



PHYSICIAN QUESTIONNAIRE

O.H.S. 0925-0281
exp. 7-31-89

1-291

Decedent's Name: _____ ID _____ No. _____

Age: _____ Date of Birth: ____/____/____ Date of Death: ____/____/____

Physician's Name: _____ Form PHQ A: 4-12-88

Please complete the following to the best of your ability and return in the enclosed envelope.

A. MEDICAL HISTORY

1. Are you familiar with the decedent's medical history?

Yes No

If No, skip to Item 5 on Page 3

2. When did you last see the decedent? -
Month Year

3. Did the decedent have a history of any of the following?

	<u>Yes</u>	<u>No</u>	<u>Uncertain</u>
a. Angina pectoris or coronary insufficiency .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Valvular disease or cardiomyopathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Coronary bypass surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Coronary angioplasty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Myocardial infarction			

Yes No Uncertain

g. If Yes, date of most recent event: -
Month Year

B. DETAILS OF DEATH

5. Are you familiar with the events surrounding the decedent's death?

Yes No

6. Did you witness the death?

Yes No

If you answered No to both 5 & 6,
 skip to item 14 on page 4.
 Otherwise, continue with item 7.

7. a. Was there any pain in the chest, left arm or shoulder or jaw
 within 72 hours of death?

Yes No Uncertain

If No or Uncertain, skip to item 8

b. Did the pain include the chest?

Yes No Uncertain

c. Did you think this pain was of a cardiac origin?

Yes No Uncertain

d. If No, specify what you think was the cause:

8. Did the decedent take (or was he/she given) nitrates
 at the time of the acute episode?

Yes No Uncertain

9. Was coronary reperfusion (intravenous or intracoronary streptokinase or
 TPA, angioplasty, etc.) attempted during the acute episode?

Yes No Uncertain

10. Was CPR and/or cardioversion performed within 24 hours of death?

Yes No Uncertain

11. Please give time between onset of acute symptoms to death. (We are defining death as the point where spontaneous breathing ceased and the patient never recovered.)

- More than 3 days
- 2 - 3 days
- 1 day
- At least 12 hours, but less than 24 hours
- At least 4 hours, but less than 12 hours
- At least 1 hour, but less than 4 hours
- Less than 1 hour
- Death instantaneous, no symptoms
- Unknown

12. Would you classify the decedent's cause of death as due to CHD?

- Yes No Uncertain
-

13. If No, what do you believe to be the cause of death?

- | | <u>Yes</u> | <u>No</u> | <u>Uncertain</u> |
|----------------------------|--------------------------|--------------------------|--------------------------|
| a. Pulmonary embolism | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Acute pulmonary edema . | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Stroke | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Pneumonia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Other | | | |

- Yes No Uncertain
-

f. Specify: _____

C. SIGNATURE

14. Form completed by: _____
Signature

15. Date: - -
Month Day Year

Thank you very much for your help. Please return this questionnaire in the enclosed self-addressed envelope or mail it to:
ARIC Central Receiving, Collaborative Studies Coordinating Center
Suite 203 NCNB Plaza, 137 E. Franklin Street, Chapel Hill NC 27514

OFFICE USE ONLY: 16. Self__ Interview __ E.R. records __