



Annual Follow-Up Other Form

ID NUMBER:

CONTACT YEAR:

FORM CODE: AFO
VERSION D 10/15/2006

LAST NAME:

INITIALS:

INSTRUCTIONS: This form should be completed each year during the annual follow-up call. ID Number, Contact Year, and Name must be entered above. Whenever numerical responses are required, enter the number so that the last digit appears in the rightmost box. Enter leading zeroes where necessary to fill all boxes. If a number is entered incorrectly, mark through the incorrect entry with an "X". Code the correct entry clearly above the incorrect entry. For "multiple choice" and "yes/no" type questions, circle the letter corresponding to the most appropriate response. If a letter is circled incorrectly, mark through it with an "X" and circle the correct response.

I would like to ask you about some health care experiences you may have had in the past year.

1. In the past year have you had any of the following tests or procedures?

	<u>Yes</u>	<u>No</u>	<u>Don't Know</u>	<u>Refused</u>	<u>Missing</u>	1a1-1c1. <u>Reason?</u> (see codes below)
1a. Echocardiogram	1	2	7	8	9	<input type="text"/> <input type="text"/>
1b. ECG	1	2	7	8	9	<input type="text"/> <input type="text"/>
1c. Exercise stress test	1	2	7	8	9	<input type="text"/> <input type="text"/>

IF YES TO ITEMS 1a-c, ASK: What was the reason for the test / procedure?

[IF USING PAPER FORM ENTER NUMBER IN TEXT BOX THAT CORRESPONDS TO ONE OF THE CODES DESIGNATED BELOW FOR EACH ITEM. IF USING DMS, SELECT FROM DROP DOWN MENU FOR EACH ITEM]

1a1 -1c1. Select from one of the following codes:

- | | | | |
|--------------------------------------------------|----|-------------------------------------|----|
| Routine physical..... | 01 | Heart failure / fluid on lungs..... | 02 |
| Follow up of heart problem (surgery/stent) | 03 | Heart murmur | 04 |
| Chest pain / discomfort | 05 | Heart rhythm disturbance..... | 06 |
| Other (Specify) | 07 | Don't know | 77 |
| Refused | 88 | Missing | 99 |

1a2-1c2. Specify:

	<u>Yes</u>	<u>No</u>	<u>Don't Know</u>	<u>Missing</u>	<u>Refused</u>	
1d. CT/ MRI head	1	2	7	8	9	<input type="text"/> <input type="text"/>

IF YES TO ITEMS 1d, ASK: What was the reason for the test / procedure?

[IF USING PAPER FORM ENTER NUMBER IN TEXT BOX THAT CORRESPONDS TO ONE OF THE CODES DESIGNATED BELOW FOR EACH ITEM. IF USING DMS, SELECT FROM DROP DOWN MENU FOR EACH ITEM]

1d1. Select from one of the following codes:.....

- | | | | |
|---------------------------------------|---|-----------------------|---|
| Forgetfulness / trouble thinking..... | 1 | Stroke | 2 |
| TIA or "little" strokes | 3 | Other (specify) | 4 |
| Don't know | 7 | Refused | 8 |
| Missing | 9 | | |

1d2. Specify:

1e. Catheterization or angiogram..... 1 2 7 8 9

IF 1 e. is YES, ASK: Was that arteriogram to look at the blood vessels in your:

2a1-2d1. Reason?
(see codes below)

- | | | | | | | |
|----------------------------------------|---|---|---|---|---|-------------------------------------------|
| 1e-1. neck (Carotid arteriogram) | 1 | 2 | 7 | 8 | 9 | <input type="text"/> <input type="text"/> |
| 1e-2. heart (Coronary arteriogram). .. | 1 | 2 | 7 | 8 | 9 | <input type="text"/> <input type="text"/> |
| 1e-3. kidneys (Renal arteriogram) .. | 1 | 2 | 7 | 8 | 9 | <input type="text"/> <input type="text"/> |
| 1e-4. legs (peripheral vascular) | 1 | 2 | 7 | 8 | 9 | <input type="text"/> <input type="text"/> |

IF YES TO ITEMS 1e1-1e4. ASK: What was the reason for the test / procedure?

[IF USING PAPER FORM ENTER NUMBER IN TEXT BOX THAT CORRESPONDS TO ONE OF THE CODES DESIGNATED BELOW FOR EACH ITEM. IF USING DMS, SELECT FROM DROP DOWN MENU FOR EACH ITEM]

2a-d. Select from one of the following codes:

- | | | | |
|------------------------------------------------------|---|-------------------------------------|---|
| Emergency for a heart attack..... | 1 | Emergency for a stroke | 2 |
| Follow up after heart attack or surgery / stent..... | 3 | Doctors suspected disease/blockage. | 4 |
| Chest pain / discomfort | 5 | Leg pain with walking..... | 6 |

Other (Specify) 7

Don't know 77

Refused 88

Missing 99

2d. Specify:

Grid of 14 empty boxes for specifying information.

Grid of 14 empty boxes for specifying information.

3. In the past year (that is, since your last JHS contact), have you had any change in your family history? That is, have your natural parents, any of your full brothers or sisters, or your natural children died?

..... Yes 1

No 2

Don't Know 7

Refused 8

Missing 9

Go to Item 5

4. For each person who died, determine:

4-a1. Relationship?

4-a2. Cause of death?

4-a3. Age at death?

Mother 1

Cancer 1

Grid of 3 empty boxes for age at death.

Father 2

Heart Attack 2

Sibling 3

Stroke 3

Child 4

Other (Specify) 4

Unknown 7

4.a4 Specify:

Grid of 14 empty boxes for specifying information.

Grid of 14 empty boxes for specifying information.

4-b1. Relationship?

4-b2. Cause of death?

4-b3. Age at death?

Mother 1

Cancer 1

Grid of 3 empty boxes for age at death.

Father 2

Heart Attack 2

Sibling 3

Stroke 3

Child 4

Other (Specify) 4

Unknown 7

4-b4. Specify:

Grid of 14 empty boxes for specifying information.

Grid of 14 empty boxes for specifying information.

4-c1. Relationship?

Mother	1
Father	2
Sibling	3
Child	4

4-c2. Cause of death?

Cancer	1
Heart Attack	2
Stroke	3
Other (Specify)	4
Unknown	7

4-c3. Age at death?

--	--	--

4-c4. Specify:

4-d1. Relationship ?

Mother	1
Father	2
Sibling	3
Child	4

4-d2. Cause of death ?

Cancer	1
Heart Attack	2
Stroke	3
Other (Specify)	4
Unknown	7

4-d3. Age at death?

--	--	--

4-d4. Specify:

5. In the past year (that is, since you last JHS contact), have any members of your family (natural parents, full siblings, natural children) been newly diagnosed (that is, have they been told by a health care provider that they have) with high blood pressure, heart disease, stroke, diabetes (sugar in the blood) or cancer?

..... Yes 1

No 2

Don't Know 7

Refused 8

Missing 9

Go to Item 7

6. For each person who has a new diagnosis (been told by health care professional), determine:

6-a1. Relationship ?		6-a2. Told has ?		6-a3. Age at diagnosis		
Mother	1	High blood pressure	1	<input type="text"/>	<input type="text"/>	<input type="text"/>
Father	2	Stroke	2	<input type="text"/>	<input type="text"/>	<input type="text"/>
Sibling	3	Heart Disease	3	<input type="text"/>	<input type="text"/>	<input type="text"/>
Child	4	Diabetes	4			
		Cancer	5			
		Other (Specify)	7			

6-a4. Specify:

6-b1. Relationship ?		6-b2. Told has ?		6-b3. Age at diagnosis		
Mother	1	High blood pressure	1	<input type="text"/>	<input type="text"/>	<input type="text"/>
Father	2	Stroke	2	<input type="text"/>	<input type="text"/>	<input type="text"/>
Sibling	3	Heart Disease	3	<input type="text"/>	<input type="text"/>	<input type="text"/>
Child	4	Diabetes	4			
		Cancer	5			
		Other (Specify)	7			

6-b4. Specify:

6-c1. Relationship ?		6-c2. Told has ?		6-c3. Age at diagnosis		
Mother	1	High blood pressure	1	<input type="text"/>	<input type="text"/>	<input type="text"/>
Father	2	Stroke	2	<input type="text"/>	<input type="text"/>	<input type="text"/>
Sibling	3	Heart Disease	3	<input type="text"/>	<input type="text"/>	<input type="text"/>
Child	4	Diabetes	4			
		Cancer	5			
		Other (Specify)	7			

6-c4. Specify:

8. How often have you felt sad or depressed

over the past year: almost never, seldom, sometimes,

- often, very often, or constantly?.....
- | | |
|--------------|---|
| Almost never | 1 |
| Seldom | 2 |
| Sometimes | 3 |
| Often | 4 |
| Very often | 5 |
| Constantly | 6 |
| Don't Know | 7 |
| Refused | 8 |
| Missing | 9 |

9. How often have you felt nervous or tense

- over the past year?
- | | |
|--------------|---|
| Almost never | 1 |
| Seldom | 2 |
| Sometimes | 3 |
| Often | 4 |
| Very often | 5 |
| Constantly | 6 |
| Don't Know | 7 |
| Refused | 8 |
| Missing | 9 |

10. How often have you felt you were treated unfairly

- or discriminated against over the past year?
- | | |
|--------------|---|
| Almost never | 1 |
| Seldom | 2 |
| Sometimes | 3 |
| Often | 4 |
| Very often | 5 |
| Constantly | 6 |
| Don't Know | 7 |
| Refused | 8 |
| Missing | 9 |

11. How well have you handled or coped with stressors you experienced over the past year? Would you say very poorly, poorly, fair, pretty well, well, or very well?

Very poorly	1
Poorly	2
Fair	3
Pretty well	4
Well	5
Very well	6
Don't Know	7
Refused	8
Missing	9

12. How satisfied are you with the help or support that you've received from others over the past year? Are you very dissatisfied, somewhat dissatisfied, a little dissatisfied, a little satisfied, somewhat satisfied, or very satisfied?

Very dissatisfied	1
Somewhat dissatisfied	2
A little dissatisfied	3
A little satisfied	4
Somewhat satisfied	5
Very satisfied	6
Don't Know	7
Refused	8
Missing	9

13. In the past year, have you seen:

	<u>Yes</u>	<u>No</u>	<u>Don't Know</u>	<u>Refused</u>	<u>Missing</u>
a. a dentist	1	2	7	8	9
b. a doctor or health professional for routine physical exam or general check-up, that is when you are not sick	1	2	7	8	9
c. a chiropractor	1	2	7	8	9
d. a person who uses acupuncture	1	2	7	8	9

	<u>Yes</u>	<u>No</u>	<u>Don't Know</u>	<u>Refused</u>	<u>Missing</u>
e. a faith healer	1	2	7	8	9
f. a person who heals with roots or herbs	1	2	7	8	9
g. a person who practices astrology or reads zodiac signs	1	2	7	8	9
h. a person who reads tea leaves, roots or palms	1	2	7	8	9

14. Are you currently covered by one or more health insurance programs that pays most or all of your health care expenses?

Yes	1	Skip 16
No	2	
Don't Know	7	
Refused	8	
Missing	9	

15. How long has it been since you had health insurance coverage?

Less than 1 year	1	Skip 20
1 to 2 years	2	
More than 3 years	3	
Don't Know	7	
Refused	8	
Missing	9	

16. Are you currently covered by any of the following program (Answer each item)

	<u>Yes</u>	<u>No</u>	<u>Don't Know</u>	<u>Refused</u>	<u>Missing</u>
a. Private health insurance such as Blue Cross/Blue Shield?	1	2	7	8	9
b. Medicaid or public aid?	1	2	7	8	8

	<u>Yes</u>	<u>No</u>	<u>Don't Know</u>	<u>Refused</u>	<u>Missing</u>
c. Medicare, a government plan that pays health care bills for people aged 65 and over?	1	2	7	8	9
d. Veterans Administration, CHAMPUS, or TRICARE?	1	2	7	8	9
e. Other	1	2	7	8	9

17. (Answer all items) Have you experienced any of the following changes in health insurance benefits in the past year, or since your last JHS annual follow up telephone call?

	<u>Yes</u>	<u>No</u>	<u>Don't Know</u>	<u>Refused</u>	<u>Missing</u>
a. An increase in the price of the premiums	1	2	7	8	9
b. A cut in benefits	1	2	7	8	9
c. An increase in your share of the medical costs	1	2	7	8	9

18. Has there been a time in the past year when you did not have health insurance coverage?.....

Yes	1
No	2
Don't Know	7
Refused	8
Missing	9

19. On average, how much do you pay each month for your medication?

Less than \$20	1
\$20 - \$40	2
\$41 - \$75	3
\$76 - 100	4
\$101 - \$250	5
More than \$250	6
Don't know	7
Refused	8
Missing	9

20. Do you have health insurance that helps you pay for your medications?

Yes	1	
No	2	Go to Item 23
Don't Know	7	
Refused	8	
Missing	9	

21. Do you pay a co-payment when you fill your medication?

Yes	1
No	2
Don't Know	7
Refused	8
Missing	9

22. Some medication insurance plans have various "limits" on what they will cover when paying for medications. I am going to read a list of possible limitations that your insurance plan may have. For each item, please tell me if your plan this limit.

	<u>Yes</u>	<u>No</u>	<u>Don't Know</u>	<u>Refused</u>	<u>Missing</u>
a. My plan has no limits on my medication coverage	1	2	7	8	9
b. My plan has a dollar limit per month	1	2	7	8	9
c. IF YES to 22b, ask: How much is the dollar limit?	<input type="text"/> <input type="text"/> <input type="text"/>				
d. My plan limits the number of medications it will pay for per month (or quarter if using 3 month prescriptions).	1	2	7	8	9
e. IF YES to 22d, ask: How many medications can you obtain?	<input type="text"/> <input type="text"/>				
f. My plan limits how often I can fill my prescriptions.....	1	2	7	8	9
g. IF YES to item 22f, ask: What is the time limit for filling your prescriptions?	<input type="text"/> <input type="text"/>				
h. Any other limits?	1	2	7	8	9

i. List.....

Next I will ask you some questions regarding the care that you have received in your doctor's or nurse practitioner's office or in some health care clinic.

23. How many times in the past year did you go to a doctor's or nurse practitioner's office to get care for yourself?.....	None	01	<div style="border: 1px solid black; padding: 2px; display: inline-block;">Go to Item 29</div>
	1	02	
	2	03	
	3	04	
	4	05	
	5 to 9	06	
	10 or more	07	
	Don't Know	77	
	Refused	88	
	Missing	99	

24. How often did your doctor or other health care providers listen carefully to you?	Never	1
	Sometimes	2
	Usually	3
	Always	4
	Don't know	7
	Refused	8
	Missing	9

25. How often did your doctor or other health providers explain things in a way you could understand?	Never	1
	Sometimes	2
	Usually	3
	Always	4
	Don't Know	7
	Refused	8
	Missing	9

26. How often did your doctor or other health care providers show respect for what you had to say? Never 1
- Sometimes 2
- Usually 3
- Always 4
- Don't Know 7
- Refused 8
- Missing 9
27. How often did your doctor or other health care providers spend enough time with you? Never 1
- Sometimes 2
- Usually 3
- Always 4
- Don't Know 7
- Refused 8
- Missing 9
28. Overall, how satisfied have you been with the quality of health care you have received in the past year?..... Very satisfied 1
- Somewhat satisfied 2
- Somewhat dissatisfied 3
- Very dissatisfied 4
- Not sure 5
- Don't Know 7
- Refused 8
- Missing 9

Now I will ask you questions regarding any problems that you have had when you have tried to get health care.

29. In the past year, how much of a problem has it been to get the health care, medical tests, or treatment you or your doctor or nurse practitioner believed necessary? ..A big problem 1
 A small problem 2
 Not a problem 3
 Don't Know 7
 Refused 8
 Missing 9

30. Has there been a time in the past year when you went without needed health care because of costs? Yes 1
 No 2 — Skip to 32
 Don't Know 7
 Refused 8
 Missing 9

31. What type of health care did you do without because of costs? (**Answer each item**)

	<u>Yes</u>	<u>No</u>	<u>Don't Know</u>	<u>Refused</u>	<u>Missing</u>
a. Did not fill a prescription	1	2	7	8	9
b. Did not see a specialist when needed	1	2	7	8	9
c. Skipped a medical test, treatment of follow-up	1	2	7	8	9
d. Had medical problems, but did not see a doctor or nurse practitioner	1	2	7	8	9
Other					

32. How confident are you that you can get high quality health care when you need it?..... Very confident 1
 Somewhat confident 2
 Not too confident 3
 Not at all confident 4
 Don't Know 7
 Refused 8
 Missing 9

33. [DO NOT ASK] Is the participant male or female? Male 1 — Go to Item 39
 Female 2

34. [DO NOT ASK] Has the participant completed a previous version "A" or "B" of Annual Follow-up? Yes 1
 No 2
 Go to Item 35b

35 a. Since we last contacted you on (mm/dd/yyyy), have you taken or used any female hormone pills, skin patches, shots or implants? Yes 1
 No 2
 Go to Item 35c
 Go to Item 39

35 b. Since your JHS visit on (mm/dd/yyyy), have you taken or used any female hormone pills, skin patches, shots or implants?..... Yes 1
 No 2
 Go to Item 39

Please give me the names of the female hormones you have used since our last contact (since that exam), starting with any you may be taking currently or with the most recent one. Please exclude hormone creams.

35 c. Name 1:

36. Code 1:

--	--	--	--	--	--

37. Have you also used a second female hormone since we last contacted you?..... Yes 1
 No 2
 Go to Item 39

37a. Name 2:

38. Code 2:.....

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I. FUNCTIONAL STATUS:

“Now I would like to find out whether you can do some physical activity without help. By ‘without help’ I mean without the assistance of another person. These questions refer to the last 4 weeks.”

39. Are you able to do heavy work around the house, like shoveling snow or washing windows, walls or floors without help?	Yes	1	
	No	2	
	Don't Know	7	
	Refused	8	
	Missing	9	
40. Are you able to walk up and down stairs without help?.....	Yes	1	
	No	2	
	Don't Know	7	
	Refused	8	
	Missing	9	
41. Are you able to walk half a mile without help? That's about 8 ordinary blocks.	Yes	1	
	No	2	
	Don't Know	7	
	Refused	8	
	Missing	9	
42a. Are you ABLE to go to work?.....	Yes	1	<input type="checkbox"/> Go to Item 43a
	No	2	
	Not Applicable	9	<input type="checkbox"/> Go to Item 44a
42b. Is a heart problem the main cause of your not being able to work?	Yes	1	<input type="checkbox"/> Go to Item 44a
	No	2	
	Don't Know	7	
	Refused	8	
	Missing	9	
43a. During the past 4 weeks, have you missed work for at least half a day because of your health?.....	Yes	1	
	No	2	<input type="checkbox"/> Go to Item 44a

43b. On how many days has this happened? (maximum 28) days

44a. Are you able to do your usual activities, such as work around the house or recreation? Yes 1 —
No 2

44b. Is a heart problem the main cause of your being unable to do this (these) activity(ies)? Yes 1 —
No 2 —
Don't Know 7 —
Refused 8 —
Missing 9 —

When you add the refused and missing codes to this one, make sure to extend the go to box to include all responses

45a. During the past 4 weeks, have you had to cut down on your usual activities, (such as work around the house or recreation), for half a day or more because of your health? Yes 1
No 2

45b. On how many days has this happened? (maximum 28) days

L. EMPLOYMENT STATUS

46a. Please tell me which of the following best describes your employment status: Homemaking 1 —
Employed 2
Unemployed 3 —
Retired 4 —

46b. Which of these two categories best describes your "employed" status:.....

Employed at a job for pay, either full or part-time	1	} <input type="checkbox"/> STOP
Employed, but temporarily away from regular work	2	

46c. Which of these two categories best describes your "unemployed" status:

Unemployed, looking for work	1	} <input type="checkbox"/> STOP
Unemployed, not looking for work	2	

46d. Which of these two categories best describes your "retired" status:.....

Retired from my usual occupation and not working	1
Retired from my usual occupation, but working for pay	2

Administrative Information

47. Date of data collection:

		/			/				
m	m		d	d		y	y	y	y

48. Method of data collection:.....

Computer	1
Paper Form	2

49. Data Collection

In Clinic	1
Off Site	2

50. Code number of person completing this form:.....

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