Heart Failure Survey

FORM CODE: PHF 05/02/2011
VERSION: 1.0

ID NUMBER: ☐☐☐☐☐☐☐ CONTACT ☐☐

LAST NAME: ☐☐☐☐☐☐☐☐☐☐☐☐ INITIALS: ☐☐

ADMINISTRATIVE INFORMATION

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

0c. Consent Form Status:

Consent form mailed to participant……..☐
Consent form received from participant……..☐

Note: Sections I and II will not appear on the data entry screen.

Section I: Instructions to Physicians:

Dear < Dr >,

Your patient, < Ms/Mr. > who is a long time participant in the JHS Study, has indicated to JHS study personnel that < s/he > has been diagnosed with heart failure. We have your patient's authorization to ask you to provide this information for our study records. We appreciate your response to the following questions and request that you return this form in the enclosed envelope at your earliest convenience (ideally within 2 weeks).

Thank you.

Sincerely,
< Field center medical director > Date < Date letter is sent >

Section II: Patient Confidential Information:

Patient Name: _____

Patient Date of Birth: _____

Section III: Data Reported by Physician:

0. Name of medical doctor to whom inquiry sent:

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1. Has this patient ever had heart failure or cardiomyopathy of any type?

Yes..... ☐
No ..... ☐→ **GO TO QUESTION 3**

2. If the patient has or ever had heart failure or cardiomyopathy:

a. Is this patient's condition characterized as predominantly:

Systolic dysfunction..... ☐
Diastolic dysfunction..... ☐
Mixed ..... ☐
Not Determined..... ☐

b. Estimated LVEF (worst): ☐☐ %

b.1. If LVEF is not specifically available, estimate LV function:

Normal..... ☐
Decreased mildly ..... ☐
Decreased moderately..... ☐
Decreased severely ..... ☐

c. Estimated date of onset or diagnosis (month/year): ☐☐ / ☐☐☐☐

3. Has this patient ever had (check all that apply):

Atrial fibrillation on an ECG?..... ☐
Angina pectoris?..... ☐
Pulmonary rales on a physical examination?..... ☐
Previous MI? ..... ☐
Rhonchi on a physical examination? ..... ☐
Other coronary heart disease? ..... ☐
None of the above? ..... ☐

4. Was s/he prescribed treatment specifically for heart failure during the past year?

Yes..... ☐
No ..... ☐

5. Was this patient prescribed any of the following during the past year (check all that apply):

ACE inhibitors ..... ☐
Aldosterone blocker..... ☐
Alpha blockers..... ☐
Amiodarone / Antiarrhythmics..... ☐
Angiotensisn II receptor blockers..... ☐
Anticoagulants..... ☐
Aspirin / Antiplatelets..... ☐
Beta blockers ..... ☐
Calcium channel blockers..... ☐
Digitalis ..... ☐
Diuretics ..... ☐
Hydralazine ..... ☐
Lipid-lowering agents..... ☐
Nitrates..... ☐
Other antihypertensives..... ☐

6. Form completed by:

MD ..... ☐
Other..... ☐

7. Date: ☐☐/☐☐/☐☐☐☐
Month Day Year