I. GENERAL INSTRUCTIONS

The Personal and Family History (PFH) is completed during the participant’s clinic visit and collects information on the participant’s health status, personal health history, and family health history. Questions should not be skipped unless indicated by the skip pattern instructions. Because there are several skip patterns in this section, the interviewer should be very familiar with the flow of the questions to insure smooth administration with a conversational tone. The interviewer must be certified and have working knowledge of the document “General Instructions for Completing Paper Forms” prior to completing this form. ID Number, Contact Year, and Name should be completed as described in this form. Initiate the form by reading the script at the beginning of the form as printed.

II. SPECIFIC INSTRUCTIONS

Health Status

1. This standardized question is intended to assess the participant’s assessment of their overall health status in comparison with other persons in their same age range. Record the response provided by the respondent.

2. This standardized question is intended to assess the participant’s assessment of how their current health status compares with their perception of what it was one year ago. The time frame is one year prior to the date of the Exam 2 clinic visit. Record the response provided by the respondent.

This next set of items is intended to determine NEW health problems since the last JHS examination. This is a series of questions regarding particular health conditions diagnosed by a health care provider. Remind the participant of the date of the Exam 2 visit and ask them to think about the time frame from that point to the present date. Continue to remind them throughout the questioning process that you are referring to NEWLY DIAGNOSED health problems occurring in the time period between JHS Exam 2 and JHS Exam 3.

For each of the specified conditions, ask the participant if a health care provider has told them that they have that condition SINCE THE LAST JHS EXAM. Enter YES, NO or UNSURE/UNKNOWN for each item that identifies a specific condition. A response is positive (YES) only if the condition was diagnosed by a health care provider. A diagnosis of “borderline” is coded as YES if the participant’s condition was diagnosed by a health care provider as borderline. For example, a participant may tell you that “My
doctor told me I have borderline diabetes” or “My doctor said I had a touch of sugar.”

NO is recorded if (1) the respondent was told by a health care provider that s/he did not have the condition specified, (2) was never told by a health care provider that s/he had the condition, or (3) was never tested for the condition.

UNSURE/UNKNOWN is recorded if the respondent is not sure that the health care provider said s/he had this condition. The code of UNSURE/UNKNOWN is most frequently used when the respondent cannot remember accurately what the health care provider said. Do not define the condition yourself based on the respondent’s answer. Record ambiguous responses in a note log.

For each YES response, enter the age at which the respondent was first told of this condition by a health care provider (PLEASE NOTE: If the age of first diagnosis is out of the time range for this item, e.g., since the last JHS Exam—clarify with the participant whether this is actually a NEW diagnosis since the date of Exam 2]. If the respondent does not remember the exact age or year which a health care provider first told her or him of the condition, ask for and record a best estimate of the age. You may assist the respondent in pinpointing an age by asking if they can recall any particular events or other timing that may help them specify the age at which this occurred.

2a. This item ascertains new diagnosis of hypertension. Record as responded.
   2b. If YES, determine the age at which the new diagnosis of hypertension was made. Use leading zeros as needed and record to the nearest year.

3a. This item ascertains new diagnosis of high cholesterol (blood fats). Record as responded.
   3b. If YES, determine the age at which the new diagnosis of high cholesterol was made. Use leading zeros as needed and record to the nearest year.

4a. This item ascertains new diagnosis of heart attack. Record as responded.
   4b. If YES, determine the age at which the new diagnosis of heart attack was made. Use leading zeros as needed and record to the nearest year.

5a. This item ascertains new diagnosis of stroke. Record as responded.
   5b. If YES, determine the age at which the new diagnosis of stroke was made. Use leading zeros as needed and record to the nearest year.

6a. This item ascertains new diagnosis of diabetes (sugar).
   6b. If YES, determine the age at which the new diagnosis of diabetes was made. Use leading zeros as needed and record to the nearest year.

7a. This item ascertains new diagnosis of kidney problem. NOTE: "kidney problem" does not refer to bladder infections. Record as responded.
   7b. If YES, determine the age at which the new diagnosis of kidney problem
was made. Use leading zeros as needed and record to the nearest year.

8a. This item ascertains new diagnosis of cancer. Record as responded.
   8a. If YES determine the age at which the new diagnosis of cancer. Use leading zeros as needed and record to the nearest year.

9a. This item ascertains new diagnosis of chronic lung disease (STRESS that this is OTHER THAN ASTHMA). Record as responded.
   9b. If YES, determine the age at which the new diagnosis of chronic lung disease was made. Use leading zeros as needed and record to the nearest year.

10a. This item ascertains new diagnosis of asthma. Record as responded.
    10b. If YES, determine the age at which the new diagnosis of asthma was made. Use leading zeros as needed and record to the nearest year.

11a. This item ascertains new diagnosis of a blood circulation problem. Record as responded.
    11b. If YES, determine the age at which the new diagnosis of a blood circulation was made. Use leading zeros as needed and record to the nearest year.

12a. This item is intended to determine whether the participant has had any overnight hospitalizations during the PAST YEAR. Please note that the time frame changes with this item. Ask the respondent to think back to the past year, that is 12 months prior to the Exam 3 clinic visit. Enter YES or NO. If YES, record reason for hospitalization in the boxes for Item 12b. If additional space is needed to capture complete response, use note log.

13. FOR WOMEN ONLY: Ask if she has ever had a tubal ligation, that is one or more of her tubes tied. Record as responded.
    13b. If YES--- ask the respondent to recall the age at which she had a tubal ligation. Record to the nearest year, using leading zeros as needed.

14. FOR WOMEN < 55 YEARS ONLY—This item is intended to determine current pregnancy. Record as responded

15. FOR MEN ONLY: Ask if he has ever had a vasectomy. Record as responded

16. **B. Personal Health Problems**

This next set of items is intended to determine NEW health problems since the last JHS examination. This is a series of questions regarding particular health conditions diagnosed by a health care provider. Remind the participant of the date of the Exam 2 visit and ask them to think about the time frame from that point to the present date. Continue to remind them throughout the questioning process that you are referring to NEWLY DIAGNOSED health problems occurring in the time period between JHS Exam
2 and JHS Exam 3.

For each of the specified conditions, ask the participant if a health care provider has told them that they have that condition SINCE THE LAST JHS EXAM. Enter YES, NO or UNSURE/UNKNOWN for each item that identifies a specific condition. A response is positive (YES) only if the condition was diagnosed by a health care provider. A diagnosis of “borderline” is coded as YES if the participant’s condition was diagnosed by a health care provider as borderline. For example, a participant may tell you that “My doctor told me I have borderline diabetes” or “My doctor said I had a touch of sugar.”

NO is recorded is (1) the respondent was told by a health care provider that s/he did not have the condition specified, (2) was never told by a health care provider that s/he had the condition, or (3) was never tested for the condition.

UNSURE/UNKNOWN is recorded if the respondent is not sure that the health care provider said s/he had this condition. The code of UNSURE/UNKNOWN is most frequently used when the respondent cannot remember accurately what the health care provider said. Do not define the condition yourself based on the respondent’s answer. Record ambiguous responses in a note log.

For each YES response, enter the age at which the respondent was first told of this condition by a health care provider (PLEASE NOTE: If the age of first diagnosis is out of the time range for this item, e.g., since the last JHS Exam—clarify with the participant whether this is actually a NEW diagnosis since the date of Exam 1]. If the respondent does not remember the exact age or year which a health care provider first told her or him of the condition, ask for and record a best estimate of the age. You may assist the respondent in pinpointing an age by asking if they can recall any particular events or other timing that may help them specify the age at which this occurred.

2a. This item ascertains new diagnosis of hypertension. Record as responded.

2b. If YES, determine the age at which the new diagnosis of hypertension was made. Use leading zeros as needed and record to the nearest year.

3a. This item ascertains new diagnosis of high cholesterol (blood fats). Record as responded.

3b. If YES, determine the age at which the new diagnosis of high cholesterol was made. Use leading zeros as needed and record to the nearest year.

4a. This item ascertains new diagnosis of heart attack. Record as responded.

4b. If YES, determine the age at which the new diagnosis of heart attack was made. Use leading zeros as needed and record to the nearest year.

5a. This item ascertains new diagnosis of stroke. Record as responded.

5b. If YES, determine the age at which the new diagnosis of stroke was made.
Use leading zeros as needed and record to the nearest year.

6a. This item ascertains new diagnosis of diabetes (sugar).
   6b. If YES, determine the age at which the new diagnosis of diabetes was made. Use leading zeros as needed and record to the nearest year.

7a. This item ascertains new diagnosis of kidney problem. NOTE: "kidney problem" does not refer to bladder infections. Record as responded.
   7b. If YES, determine the age at which the new diagnosis of kidney problem was made. Use leading zeros as needed and record to the nearest year.

8a. This item ascertains new diagnosis of cancer. Record as responded.
   8b. If YES determine the age at which the new diagnosis of cancer was made. Use leading zeros as needed and record to the nearest year.

9a. This item ascertains new diagnosis of chronic lung disease (STRESS that this is OTHER THAN ASTHMA). Record as responded.
   9b. If YES, determine the age at which the new diagnosis of chronic lung disease was made. Use leading zeros as needed and record to the nearest year.

10a. This item ascertains new diagnosis of asthma. Record as responded.
    10b. If YES, determine the age at which the new diagnosis of asthma was made. Use leading zeros as needed and record to the nearest year.

11a. This item ascertains new diagnosis of a blood circulation problem. Record as responded.
    11b. If YES, determine the age at which the new diagnosis of a blood circulation was made. Use leading zeros as needed and record to the nearest year.

12. This item is intended to determine whether the participant has had any overnight hospitalizations during the PAST YEAR. Please note that the time frame changes with this item. Ask the respondent to think back to the past year, that is 12 months prior to the Exam 2 clinic visit. Enter YES or NO. If YES, record reason for hospitalization in the boxes for Item 12b. If additional space is needed to capture complete response, use note log.

   **NOTE:** Hospitalization data is to be sent to the Surveillance Unit as part of a regular monthly data report from Exam 3 clinic visits.

13. FOR WOMEN ONLY: Ask if she has ever had a tubal ligation, that is one or more of her tubes tied. Record as responded.
    13b. If YES--- ask the respondent to recall the age at which she had a tubal ligation. Record to the nearest year, using leading zeros as needed.

14. FOR WOMEN < 55 YEARS ONLY—This item is intended to determine current pregnancy. Record as responded
15. **FOR MEN ONLY:** Ask if he has ever had a vasectomy. Record as responded.

C. **Health Behaviors**

16. This item is intended to obtain information on the participant’s lifetime maximum weight. For women, ask them to exclude the time when they were pregnant. You may prompt the participant to think over her/his lifetime and recall their highest weight. Record to the nearest pound.

16a. Ask the participant to recall how old s/he was when they attained their maximum lifetime weight. Record to the nearest year using leading zeros as needed.

17. This item is intended to assess the participants' perception of her or his current weight. There is no right or wrong answer. Maintain a nonjudgmental attitude and carefully avoid giving any indication of how you view the participant's current weight. Record as responded.

18. This item is intended to determine if the participant has EVER been on a diet to lose weight. No time line is implied by the question. Record as responded.

18a. If YES, ascertain if the participant is currently on a weight loss diet.

19. This item is a repeat of a similar item asked during Exam 2. It is intended to determine the participant’s general level of physical activity or exercise. Please note that the time frame is during the past MONTH, that is, 30 days prior to the date of the Exam 3 clinic visit. Read the example exercises listed in the item and record as responded.

**Family Health History**

This next series of questions is intended to obtain information on parental, sibling and children’s health history. The same series of questions is asked for each relative group. Careful attention to the skip patterns is needed to assure a conversational tone in asking these questions.

20. Do not ask this question. Record YES, NO or UNKNOWN from information obtained on the ELG form. If mother is still living (YES), SKIP to item 23. If mother is no longer living (NO), continue with the next item in the series. If UNKNOWN, SKIP to Item 20.

21. Record age at which mother died in years.

22a. Record cause of mother’s death using the pre-coded responses. Do not read the list to the respondent, simply mark the best answer from what they say. If the cause of death is not in the list, specify cause in the response boxes in 22.b.
23. Record current age of mother in years.

24-28. This series of items is intended to capture current health history information if the respondent’s mother is still living. Read each condition and record YES, NO or UNSURE/UNKNOWN. As before for the respondent health history, for each YES response, ask the age at which the mother was first told of this condition and record the age in years in items 24b-28b, as appropriate.

29. Do not ask question. Record YES, NO or UNKNOWN from information obtained on the ELG form. If father is still living (YES), SKIP to item 32. If father is no longer living (NO), continue with the next item in the series. If UNKNOWN, SKIP to Item 32.

30. Record age at which father died in years.

31a. Record cause of father’s death using the pre-coded responses. Do not read the list to the respondent, simply mark the best answer from what they say. If the cause of death is not in the list, specify cause in the response boxes in 31b.

32. Record current age of father in years.

33-37. This series of items is intended to capture health history information on the respondent’s father. Read each condition and record YES, NO or UNSURE/UNKNOWN. As before for the respondent health history, for a YES response to items 33, 34, 35, 36 or 37, ask the age at which the father was first told of this condition and record the age in years in items 33-37b, as appropriate.

38. This series of items is intended to clarify numeric information on respondents siblings. Read the transition script as written. Obtain information on number of living brothers and sisters from earlier and clarify the number as per the script.

“Now I have a few questions about your full brothers and sisters. Count only those who have the same natural mother and natural father as you, even if they are no longer living or you are no longer in touch with them. Do not include adopted or step brothers or sisters. Earlier you indicated that you have ___ brothers and ___sisters still living.”

38a. Do not use this question. Using information already obtained from the ELG form, Item 14. Record the number of full brothers still living. If the respondent changes the number based on your summary in the script above, clarify the accurate number and correct as needed on the ELG form as well as in this item.
38b. Using information already obtained from the ELIGIBILITY FORM, Item 14, Record the number of full sisters still living. If the respondent changes the number based on your summary in the script above, clarify the accurate number and correct as needed on the ELG form as well as in this item.

38c. Record YES if there are other siblings who are no longer living and continue with the next item. If there are no other siblings who are no longer living, record NO and SKIP to Item 38f.

38d. Record number of full brothers who are no longer living.

38e. Record number of full sisters who are no longer living.

38f. Total the number of full brothers and sisters adding together the number from Items 31a, 31b, 31d, and 31c. If there are no siblings, enter 00 in the appropriate space.

39-43. This next series of item is to obtain health history information on the respondent’s siblings. For each item, the respondent is asked if any of their siblings have ever had each of the specific diseases listed. If YES, in 39-43b, record the number of siblings affected with the condition. For items 39-43, if YES record the number of siblings who were younger than age 60 when they were first told of the condition.

44a. This item is intended to verify the number of living adult children. Read the transition script as written to move the interview from information on siblings to obtaining information on the respondent’s children. Obtain information on number of children from Item 13 on the ELG Form, already completed earlier in the interview:

“I have a few questions about your natural children. Earlier you indicated that you have ___ biological children still living.

Verify that the number is the same as recorded in Item 6, ELG. If different, clarify the difference and make the correction on the ELG form.

44a. Using information already obtained from the ELG from, item 16, record the number of natural children still living.
44b. Record the number of children currently over the age of 18.
44c. Determine if there are other biological children no longer living. If there are biological children no longer living record number.

45-49. This next series of item is to obtain health history information on the respondent’s adult children. For each item, the respondent is asked if any of their children over the age of 18, living or no longer living, have ever had each of the specific diseases listed. If YES, in 45-48b, record the number of children affected with the condition. For items 45-48, if YES record the number of children who were younger than age 60 when they were first told of the condition.

ADMINISTRATIVE
50. Enter date of data collection
51. Enter code of person completing this form.
52. Enter how data was collected.
53. Enter where data was collected.