INSTRUCTIONS: This form should be completed on paper during the participant's visit.

A. MEDICAL HISTORY

1. Has a doctor ever said you had any of the following?
   a. Kidney stones? ........................................... Yes Y
      No N
      Unknown U
   b. Any other kidney disease, apart from a temporary infection? ........................................... Yes Y
      No N
      Unknown U
   c. Have you ever had a kidney transplant or been treated with dialysis for more than 6 months? Yes Y
      No N

B. FASTING BLOOD DRAWING

2. Do you have any bleeding disorders? .......................... Yes Y
   No N
   Unknown U
   If Yes,specify in Item 16, Page 3.

3. Date of blood drawing: ................................... month / day / year

4.a. Time of fasting blood drawing: ............... h h : m m
    b. AM or PM: ............................................... AM A
       PM P
5. Was fasting blood drawn before the glucola/snack? 
   Yes  Y  No  N

6. Number of venipuncture attempts: 
   

7. Was the tourniquet reapplied? 
   Yes  Y  No  N

8. Phlebotomist ID: 

C. BLOOD PROCESSING

9.a. Time at which specimen tubes 2-4 were spun: 
   h h : m m
   AM or PM: AM  A  PM  P

9.b. AM or PM: AM  A  PM  P

10.a. Time at which specimen Tube 1 was spun: 
   h h : m m
   AM or PM: AM  A  PM  P

10.b. AM or PM: AM  A  PM  P

11.a. Time at which specimen tubes 1-4 were placed in freezer: 
   h h : m m
   AM or PM: AM  A  PM  P

11.b. AM or PM: AM  A  PM  P

12.a. Time at which specimen Tube 6 was spun: 
   h h : m m
   AM or PM: AM  A  PM  P

12.b. AM or PM: AM  A  PM  P

13.a. Time at which specimen Tube 6 was placed in the freezer? 
   h h : m m
   AM or PM: AM  A  PM  P

13.b. AM or PM: AM  A  PM  P
14. Technician ID for fasting samples: ..............

15. Code number of technician processing
    post-glucose load samples: .................

16. Comments on blood drawing/processing: .......... Yes Y
    No N

If Yes, Specify: _______________________________________

D. URINE SAMPLE

17. Urine sample collected? ......................... Yes Y
    No N

    Go To Item 25.

18. Date of urine sample: .........................

19.a. Time of urine sample: ......................

    b. AM or PM .............................. AM A
        PM P

20. Volume adequate for processing? ............ Yes Y
    No N

    Go To Item 25.

21. Creatinine/Albumin RECORD box number. ......

22.a. Creatinine vial processed? .................. Yes Y

    Go To Item 23.a.

    b. Creatinine POSITION number. ..............

23.a. Albumin vial processed? .................... Yes Y

    Go To Item 24.

    b. Albumin POSITION number. .................

24. Hemostasis vial processed? ................... Yes Y
    No N

25. Technician ID for urine samples. ............

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