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ARIC ANNUAL FOLLOW-UP QUESTIONNAIRE FORM

ID NUMBER: [| | | | | |] CONTACT YEAR: [|] FORM CODE: A F U VERSION: B 09-1

LAST NAME: [| | | | | | | | | | |] INITIALS: [|]

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to Reports Clearance Officer, PHS, 721-H Hubert H. Humphrey Bldg., 200 Independence Ave. SW, Washington, D.C. 20201, Attn. PRA; and to the Office of Management and Budget, Paperwork Reduction Project (OMB 0925-0281), Washington, D.C. 20503.

INSTRUCTIONS: This form should be completed during the interview portion of the participant's annual follow-up. 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 zeros 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. VITAL STATUS

1. Date of status determination: ....

[|] / [|] / [|]
Month Day Year

2. Final Status: ..... {Circle one below}

3. Information obtained from: ..... {Circle one corresponding choice below}

Final Status		Information obtained from		Instruction
Contacted and alive	C	Phone	A	Go to Item 6, Screen 2
		Personal Interview	B	Go to Item 6, Screen 2
		Letter	C	Go to Item 30, Screen 8
Contacted & Refused	F			Go to Item 32, Screen 8
Reported alive	R	Relative, spouse, acquaintance	D	Go to Item 30, Screen
		Employer information	E	Go to Item 30, Screen
		Other	F	Go to Item 30, Screen
Reported Deceased	D	Relative, spouse, acquaintance	G	Continue to Item 4
		Surveillance	H	Continue to Item 4
		Other (National Death Index)	I	Continue to Item 4
Unknown	U			Go to Item 32, Screen 8

ANNUAL FOLLOW-UP QUESTIONNAIRE (AFUB screen 2 of 8)

3. DEATH INFORMATION

4. Date of death: ... [ ][ ] / [ ][ ] / [ ][ ]
Month Day Year

5. Location of death:
a. City/County [ ][ ][ ][ ][ ][ ][ ][ ][ ]
[ ][ ][ ][ ][ ][ ][ ][ ][ ]

b. State: [ ][ ]

After Item 5, skip to Item 30, Screen 8

C. GENERAL HEALTH

6. Now I will ask you some questions about your health since we last spoke with you; that is, since we last contacted you on (mm/dd/yy) until today. During that time, compared to other people your age, would you say that your health has been excellent, good, fair or poor?..... Excellent

Good

Fair

Poor

ANNUAL FOLLOW-UP QUESTIONNAIRE (AFUB screen 3 of 8)

D. CHEST PAIN ON EFFORT

7. Since we last contacted you, have you had any pain or discomfort in your chest?........... Yes Y

No N → Go to Item 20, Screen 5

8. Do you get it when you walk uphill or hurry? ....Yes Y

No N → Go to Item 17, Screen 5

Never hurries or walks uphill H

9. Do you get it when you walk at an ordinary pace on the level?......... Yes

No

10. What do you do if you get it while you are walking?......Stop or slow down

Carry on → Go to Item 17, Screen 5

{Record "Stop or slow down" if subject carries on after taking nitroglycerin}

11. If you stand still, what happens to it?........... Relieved

Not relieved → Go to Item 17, Screen 5

12. How soon?................10 minutes or less L

More than 10 minutes M

Go to Item 17, Screen 5

13. Will you tell me where it was?
{Record answer verbatim in space below.
Then, circle Y or N for all areas.}

____

____

	Yes	No
a. Sternum (upper or middle)............	Y	N
b. Sternum (lower)......................	Y	N
c. Left anterior chest..................	Y	N
d. Left arm.............................	Y	N
e. Other................................	Y	N

f. Specify: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

14. Do you feel it anywhere else?............Yes Y
{If "Yes", record above}
No N

15. Did you see a doctor because
of this pain or discomfort?.............Yes Y

No N

Go to Item 17, Screen 5

16. What did he say it was?... Angina A

Heart Attack H

Other Heart Disease I

Other O

E. POSSIBLE INFARCTION

17. Since our last contact have
you had a severe pain across
the front of your chest lasting
for half an hour or more?...............Yes Y

No N

Go to Item 20

18. Did you see a doctor
because of this pain?..................Yes Y

No N

Go to Item 20

19. What did he say it was?.........Heart Attack H

Other Disorder O

F. INTERMITTENT CLAUDICATION

20. Since we last contacted
you, have you had pain in
either leg on walking?.................Yes

No

Go to Item 29, Screen 7

21. Does this pain ever begin when
you are standing still or sitting?.....Yes

No

Go to Item 29, Screen 7

22. 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 (Go to Item 29, Screen 7)	N

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

Yes	Y
No (Go to Item 29, Screen 7)	N
Never hurries or walks uphill	H

24. Do you get it if you walk at an ordinary pace on the level?..........Yes — Y

Yes	Y
No	N

25. Does the pain ever disappear while you are walking?..................Yes (Go to Item 29, Screen 7)

No

26. What do you do if you get it when you are walking?....Stop or slow down

Carry on (Go to Item 29, Screen 7)

27. What happens to it if you stand still?............Relieved — R

Not relieved (Go to Item 29) — N

28. How soon?.............10 minutes or less — L

More than 10 minutes — M

G. STROKE/TIA

29. Since our last contact have you been told by a physician that you had a stroke, slight stroke, transient ischemic attack, or TIA?.......Yes

No

If "Yes", ensure that this event is included in t "HOSPITALIZATIONS" section.

H. HOSPITALIZATIONS

30. Were you (Was [name]) hospitalized for a heart attack since our last contact on (mm/dd/yy)?.......Yes — Y

Yes	Y
No	N
Unknown	U

If "Yes", complete "HOSPITALIZATIONS" section.

31. Have you stayed (Did [name] stay) overnight as a patient in a hospital for any other reason since our last contact?..................Yes Y

No N

If "Yes", add to "HOSPITALIZATIONS" section.

I. INTERVIEWER CODE NUMBER

32. Code number of person completing this form:.... | | | |

NAME: ____________________ ID: [ ][ ][ ][ ][ ][ ][ ] CONTACT YEAR: [ ][ ]

J. HOSPITALIZATIONS (Obtain following questionnaire)

33. For each time you were (he/she was) a patient over night in a hospital, I would like to obtain the reason you were (he/she was) admitted, the name of the hospital, and the date. When was the first time you were (he/she was) hospitalized since our last contact with you (him/her) on (mm/dd/yy of last contact)?

    [Fill in, probing as necessary. If reason and/or hospital are repeated, record "same as (a/b/c/d/e, etc.)". Probe for additional hospitalizations.]

	Hospitalization Reason	Name, City and St of Hospital	Mnth/Yr	Transmit to Surveillance
a.			/	[ ]
b.			/	[ ]
c.			/	[ ]
d.			/	[ ]
e.			/	[ ]
f.			/	[ ]
g.			/	[ ]
h.			/	[ ]
i.			/	[ ]
j.			/	[ ]

NAME: ____________________ ID: | | | | | | | | CONTACT YEAR: | | |

	Hospitalization Reason	Name, City and St of Hospital	Mnth/Yr	Transmit to Surveillance
k.	____________	____________		
	____________	____________	___/___	☐
l.	____________	____________		
	____________	____________	___/___	☐
m.	____________	____________		
	____________	____________	___/___	☐

"As explained in your original clinic visit, records of these hospitalizations will be checked for medical information that may apply to the ARIC Study."