ANNUAL FOLLOW-UP QUESTIONNAIRE FORM

Atherosclerosis Risk in Communities

ID NUMBER: [ ] [ ] [ ] [ ] CONTACT YEAR: ___ FORM CODE: A F U VERSION: E DATE: 03-01-94

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

Public reporting burden for this collection of information is estimated to average 5 minutes, including time for reviewing instructions, gathering needed information and completing and reviewing the questionnaire. If you have any comments regarding this burden, please send them to Attention: PRA Reports Clearance Officer, PHS, 721-B Hubert H. Humphrey Building, 200 Independence Avenue, SW, Washington, D. C. 20201, and to the Paperwork Reduction Project (0925-0281), Office of Information and Regulatory Affairs, Office of Management.

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: ____________

2. Final Status:
   (Circle one below)
   - Contacted and alive
   - Contacted & Refused
   - Reported alive
   - Reported Deceased
   - Unknown
       
   ______ Phone
       
   ______ Personal Interview
       
   ______ Letter
       
   ______ Relative, spouse, acquaintance
       
   ______ Employer information
       
   ______ Other
       
   ______ Relative, spouse, acquaintance
       
   ______ Surveillance
       
   ______ Other (National Death Index)

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

       ______ A Go to Item 6, Screen 2
       ______ B Go to Item 30, Screen 7
       ______ C Go Item 33, Screen 8
       ______ D Go to Item 30, Screen 7
       ______ E Go Item 33, Screen 8
       ______ F Continue to Item 4
       ______ G Go to Item 33, Screen 8

ANNUAL FOLLOW-UP QUESTIONNAIRE (AFUE screen 1 of 10)
B. DEATH INFORMATION

4. Date of death:

[Date fields]

Month / Day / Year

5. Location of death:

a. City/County

[Field]

b. State

[Field]

After Item 5, skip to Item 30, Screen 7.

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 ... E
- Good ........ G
- Fair ........ F
- Poor ........ P

D. CHEST PAIN ON EFFORT

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

Go to Item 20, Screen 5

No N

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

Go to Item 17, Screen 5

No N

Never hurries or walks uphill

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

Go to Item 17, Screen 5

No N

Stop or slow down

10. What do you do if you get it while you are walking?

- Stop or slow down S
- Carry on C

[Record “Stop or slow down” if subject carries on after taking nitroglycerin]

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

Go to Item 17, Screen 5

Not relieved N
12. How soon?........ 10 minutes or less L
Go to Item 17, Screen 5
More than 10 minutes M

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

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Sternum (upper or middle)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>b. Sternum (lower)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>c. Left anterior chest</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>d. Left arm</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>e. Other</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

13.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 D
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 Y No N
Go to Item 29, Screen 7

21. Does this pain ever begin when you are standing still or sitting?............ Yes Y No N
Go to Item 29, Screen 7
ANNUAL FOLLOW-UP QUESTIONNAIRE (AFUE screen 6 of 10)

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    No N

   Never hurries
   or walks uphill H

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

   No N

25. Does the pain ever
    disappear while you are walking? ...... Yes Y

   Go to Item 29,
   Screen 7

   No N

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

   Go to Item 29,
   Screen 7    Carry on C

ANNUAL FOLLOW-UP QUESTIONNAIRE (AFUE screen 7 of 10)

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 Y

   No N

   If 'Yes', ensure that this event is
   included in the 'HOSPITALIZATIONS' section, if appropriate.

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 Unknown U

If "Yes," add to "HOSPITALIZATIONS" section. For DECEASED AND REPORTED ALIVE participants, go to Item 33.

I. WEIGHT

32.a. Over the past year, have you lost more than 10 pounds?
Yes Y No N Unknown U
Go to Item 33
Go to Item 32c

32.b. About how much lower is your weight now than a year ago?

32.c. Were you trying to lose this weight? ....... Yes Y No N Unknown U

J. ADMINISTRATIVE INFORMATION

33. Code number of person completing this form:
F. HOSPITALIZATIONS

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/yyyy of last contact)? [Fill in, probing as necessary. Abbreviations can be used for local hospitals. Probe for additional hospitalizations. For linkage, H indicates that the hospitalization was reported; N indicates that the hospitalization was fully sought by Surveillance, and not found.]

34.a. Hospitalization Reason:

35.a. Hospital Name, City, and State:

36.a. Month and Year: [ ] [ ] 37.a. Linkage Status: [ ]
M M Y Y Y Y

34.b. Hospitalization Reason:

35.b. Hospital Name, City, and State:

36.b. Month and Year: [ ] [ ] 37.b. Linkage Status: [ ]
M M Y Y Y Y

34.c. Hospitalization Reason:

35.c. Hospital Name, City, and State:

36.c. Month and Year: [ ] [ ] 37.c. Linkage Status: [ ]
M M Y Y Y Y
34.d. Hospitalization Reason:  

35.d. Hospital Name, City, and State:  

36.d. Month and Year: [ ] / [ ]  

37.d. Linkage Status: [ ]  

(H) or (N)  

34.e. Hospitalization Reason:  

35.e. Hospital Name, City, and State:  

36.e. Month and Year: [ ] / [ ]  

37.e. Linkage Status: [ ]  

(H) or (N)  

34.f. Hospitalization Reason:  

35.f. Hospital Name, City, and State:  

36.f. Month and Year: [ ] / [ ]  

37.f. Linkage Status: [ ]  

(H) or (N)