AFU MEDICAL HISTORY FORM

INSTRUCTIONS:
This form asks about a variety of health issues. It should be completed during the appropriate annual follow-up call. 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 on a paper form, 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.
This year we have a few additional medical questions.

1. Has a doctor ever said you had diabetes, or sugar in the blood? ...
   - Yes
   - No
   - Unknown

   a. At what age were you first told you had diabetes? .................
   - Y
   - N
   - Unknown

2. Has a doctor ever said you had any of the following?

   a. Kidney stones? ......................
      - Yes
      - No
      - Unknown

   b. Any other kidney disease, apart from a temporary infection? .......
      - Yes
      - No

   c. Have you ever had a kidney transplant or been treated with dialysis for more than 6 months? .......
      - Yes
      - No

   d. Has a doctor ever said you had hepatitis? .....................
      - Yes
      - No
      - Unknown
2.e. Cirrhosis or another chronic liver disease? .................. Yes
   Y
   No
   N
   Unknown
   U

f. A thyroid disease, such as hypo- or hyperthyroidism or a goiter? .... Yes
   Y
   No
   N
   Unknown
   U

3. Have you ever been diagnosed by a doctor as having gallstones or a gallbladder attack? ................. Yes
   Y
   Go to Item 4
   N
   No
   Unknown
   U

3.a. At what age were you first told you had a gallbladder problem? ............... Yes

b. Has your gallbladder been removed? .................. Yes
   Y
   Go to Item 5
   N
   No
   Unknown
   U

4. Have you ever had a test, for example ultrasound or x-ray, to check for gallstones? ............ Yes
   Y
   No
   N
   Unknown
   U
5. Have you ever had a head injury which led you to see a physician or seek hospital care? 
   Yes \(Y\) \(\square\) \(\text{Go to Item 6} \quad \square\) No \(N\) \(\square\)

   a. How many times has this happened? 
   ........................

   b. How many of these head injuries resulted in your losing consciousness, no matter how briefly? 
   ..............................

   c. In what year was your last head injury for which you sought medical care? ...... 19

6. During your lifetime, have you ever used aspirin, or a medicine containing aspirin, on a regular basis? This does not include Tylenol. 
   Yes \(Y\) \(\square\) \(\text{Go to Item 9} \quad \square\) No \(N\) \(\square\)

   a. How many times has this happened? 
   ..............

   b. How many of these head injuries resulted in your losing consciousness, no matter how briefly? 
   ........................

   c. In what year was your last head injury for which you sought medical care? ...... 19

   When did you first take aspirin, or a medicine containing aspirin, on a regular basis?

   a. 19

   year
7. Please think back about the time when you FIRST came to the ARIC clinic on [insert date]. At that time, were you taking aspirin, or a medicine containing aspirin, on a regular basis? ................. Yes Y

No N

' Go to Item 8 .

Unknown U

a. At that time, which were you taking--aspirin alone or a medicine containing aspirin? .. Aspirin A

' Go to Item 7.d. Other O

b. What was the brand name?

__________________________________________________

__________________________________________________

d. Can you recall what strength of aspirin was in the pill? Was it baby, regular, or extra strength?

Baby (Less than 300 milligrams) ........... B

Regular (300-499 milligrams) ........... R

Extra Strength (500 milligrams or more) ......................... E

Don't Know ............................... D

e. How many days a week, on average, were you taking aspirin, or a medicine containing aspirin on [insert FIRST clinic date]? .................

} days per week
7.f. How many pills were you taking per week, on average? .................

8. Are you NOW taking aspirin, or a medicine containing aspirin, on a regular basis? ........Yes
    Y
    No
    U

When did you stop taking aspirin, or a medicine containing aspirin, on a regular basis?

a. 19 year

9. [ DO NOT ASK ]

Gender of Participant................. Male
    M
    Females

10. Except for aspirin or Tylenol, have you ever used other nonsteroidal anti-inflammatory drugs or arthritis medicines on a regular basis?
Examples include Ibuprofen, Advil, Naprosyn, Motrin, Naprosyn, Feldene and Clinoril.

Yes

Y

No

U

When did you start taking that medicine on a regular basis?

a. 19 year
11. Please think back about the time when you FIRST came to the ARIC clinic on [insert date]. At that time, were you taking a nonsteroidal anti-inflammatory or arthritis medication on a regular basis?

   Yes

   Y

   No

   N

   Unknown

a. What was the brand name of the medicine you were taking at that time?

   Ibuprofen or Advil

   Other

b. If "Other", specify: _______________________

   Go to Item 11.d.

11.c. Code ........................................

   _______________________

11.d. How many pills per week were you taking, on average, on [insert FIRST clinic date]?

   Less than 1 tablet per week

   A

   1 tablet per week

   B

   2-5 tablets per week

   C

   6 or more tablets per week

   D

12. Are you now taking a nonsteroidal anti-inflammatory or arthritis medication on a regular basis?

   Yes

   Y

   No

   N

   Unknown

   U
12. When did you stop taking that medicine on a regular basis?
   a. 19
   b. year

13. [IF MALE, SKIP TO ITEM 20]
   Have you ever been pregnant? .......... Yes Y
   Go to Item 15 No
   a. How old were you when you first became pregnant? .................

14. Have you ever given birth? ............
   Yes Y
   Go to Item 15 No
   a. How old were you when your first child was born? .................
   b. What is the total number of months, adding together all children, that you breast fed? .................

15. Have you ever had a mammogram, an x-ray like examination of your breast? ......
   Yes Y
   Go to Item 16 No
   N
15.a. In what year was your last mammogram? ........... 19

16. Have you ever had a breast biopsy, by surgery or needle, to remove and examine a small piece of breast tissue? ..................... Yes

17. Have you ever had a mastectomy or lumpectomy to remove part or all of a breast? .............. Yes

18. Have you ever had breast cancer? .............

a. Which breast(s)? ..................... Right only

b. Which breast(s)? ..................... Left only

c. Both

Go to Item 19

No
19. Has your mother, a full sister, or a child had cancer in both breasts? .. Yes
   Y
   No
   N
   Unknown
   U

20. Have you ever had chemotherapy or radiation treatment for any kind of cancer? ..................... Yes
    Y
    No
    N
    Unknown
    U

21. Have you ever had a sigmoidoscopy or colonoscopy to detect an abnormality in your colon, large intestine or rectum? ..................... Yes
    Y
    No
    N
    Unknown
    U

22. Have you ever had a stool test for blood to detect cancer of the colon or rectum? ............ Yes
    Y
    No
    N
    Unknown
    U

23. Have you ever been diagnosed by a doctor as having a polyp or noncancerous tumor of the colon or rectum? ............... Yes
    Y
    No
    N
    Unknown
    U
"The next questions ask about diabetes and cancer in your family. Only full blood relatives should be considered. Do not count half or adopted relatives."

25. Did your mother ever have cancer? .. Yes

  | Y | No

  | N | Go to Item 26

  | Unknown | U

What types or location of cancer(s)?

a. ____________________________________________

b. ____________________________________________

c. At approximately what age was the (first) cancer diagnosed? ...............
26. Did your father ever have diabetes, or sugar in the blood? .......... Yes
   Y
   N
   U

   a. Did this start before or after the age of 30? ............... Before
      B
      After
      Unknown

27. Did your father ever have cancer? .. Yes
   Y
   N
   U

   a. How many sisters, if any, had diabetes, or sugar in the blood? ............
      
      b. How many sisters had cancer? ...........
      
      c. At approximately what age was the (first) cancer diagnosed? ........
      
28. How many full sisters did you have, living or dead? ................
   Y
   N
   U

   a. How many sisters, if any, had diabetes, or sugar in the blood? ............

   b. How many sisters had cancer? ...........

What types or location of cancer(s)?

27.a.

b.

c. At approximately what age was the (first) cancer diagnosed? ........

28. How many full sisters did you have, living or dead? ................
   Y
   N
   U

   a. How many sisters, if any, had diabetes, or sugar in the blood? ............

   b. How many sisters had cancer? ...........

   c. At approximately what age was the (first) cancer diagnosed? ........

If 00, Go to Item 29.
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28.s. For how many of your sisters do you feel you really know their medical history? ..

29. How many full brothers did you have, living or dead?

a. How many brothers, if any, had diabetes, or sugar in the blood?

b. How many brothers had cancer?

If 00, Go to Item 29.s.

If 00, Go to Item 30.
Could you please provide the types or locations of cancer in your brothers and the age the first cancer was first diagnosed. [ONE BROTHER PER LINE]

29. Type
   Age
   a. ____________________________
   b. ____________________________
   c. ____________________________
   d. ____________________________
   e. ____________________________
   f. ____________________________

29.s. For how many of your brothers do you feel you really know their medical history? ..

30. Do you have a brother or a sister diagnosed as having high blood pressure? .................
    Yes
    No
    Unknown

   U

ADMINISTRATIVE INFORMATION

31. Date of data collection: ........../.../...
    month   day   year

32. Method of data collection: ........ Computer
    Paper

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

q. ____________________________