

Physician Questionnaire Form

FORM CODE: PHQ 05/05/2014 VERSION: C

WITHARH ONE HITARY														
ID NUMBER:						CONT	ACT \	YEAR:						
LAST NAME:								INITI	ALS:					
Public reporting burde searching existing data conduct or sponsor, an comments regarding the Project Clearance Brato this address.	a sources, gatherind a person is not nis burden estima	ng and maint required to r te or any oth	taining the dat espond to, a co er aspect of th	a neede ollection is collec	d, and comp n of informa ction of info	leting and tion unle rmation,	d review ss it disp includin	ving the co plays a cur ng suggesti	llection or rently valons for re	of infor lid OM educing	mation. B contro g this bur	An agence of number rden, to: 1	cy may not Send NIH,	
				JHS (Center use	only								
Decedent's Name:				Ag	e: D	ate of B	irth:	_//_	Da	ate of	Death:	/_	_/	
EVENT ID: Sequence Number: Physician's Name														
	Plea	se compl	ete the foll	owin	g and ret	urn in	the en	closed e	nvelop	pe.				
A. MEDICAL H	Please complete the following and return in the enclosed envelope. A. MEDICAL HISTORY													
1. Are you famili	ar with the d	ecedent's	medical h	istory	?									
	Yes	No.		No, s	skip to Ito	em 5 o	n Page	e 3.						
2. When did you last see the decedent? Month Year														
3. Did the decedent have a history of any of the following?														
a. Angina pector	ris or corona	ry insuffi		Yes	<u>No</u>	<u>Unc</u>	certair	1						
b. Valvular disea	ase or cardic	myopath	y	П		[
c. Coronary byp	ass surgery					· [
d. Coronary ang	ioplasty					· [
e. Hypertension														
f. Myocardial in	farction					ا]								
					ш	L								

g. If MI Yes, date of most recent e	event:	Month	_	Year				
3. (cont'd) Did the decedent have a	history	of any of	the follo	owing?				
		<u>Yes</u>	<u>No</u>	<u>Uncertain</u>				
h. Other chronic ischemic heart di	sease:							
i. Stroke (CVA):		. 🖵						
j. <u>If Yes</u> , date of most recent event: Month Year								
k. Any non-cardiac condition that have contributed to this death:	might	Yes	No	<u>Uncertain</u>				
└ <u>If Yes</u> , specify:								
		Yes	<u>No</u>	<u>Uncertain</u>				
l. Diabetes:								
m. Cigarette smoking:								
4. Was the decedent taking any of the following medications within four weeks prior to death?								
	Yes	<u>No</u>	Uncert	ain_				
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:								

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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 & 6, skip to Item 14 on page 4.
Yes No	Otherwise, continue with Item 7.
7.a. Was there any pain in the chest, left arm or shou within 72 hours of death?	ılder or jaw
Yes No Uncertain If No or Uncertain,	, skip 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 thin	nk was the cause:
8. Did the decedent take (or was he/she given) nitrate at the time of the acute episode?	es
Yes No Uncertain	
9. Was coronary reperfusion (intravenous or intracor TPA, angioplasty, etc.) attempted during the acute	
Yes No Uncertain	
10. Was CPR and/or cardioversion performed within	n 24 hours of death?
Yes No Uncertain	

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11. Please give time between onset of acute sympton defining death as the point where spontaneous bruthe 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) 12. Would you classify the decedent's cause of death Yes No Uncertain 13. If No, what do you believe be the cause of death? 				
a. Pulmonary embolism b. Acute pulmonary edema c. Stroke d. Pneumonia e. Other	No Uncertain			
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: 16. Self (A) Interview	/ (B) E.R. records (C)			

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