



GENERAL INTERVIEW FORM

SEMI-ANNUAL FOLLOW-UP (Mail Version)

PPT NAME:

(To be completed by research staff member)

FORM CODE:

G	L	X
---	---	---

DATE:[01/21/2026]

Version 1.0

ADMINISTRATIVE INFORMATION

Instructions: Please tell us who is completing this form and today's date.

Full name of person completing this form: _____ (first) _____ (last)

0a. Today's Date: / /
 Month Day Year

QUESTIONS

Instructions: Please answer the questions below to the best of your ability. Please answer the questions in the order they appear on the form and follow directions to skip questions, as applicable. Please note that some question numbers are not in order and some numbers are skipped.

A. Falls

The first question is about falls the participant may have experienced during the past 12 months.

6. In the past 12 months did the participant fall?

Yes
 No
 Don't know

B. Traumatic Brain Injuries

The next questions are about any head injuries the participant may have experienced in the past 12 months which led him/her to seek medical care. A head injury may also be referred to as a concussion or traumatic brain injury. Head injuries may happen from a fall, motor vehicle crash, or being hit by something or someone.

8. In the past 12 months did the participant have a head injury which led him/her to seek medical care?

Yes → Continue to Question 8a.
 No → Skip to Question 12a.
 Don't know → Skip to Question 12a.

8a. In the past 12 months, how many times did the participant have a head injury which led him/her to seek medical care?

1	<input type="checkbox"/>
2	<input type="checkbox"/>
3	<input type="checkbox"/>
4	<input type="checkbox"/>
5	<input type="checkbox"/>
6 or more	<input type="checkbox"/>
Don't know	<input type="checkbox"/>

C. Digital Access

The next questions are about the participant's internet use in the past month and year.

12a. In the last month, has the participant used the Internet for household activities (e.g., shopping, paying bills)?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>
Don't know	<input type="checkbox"/>

12b. In the last month, has the participant used the Internet to connect with others (e.g., social networking, video calls with family or friends)?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>
Don't know	<input type="checkbox"/>

12c. In the last year, has the participant used the Internet to manage health-related tasks, such as having a telehealth visit, refilling prescriptions, or learning about a health condition?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>
Don't know	<input type="checkbox"/>

D. Alcohol Consumption

The next question is about the participant's consumption of wine, beer and drinks made with hard liquor.

13. Does the participant currently drink alcoholic beverages?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>
Don't know	<input type="checkbox"/>

E. Arthritis

The next questions are about arthritis.

15. Has a doctor or healthcare professional ever said that the participant has arthritis or osteoarthritis?

Yes → Continue to Question 15h.

No → Skip to Question 16a.

Don't know → Skip to Question 16a.

15h. In which areas of the body does the participant have arthritis? (Mark all that apply.)

Feet or ankles
 Knees
 Hips

Back
 Neck
 Shoulders

Hands or wrists

F. Unintentional Weight Loss

The next questions are about the participant's weight loss to track potential changes.

16a. Over the past year, has the participant lost more than 10 pounds?

Yes → Continue to Question 16c.

No → Skip to Question 20.

Do not know → Continue to Question 16c.

16c. Was the participant trying to lose weight?

Yes
No
Do not know

G. Physical Ability

These next questions are about how well the participant typically functions on his/her own. Do not include difficulties due to a temporary condition like a broken limb. Can the participant do the following activities without help from another person or special equipment, such as a cane or walker?

20. Is the participant able to walk for a quarter of a mile (about 2 or 3 blocks)?

Yes

No

Participant does not do this activity

Don't know

21. Is the participant able to walk from one room to another on the same level?

Yes.....	<input type="checkbox"/>
No.....	<input type="checkbox"/>
Participant does not do this activity.....	<input type="checkbox"/>
Don't know.....	<input type="checkbox"/>

22. Is the participant able to get in or out of bed?

Yes.....	<input type="checkbox"/>
No.....	<input type="checkbox"/>
Participant does not do this activity.....	<input type="checkbox"/>
Don't know.....	<input type="checkbox"/>

23. Is the participant able to walk up 10 steps without resting?

Yes.....	<input type="checkbox"/>
No.....	<input type="checkbox"/>
Participant does not do this activity.....	<input type="checkbox"/>
Don't know.....	<input type="checkbox"/>

24. Is the participant able to do chores around the house (like vacuuming, sweeping, dusting, or straightening up)?

Yes.....	<input type="checkbox"/>
No.....	<input type="checkbox"/>
Participant does not do this activity.....	<input type="checkbox"/>
Don't know.....	<input type="checkbox"/>

25. Is the participant able to prepare his/her own meals?

Yes.....	<input type="checkbox"/>
No.....	<input type="checkbox"/>
Participant does not do this activity.....	<input type="checkbox"/>
Don't know.....	<input type="checkbox"/>

26. Is the participant able to manage his/her money (such as keeping track of his/her expenses or paying bills)?

Yes.....	<input type="checkbox"/>
No.....	<input type="checkbox"/>
Participant does not do this activity.....	<input type="checkbox"/>
Don't know.....	<input type="checkbox"/>

27. Is the participant able to eat, including holding a fork, cutting food, or drinking from a glass?

Yes.....	<input type="checkbox"/>
No.....	<input type="checkbox"/>
Participant does not do this activity.....	<input type="checkbox"/>
Don't know.....	<input type="checkbox"/>

28. Is the participant able to dress himself/herself, including tying shoes, working zippers, or doing buttons?

Yes.....	<input type="checkbox"/>
No.....	<input type="checkbox"/>
Participant does not do this activity.....	<input type="checkbox"/>
Don't know.....	<input type="checkbox"/>

29. Is the participant able to lift or carry something as heavy as 10 pounds?

Yes.....	<input type="checkbox"/>
No.....	<input type="checkbox"/>
Participant does not do this activity.....	<input type="checkbox"/>
Don't know.....	<input type="checkbox"/>

30. Is the participant able to stand up from an armless chair?

Yes.....	<input type="checkbox"/>
No.....	<input type="checkbox"/>
Participant does not do this activity.....	<input type="checkbox"/>
Don't know.....	<input type="checkbox"/>

31. Is the participant able to stoop, crouch, or kneel?

Yes.....	<input type="checkbox"/>
No.....	<input type="checkbox"/>
Participant does not do this activity.....	<input type="checkbox"/>
Don't know.....	<input type="checkbox"/>

32. Is the participant able to bathe himself/herself?

Yes.....	<input type="checkbox"/>
No.....	<input type="checkbox"/>
Don't know.....	<input type="checkbox"/>

33. Is the participant able to use the toilet and clean himself/herself?

Yes.....	<input type="checkbox"/>
No.....	<input type="checkbox"/>
Don't know.....	<input type="checkbox"/>

H. Incontinence

34. Typically, does the participant have any difficulty with bladder or bowel control?

Yes.....

No.....

Don't know.....

Thank you for completing this form! Please make sure you complete all forms before mailing them back to the ARIC Study Team.