



Medical History Form

FORM CODE: MHX
VERSION A 07/27/2000

ID NUMBER:

CONTACT: 0 1

LAST NAME:

INITIALS:

INSTRUCTIONS: This form should be completed during the participant's visit. 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.

A. SLEEP

"The following questions are about your medical history. First I'd like to ask about your sleep. Using this response card [RC #1], please tell me which response best describes your sleep behavior."

	<u>Never</u>	<u>Seldom</u>	<u>Some- times</u>	<u>Often</u>	<u>Almost Always</u>
1. You are told that you snore loudly and bother others.....	A	B	C	D	E
2. You are told that you stop breathing ("hold your breath") in sleep	A	B	C	D	E
3. You fall asleep during the day, particularly when not busy	A	B	C	D	E
4. You are tired after sleeping	A	B	C	D	E
5. You feel sleepy or fall asleep while driving.....	A	B	C	D	E

"The next two questions are about your usual sleep habits during the past month only. We are interested in the majority of days and nights in the past month."

6. During the past month, how would you rate your sleep quality overall? Would you say it was excellent, very good, good, fair, or poor?.....	Excellent	E
	Very good	V
	Good	G
	Fair	F
	Poor	P

7. During the past month, excluding naps, how many hours of actual sleep did you get at night (or day, if you work at night) on average? This may be different from the number of hours spent in bed.....

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 Hours

B. CHEST PAIN ON EFFORT

8. Have you ever had any pain or discomfort in your chest?Yes Y
Go to Item 32 — No N

9. Do you get it when you walk uphill or hurry?.....Yes Y
Go to Item 29 — No N
Never hurries or walks uphill H

10. Do you get it when you walk at an ordinary pace on the level?Yes Y
Go to Item 29 — No N

11. What do you do if you get it while you are walking? Stop or slow down S
Carry on C
[RECORD "STOP OR SLOW DOWN" IF SUBJECT CARRIES ON AFTER TAKING NITROGLYCERIN]

12. If you stand still, what happens to it? Relieved R
Go to Item 29 — Not relieved N

13. How soon? 10 minutes or less L
Go to Item 29 — More than 10 minutes M

14. Will you show me where it was? **[CIRCLE "Y" OR "N" FOR ALL AREAS]** Yes No

- 14a. Sternum (upper or middle).....Y N
- 14b. Sternum (lower).....Y N
- 14c. Left anterior chest.....Y N
- 14d. Left arm.....Y N
- 14e. Other.....Y N Go to Item 15

14f. Specify:.....

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15. Do you feel it anywhere else? [IF "YES", RECORD ABOVE]Yes Y
 No N
16. Did you see a doctor because of this pain or discomfort?.....Yes Y
 — No N
17. What did the doctor say it was? Angina A
 Heart attack H
 Other Heart Disease D
 Other O
18. Have you been hospitalized because of this pain?Yes Y
 No N
19. How long ago did you start getting this pain?
 Within the past: 1 month A
 6 months B
 1 year C
 2 years D
 Over 2 years E
- "The next 3 questions on chest pain refer to 3 aspects: how often it occurs, how severe it is, and how long it lasts."
20. Within the past 2 months, has your chest discomfort occurred more often?Yes Y
 — No N
21. Has it occurred at least twice as often as before?Yes Y
 No N
22. Within the past 2 months, has the pain become more severe?Yes Y
 No N

23. Within the past 2 months, has the pain lasted longer when it occurs?Yes Y
 No N
24. Do you ever use nitroglycerin to relieve the pain?Yes Y
 Go to Item 26 — No N
25. Within the past 2 months, has the pain required more nitroglycerin to relieve it?Yes Y
 No N
26. Within the past 2 months, have you started getting the pain with less exertion?Yes Y
 No N
27. Within the past 2 months have you started getting the pain when sitting still?Yes Y
 No N
28. Within the past 2 months, have you started getting the pain when sleeping?Yes Y
 No N

C. POSSIBLE INFARCTION

29. Have you ever had a severe pain across the front of your chest lasting for half an hour or more?Yes Y
 Go to Item 32 — No N
30. Did you see a doctor because of this pain?Yes Y
 Go to Item 32 — No N
31. What did the doctor say it was? Heart Attack H
 Other disorder O

32. Have you ever had a heart attack for which you were hospitalized one week or more? Yes Y

No N
 Don't Know D

Go to Item 35

33. How many such heart attacks have you had?

34. How old were you when you had your (first) heart attack?

35. Have you ever had a test in which you were asked to exercise while an electrocardiogram was taken? Yes Y

No N

Go to Item 37

36. Were you told that the results were normal or abnormal? Normal N

Abnormal A

Don't know D

D. INTERMITTENT CLAUDICATION

37. Do you get pain in either leg on walking? Yes Y

No N

Go to Item 47

38. Does this pain ever begin when you are standing still or sitting? Yes Y Go to Item 46

No N

39. In what part of your leg do you feel it? **[IF CALVES NOT MENTIONED, ASK: "ANYWHERE ELSE?"]** Pain includes calf/calves C

Pain does not include calf/calves N

Go to Item 46

40. Do you get it if you walk uphill or hurry? Yes Y

No N

Go to Item 46

Never hurries or walks uphill H

41. Do you get it if you walk at an ordinary pace on the level?Yes Y
 No N
42. Does the pain ever disappear while you are walking?Yes Y — Go to Item 46
 No N
43. What do you do if you get it when you are walking? Stop or slow down S
Go to Item 46 — Carry on C
44. What happens to it if you stand still? Relieved R
Go to Item 46 — Not relieved N
45. How soon?10 minutes or less L
 More than 10 minutes M
46. Were you hospitalized for this problem in your legs?Yes Y
 No N

E. CONGESTIVE HEART FAILURE

47. Have you ever had to sleep on 2 or more pillows to help you breathe?Yes Y
 No N
48. Have you ever been awakened at night by trouble breathing?Yes Y
 No N
49. Have you ever had swelling of your feet or ankles (excluding during pregnancy)?Yes Y
Go to Item 51 — No N
- [INCLUDE PARENTHETICAL COMMENT FOR FEMALES ONLY]**
50. Did it tend to come on during the day and go down overnight?Yes Y
 No N

F. INVASIVE PROCEDURES

51. Have you ever had surgery on your heart, or the arteries of your neck or legs, excluding surgery for varicose veins? Yes Y
 No N
 Go to Item 53

52. Did you have:

52a. Coronary bypass: Yes Y
No N

52b1. Other heart procedure: Yes Y
 No N
 Go to Item 52c

52b2. Specify:

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52c. Carotid endarterectomy: Yes Y
 No N
 Go to Item 52e1

52d. Site: Right R
Left L
Both B

52e1. Other arterial revascularization or bypass: Yes Y
 No N
 Go to Item 52f

52e2. Specify:

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52f. Any other type of surgery on your heart or the arteries of your neck or legs? Yes Y
No N

53. Have you ever had a balloon angioplasty on the arteries of your heart, neck, or legs?Yes Y

No N
 Go to Item 55

54. Did you have:

54a. Angioplasty of the coronary arteries?Yes Y
No N

54b. Angioplasty in the arteries of your neck?Yes Y
No N

54c. Angioplasty of lower extremity arteries?Yes Y
No N

55. Have you ever had:

55a. Heart catheterization?Yes Y
No N

55b. Carotid artery catheterization?Yes Y
No N

55c1. Other arterial catheterization?Yes Y
No N
 Go to Item 56

55c2. Specify:

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G. DIAGNOSTIC PROCEDURES

56. Have you ever had any of the following procedures performed for a medical reason? Please do not include any procedures done for research studies or a fitness program.

	<u>Yes</u>	<u>No</u>
56a. Echocardiogram?	Y	N
56b. Electrocardiogram?	Y	N
56c. Treadmill or cardiac stress test?	Y	N
56d. MRI exam of the brain?	Y	N

H. DIALYSIS

57. Are you now, or have you ever been on kidney dialysis or a kidney machine?

Yes	Y
No	N

Go to Item 59

58. How long (were you/have you been) on kidney dialysis?

58a.			Months
58b.			Years

I. ADMINISTRATIVE INFORMATION

59. Date of data collection:.....

		/			/				
m	m		d	d		y	y	y	y

60. Method of data collection:

Computer	C
Paper form	P

61. Code number of person completing this form:

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