ANNUAL FOLLOW-UP QUESTIONNAIRE FORM

ID NUMBER:  CONTACT YEAR:  FORM CODE:  VERSION: B 09-13
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. FRA; 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.

ANNUAL FOLLOW-UP QUESTIONNAIRE (AFUB screen 1 of 8)

A. VITAL STATUS

1. Date of status determination: ........
   
   Month  Day  Year

2. Final Status: ........  
   (Circle one below)

   Contacted and alive  C  Go to Item 6, Screen 2
   Contacted & Refused  F  Go to Item 32, Screen 8
   Reported alive      R  Relative, spouse, acquaintance  D
   Reported Deceased  D  Surveillance  H
   Unknown             U  Go to Item 32, Screen 8

3. Information obtained from: ........  
   (Circle one corresponding choice below)

   Phone  A  Go to Item 6, Screen 2
   Personal Interview  B  Go to Item 30, Screen 8
   Letter  C  Go to Item 32, Screen 8
   Relative, spouse, acquaintance  D
   Employer information  E
   Other  F
   Relative, spouse, acquaintance  G
   Surveillance  H
   Other (National Death Index)  I
   Go to Item 30, Screen 8
   Continue to Item 4

1. Enter the date of status determination with the last digit appearing in the rightmost box.
   2. Enter the final status. Contacted and alive, Contacted & Refused, Reported alive, Reported Deceased or Unknown.
   3. Enter the information obtained from the participant's interview. Choose one corresponding choice.

This form is used to collect annual follow-up data for a survey or study.
3. DEATH INFORMATION

4. Date of death: ... [Blank spaces for Month, Day, Year]

5. Location of death:
   a. City/County
   [Blank spaces]
   b. State:
   [Blank space]

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 Y No N

10. What do you do if you get it while you are walking? ......... Stop or slow down
    {Record "Stop or slow down" if subject carries on after taking nitroglycerin}
    Carry on
    Go to Item 17, Screen 5

11. If you stand still, what happens to it? ......... Relieved
    Go to Item 17, Screen 5
    Not relieved
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.}

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

15. Did you see a doctor because
    of this pain or discomfort? ..........Yes
    No
    Go to Item 17, Screen 5

16. What did he say it was?... Angina
    Heart Attack
    Other Heart Disease
    Other

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
    No
    Go to Item 20

18. Did you see a doctor
    because of this pain? ..........Yes
    No
    Go to Item 20

19. What did he say it was? ......... Heart Attack
    Other Disorder

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 N

   Go to Item 29, Screen 7

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

   Go to Item 29, Screen 7

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

   No N

ANNUAL FOLLOW-UP QUESTIONNAIRE (AFUB screen 7 of 8)

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

ANNUAL FOLLOW-UP QUESTIONNAIRE (AFUB screen 7 of 8)

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

   Not relieved N

   Go to Item 29

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 "HOSPITALIZATIONS" section.

H. HOSPITALIZATIONS

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

<table>
<thead>
<tr>
<th>Hospitalization Reason</th>
<th>Name, City and St of Hospital</th>
<th>Mnth/Yr</th>
<th>Transmit to Surveillance</th>
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</table>
"As explained in your original clinic visit, records of these hospitalizations will be checked for medical information that may apply to the ARIC Study."