. Numbness or tingling? SEBL_16	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
qq. Trouble falling asleep? SEBL_17	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
rr. Waking up early, having trouble getting back to sleep?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
ss. Nightmares? SEBL_18	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
tt. Disturbances in memory?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
uu. Nervousness?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
vv. Mood changes? SEBL_19	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
ww. Feeling depressed (sad or blue) SEBL_20	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

PART I: DEMOGRAPHIC QUESTIONNAIRE

1. Social Security Number: - -

2. What is your present job status?

- 1 ☐ working at a job full-time for pay
- 2 ☐ working at a job part-time for pay
- 3 ☐ homemaker
- 4 ☐ retired
- 5 ☐ temporarily laid off
- 6 ☐ unemployed
- 7 ☐ other, specify: _____

3. What is/was your occupation? _____

4. What was your total family income last year before deductions and taxes? Include family income from all sources.

- | | | |
|---|---|--------|
| 1 <input type="checkbox"/> Less than \$9,999 | 5 <input type="checkbox"/> \$40,000 to \$49,999 | INCOME |
| 2 <input type="checkbox"/> \$10,000 to \$19,999 | 6 <input type="checkbox"/> \$50,000 to \$59,999 | |
| 3 <input type="checkbox"/> \$20,000 to \$29,999 | 7 <input type="checkbox"/> \$60,000 to \$69,999 | |
| 4 <input type="checkbox"/> \$30,000 to \$39,999 | 8 <input type="checkbox"/> \$70,000 or more | |

5. What is your present marital status? MARITAL

- 1 ☐ Never married 2 ☐ Separated 3 ☐ Divorced 4 ☐ Widowed 5 ☐ Married

6. How much formal education have you completed?

- 1 ☐ Eighth grade or less
- 2 ☐ Trade school or business school instead of high school
- 3 ☐ Some high school
- 4 ☐ High school graduate
- 5 ☐ Trade school or business school after graduating from high school
- 6 ☐ Some college including 2 year degrees
- 7 ☐ Received bachelor's degree
- 8 ☐ Graduate or professional education beyond the bachelor's degree
- 9 ☐ Graduate or professional degree (Specify): _____

EDUC

URINALYSIS (LABSTIX)

Check the appropriate box for each determination:

12. Blood 1 ☐ negative 2 ☐ small 3 ☐ moderate 4 ☐ large
13. Ketones 1 ☐ negative 2 ☐ small 3 ☐ moderate 4 ☐ large
14. Glucose 1 ☐ negative 2 ☐ ^{trace} 0.1 g/dl 3 ☐ ⁺ 0.25 g/dl 4 ☐ ⁺⁺ 0.5 g/dl 5 ☐ ⁺⁺⁺ 1 g/dl 6 ☐ ⁺⁺⁺⁺ 2 g/dl
15. Protein 1 ☐ negative 2 ☐ trace 3 ☐ ⁺ 30 mg/dl 4 ☐ ⁺⁺ 100 5 ☐ ⁺⁺⁺ 300 6 ☐ ⁺⁺⁺⁺ 1000
16. pH 1 ☐ - 2 ☐ five (5) 3 ☐ six (6) 4 ☐ seven (7) 5 ☐ eight (8) 6 ☐ nine (9)

17. Have you ever smoked cigarettes? EVERSMK

- 1 ☐ yes →
- 2 ☐ no
- ↓

18. Do you now smoke cigarettes?

- 1 ☐ yes →
- 2 ☐ no

NOWSMK

↓

19. On the average, about how many cigarettes do you now smoke a day?

AMTSMK

CONTINUE WITH ITEM 20.

CONTINUE WITH ITEM 20.

20. Do you smoke cigars, cigarillos or pipes? 1 ☐ yes 2 ☐ no

Reminder: Complete items 7 through 9 on the exclusion checklist (page 11).

The following questions are about your health and your daily activities. You may find that some of the questions seem alike. It is important for our study to ask the questions in this way. Please try to answer every question as accurately as you can. Check one box for each item.

81. In general, would you say your health is:

- 1 ☐ Excellent
 2 ☐ Very good
 3 ☐ Good
 4 ☐ Fair
 5 ☐ Poor
- QL12_1

82. In the past month, to what extent did health problems limit you in your everyday physical activities (such as walking and climbing stairs)?

- 1 ☐ Not at all
 2 ☐ Slightly
 3 ☐ Moderately
 4 ☐ Quite a bit
 5 ☐ Extremely
- QL12_2

83. During the past month, how much difficulty did you have doing your daily work, both inside and outside the house, because of your physical health or emotional problems?

- 1 ☐ None at all
 2 ☐ A little bit
 3 ☐ Some
 4 ☐ Quite a bit
 5 ☐ Could not do daily work
- QL12_3

84. How satisfied are you with your physical ability to do what you want to do?

- 1 ☐ Completely satisfied
 2 ☐ Very satisfied
 3 ☐ Somewhat satisfied
 4 ☐ Somewhat dissatisfied
 5 ☐ Very dissatisfied
 6 ☐ Completely dissatisfied
- QL12_4

85. How TRUE or FALSE are each of the following statements for you? There are no right or wrong answers.

		Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
QL12_5	a. My health is excellent.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
QL12_6	b. I think my health will be worse in the future than it is now.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
QL12_7	c. I have been feeling bad lately.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
	d. Good health is in my future.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
QL12_9	e. I feel about as good now as I ever have.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

QL12_8

The next questions ask about your social activities.

86. During the past month, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

- 1 ☐ Not at all
 - 2 ☐ Slightly
 - 3 ☐ Moderately
 - 4 ☐ A great deal
 - 5 ☐ Extremely
- QL12_10

87. During the past month, about how often have you had friends over to your home?

- 1 ☐ Every day
 - 2 ☐ Several days a week
 - 3 ☐ About once a week
 - 4 ☐ 2 or 3 times in the past month
 - 5 ☐ Once in the past month
 - 6 ☐ Not at all in the past month
- QL12_11

88. About how often have you visited with friends at their homes during the past month?

- 1 ☐ Every day
 - 2 ☐ Several days a week
 - 3 ☐ About once a week
 - 4 ☐ 2 or 3 times in the past month
 - 5 ☐ Once in the past month
 - 6 ☐ Not at all in the past month
- QL12_12

89. Compared to others your age, are your social activities more or less limited because of your physical health or emotional problems?

- 1 ☐ Much more limited than others
 - 2 ☐ Somewhat more limited than others
 - 3 ☐ About the same as others
 - 4 ☐ Somewhat less limited than others
 - 5 ☐ Much less limited than others
- QL12_13

These questions are about how you feel and how things have been with you during the past month. For each question, check the box which comes closest to the way you have been feeling.

90. How much of the time during the past month has your daily life been full of things that were interesting to you?

- 1 ☐ All of the time
 - 2 ☐ Most of the time
 - 3 ☐ A good bit of the time
 - 4 ☐ Some of the time
 - 5 ☐ A little of the time
 - 6 ☐ None of the time
- QL12_14

91. How often during the last month did you feel worn out?

- 1 ☐ All of the time
 - 2 ☐ Most of the time
 - 3 ☐ A good bit of the time
 - 4 ☐ Some of the time
 - 5 ☐ A little of the time
 - 6 ☐ None of the time
- QL12_15

92. During the past month, how much of the time have you felt tense or "high strung"?

- 1 ☐ All of the time
 - 2 ☐ Most of the time
 - 3 ☐ A good bit of the time
 - 4 ☐ Some of the time
 - 5 ☐ A little of the time
 - 6 ☐ None of the time
- QL12_16

93. How often during the last month did you have enough energy to do the things you wanted to do?

- 1 ☐ All of the time
 - 2 ☐ Most of the time
 - 3 ☐ A good bit of the time
 - 4 ☐ Some of the time
 - 5 ☐ A little of the time
 - 6 ☐ None of the time
- QL12_17

94. How much of the time during the past month have you felt downhearted and blue?

- 1 ☐ All of the time
 - 2 ☐ Most of the time
 - 3 ☐ A good bit of the time
 - 4 ☐ Some of the time
 - 5 ☐ A little of the time
 - 6 ☐ None of the time
- QL12_18

95. During the past month, how much of the time were you a happy person?

- 1 ☐ All of the time
 - 2 ☐ Most of the time
 - 3 ☐ A good bit of the time
 - 4 ☐ Some of the time
 - 5 ☐ A little of the time
 - 6 ☐ None of the time
- QL12_19

96. During the past month, how much of the time have you been anxious or worried?

- 1 ☐ All of the time
 - 2 ☐ Most of the time
 - 3 ☐ A good bit of the time
 - 4 ☐ Some of the time
 - 5 ☐ A little of the time
 - 6 ☐ None of the time
- QL12_20

97. During the past month, how much of the time have you been in low or very low spirits?

- 1 ☐ All of the time
- 2 ☐ Most of the time
- 3 ☐ A good bit of the time QL12_21
- 4 ☐ Some of the time
- 5 ☐ A little of the time
- 6 ☐ None of the time

98. How much of the time, during the past month, have you felt calm and peaceful?

- 1 ☐ All of the time
- 2 ☐ Most of the time
- 3 ☐ A good bit of the time QL12_22
- 4 ☐ Some of the time
- 5 ☐ A little of the time
- 6 ☐ None of the time

99. How often during the last month did you feel full of pep?

- 1 ☐ All of the time
- 2 ☐ Most of the time
- 3 ☐ A good bit of the time QL12_23
- 4 ☐ Some of the time
- 5 ☐ A little of the time
- 6 ☐ None of the time

100. How much of the time during the past month have you been a very nervous person?

- 1 ☐ All of the time
- 2 ☐ Most of the time
- 3 ☐ A good bit of the time QL12_24
- 4 ☐ Some of the time
- 5 ☐ A little of the time
- 6 ☐ None of the time

101. During the past month, how much of the time have you felt depressed?

- 1 ☐ All of the time
- 2 ☐ Most of the time
- 3 ☐ A good bit of the time QL12_25
- 4 ☐ Some of the time
- 5 ☐ A little of the time
- 6 ☐ None of the time

102. How much of the time during the past month have you felt cheerful and light-hearted?

- 1 ☐ All of the time
- 2 ☐ Most of the time
- 3 ☐ A good bit of the time QL12_26
- 4 ☐ Some of the time
- 5 ☐ A little of the time
- 6 ☐ None of the time

103. During the past month, how much of the time have you felt restless, fidgety or impatient?

- 1 ☐ All of the time
- 2 ☐ Most of the time
- 3 ☐ A good bit of the time QL12_27
- 4 ☐ Some of the time
- 5 ☐ A little of the time
- 6 ☐ None of the time

104. How often during the past month have you felt so down in the dumps that nothing could cheer you up?

- 1 ☐ Always
- 2 ☐ Very often
- 3 ☐ Fairly often QL12_28
- 4 ☐ Sometimes
- 5 ☐ Almost never
- 6 ☐ Never

105. During the past month, how much of the time have you been moody or brooded about things?

- 1 ☐ All of the time
- 2 ☐ Most of the time
- 3 ☐ A good bit of the time QL12_29
- 4 ☐ Some of the time
- 5 ☐ A little of the time
- 6 ☐ None of the time

106. How often during the last month did you feel tired?

- 1 ☐ All of the time
- 2 ☐ Most of the time
- 3 ☐ A good bit of the time QL12_30
- 4 ☐ Some of the time
- 5 ☐ A little of the time
- 6 ☐ None of the time

107. How TRUE or FALSE are each of the following statements for you? There are no right or wrong answers.

		Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
QL12_31	a. I am somewhat ill.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
QL12_32	b. I expect to have a very healthy life.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
QL12_33	c. I am in poor health.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
QL12_34	d. I am as healthy as anybody I know.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
QL12_35	e. My future will be unhealthy.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

TREATMENT OF MILD HYPERTENSION STUDY
TWELVE MONTH VISIT (12MO)

Attach ID Label Here

Date of Visit: - -
Month Day Year

Time: : 1 ☐ am
2 ☐ pm

INSTRUCTIONS: This visit should be conducted for all randomized participants 52 weeks \pm 2 weeks after randomization. Please use a ball point pen and press firmly.

Participant's name: _____

1. Did the participant attend this visit?

1 ☐ yes \longrightarrow **CONTINUE WITH QUESTION 3.**

2 ☐ no \longrightarrow

2. Why was this visit missed? (Check "yes" or "no" for each of the reasons listed below)

a. Participant refuses to come to the clinic. 1 ☐ yes 2 ☐ no

b. Clinical Center schedule or workload made it impossible to schedule the participant. 1 ☐ yes 2 ☐ no

c. Participant's work schedule or other commitments made it impossible to schedule this visit. 1 ☐ yes 2 ☐ no

d. Participant temporarily out of town. 1 ☐ yes 2 ☐ no

e. Participant hospitalized or ill. 1 ☐ yes 2 ☐ no

f. Participant moved out of the area of the Clinical Center. 1 ☐ yes 2 ☐ no

g. Other (specify): _____ 1 ☐ yes 2 ☐ no

3. Weight (nearest half pound, without shoes): lbs. WT12

4. Room Temperature: °F

5. Pulse: Beats in 30 seconds x 2 = _____ beats/minute

PULSE12