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OMB#: 0925-0585
Exp. xx/xx/xxxx

HCHS/SOL Visit 2- Personal Medical History

ID NUMBER:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	FORM CODE: MHE	Contact Occasion	<input type="text"/>	<input type="text"/>	SEQ #	<input type="text"/>	<input type="text"/>
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ADMINISTRATIVE INFORMATION

0a. Completion Date: /

0b. Staff ID:

0c. Participant Gender: (F=female, M=male)

0d. Age:

Instructions: Enter the answer given by the participant for each response. Use the CDART Notelog window to code 'Don't know/refused, Missing, etc.' for those questions that do not list these as an option.

A. Since the first SOL visit, have you had any of the following medical problems?

	No	Yes	Unsure
1. Heart attack?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
2. A balloon angioplasty, a stent, or bypass surgery to the arteries in your heart to improve the blood flow to your heart?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
3. Angina?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
4. Heart Failure?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
5. Stroke?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
6. A mini-stroke or TIA (transient ischemic attack)?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
7. A balloon angioplasty or surgery to the arteries of your neck to prevent or correct a stroke?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
8. An aortic aneurysm, an AAA, or ballooning of your aorta?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
9. Peripheral arterial disease (problems with circulation, blocked arteries to the legs)?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
9.a (IF YES TO PAD) A balloon angioplasty, a stent, or an amputation for this condition?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
10. Liver disease? <i>If No/unsure to liver disease then Go to #11</i>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>

IF YES to liver disease, then what type of liver disease?

10a. Hepatitis

No	0 <input type="checkbox"/>	→ GO TO QUESTION 10c
Yes	1 <input type="checkbox"/>	

10b. What type?

Type A	1 <input type="checkbox"/>
Type B	2 <input type="checkbox"/>
Type C	3 <input type="checkbox"/>
Don't know	9 <input type="checkbox"/>

10c. Cirrhosis

No	0 <input type="checkbox"/>
Yes	1 <input type="checkbox"/>

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11. Has a doctor ever said that you have cancer or a malignant tumor?

No 0 → **GO TO QUESTION 12**
Yes 1

11a. What type?

	No	Yes
a1. Lung	0 <input type="checkbox"/>	1 <input type="checkbox"/>
a2. Breast	0 <input type="checkbox"/>	1 <input type="checkbox"/>
a3. Cervical	0 <input type="checkbox"/>	1 <input type="checkbox"/>
a4. Blood/lymph glands	0 <input type="checkbox"/>	1 <input type="checkbox"/>
a5. Testes/scrotum	0 <input type="checkbox"/>	1 <input type="checkbox"/>
a6. Bone	0 <input type="checkbox"/>	1 <input type="checkbox"/>
a7. Melanoma	0 <input type="checkbox"/>	1 <input type="checkbox"/>
a8. Skin (not melanoma)	0 <input type="checkbox"/>	1 <input type="checkbox"/>
a9. Brain	0 <input type="checkbox"/>	1 <input type="checkbox"/>
a10. Stomach	0 <input type="checkbox"/>	1 <input type="checkbox"/>
a11. Colon	0 <input type="checkbox"/>	1 <input type="checkbox"/>
a12. Uterine	0 <input type="checkbox"/>	1 <input type="checkbox"/>
a13. Prostate	0 <input type="checkbox"/>	1 <input type="checkbox"/>
a14. Liver	0 <input type="checkbox"/>	1 <input type="checkbox"/>
a15. Kidney/renal	0 <input type="checkbox"/>	1 <input type="checkbox"/>
a16. Other	0 <input type="checkbox"/>	1 <input type="checkbox"/>

a16i. Specify: _____

12. Do you currently have a pacemaker or automatic defibrillator (AICD) for a heart rhythm problem?

No 0
Yes, pacemaker 1
Yes, automatic defibrillator (AICD) 2
Yes, both pacemaker, and automatic defibrillator (AICD) 3
Not sure 9

B. Since your last telephone interview on (date), have you had any of the following problems?

	No	Yes	Unsure
13. Do you often have swelling in your feet or ankles at the end of the day?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
14. Are there times when you wake up at night because of difficulty breathing?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
15. Are there times when you stop for breath when walking at your own pace on level ground?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
16. Are there times when you have difficulty breathing when you are not walking or active?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>

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17. Have you ever been told by a doctor or health professional that you had/have any of the following conditions that effect the brain?

	No	Yes	Unsure
Parkinson's Disease	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
Dementia	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
Alzheimers Disease	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>

C. Urinary Incontinence

Many people have leakage of urine. The next few questions ask about urine leakage.

(Other terms for urinary leakage are not being able to hold your urine until you can reach a toilet, not being able to control your bladder, loss of urine control.)

18. How often do you have urinary leakage? Would you say...

- Never 1 →Go to question 20
- Less than once a month 2
- A few times a month 3
- A few times a week, 4
- Every day and/or night 5
- Unsure / Refused 9 →Go to question 20

19. How much urine do you lose each time? Would you say...

- Drops 1
- Small splashes 2
- More 3
- Unsure / Refused 9

20. During the **past 12 months**, have you leaked or lost control of even a small amount of urine with an activity like coughing, lifting or exercise?

- No 0 →Go to question 21
- Yes 1
- Unsure / Refused 9 →Go to question 21

20a. How frequently does this occur? Would you say this occurs . . .

- Less than once a month 1
- A few times a month 2
- A few times a week 3
- Every day and/or night 4
- Unsure / Refused 9

21. During the **past 12 months**, have you leaked or lost control of even a small amount of urine with an urge or pressure to urinate and you couldn't get to the toilet fast enough?

- No 0 →Go to question 22
- Yes 1
- Unsure / Refused 9 →Go to question 22

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21a. How frequently does this occur? Would you say this occurs. . .

- Less than once a month 1
- A few times a month 2
- A few times a week 3
- Every day and/or night 4
- Unsure / Refused 9

22. During the **past 12 months**, have you leaked or lost control of even a small amount of urine without an activity like coughing, lifting, or exercise, or an urge to urinate?

- No 0 **→Go to question 23**
- Yes 1
- Unsure / Refused 9 **→Go to question 23**

22a. How frequently does this occur? Would you say this occurs . . .

- Less than once a month 1
- A few times a month 2
- A few times a week 3
- Every day and/or night 4
- Unsure / Refused 9

23. During the **past 12 months**, how much did your leakage of urine bother you? Please select one of the following choices:

- Not at all 1
- Only a little 2
- Somewhat 3
- Very much 4
- Greatly 5
- Unsure/ Refused 9

24. During the **past 12 months**, how much did your leakage of urine affect your day-to-day activities?
Please select one of the following choices:

- Not at all 1
- Only a little 2
- Somewhat 3
- Very much 4
- Greatly 5
- Unsure/ Refused 9

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25. During the **past 30 days**, how many times per night did you most typically get up to urinate, from the time you went to bed at night until the time you got up in the morning. Would you say..

- 1 time
- 2 times
- 3 times
- 4 times
- 5 or more times
- Unsure/ Refused

D. Kidney

26. Have you ever been told by a doctor or other health professional that you had weak or failing kidneys? Do not include kidney stones, bladder infections, or incontinence.

- No →Go to question 28
- Yes
- Unsure / Refused →Go to question 28

27. In the **past 12 months**, have you received dialysis (either hemodialysis or peritoneal dialysis)?

- No
- Yes
- Unsure / Refused

28. Have you ever had kidney stones?

- No →Go to question 29
- Yes
- Unsure / Refused →Go to question 29

28a. How many times have you passed a kidney stone? ENTER NUMBER OF TIMES

E. Tuberculosis Screening

29. **Since visit 1**, have you been told that you had active tuberculosis or TB?

- No →Go to question 30
- Yes
- Unsure / Refused →Go to question 30

29a. **Since visit 1**, have you been prescribed any medicine to treat active tuberculosis or TB?

- No
- Yes
- Unsure / Refused

30. **Since visit 1**, have you been given a TB or tuberculosis skin test (e.g., PPD)?

- No → For men, go to 31; for women, END of questionnaire
- Yes
- Unsure / Refused →Go to question 30b

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- 30a. Was it: Positive 1
Negative 2 → **For men, go to #31; for women, END of questionnaire**
Unsure/Ref. 9

30b. For this TB skin test, were you prescribed any medicine to keep you from getting sick with TB?

- No 0
Yes 1
Unsure/ Refused 9

For WOMEN, END of questionnaire

F. Men only

The next set of questions is about men's health including urinary and prostate problems. The prostate is a gland located just below the bladder.

For men less than 40 years of age, go to question 33.

31. For men age 40 years and older only: Do you usually have trouble starting to urinate (pass water)?

- No 0
Yes 1
Unsure / Refused 9

32. For men age 40 years and older only: After urinating (passing water), does your bladder feel empty?

- No 0
Yes 1
Unsure / Refused 9

The remainder is for men of all ages:

33. Have you ever been told by a doctor or health professional that you have any disease of the prostate?
This includes an enlarged prostate.

- No 0
Yes 1
Unsure / Refused 9

34. Have you ever been told by a doctor or health professional that you had an enlarged prostate gland?

- No 0 → **Go to question 35**
Yes 1
Unsure / Refused 9 → **Go to question 35**

34a. Was it a benign enlargement – that is, not cancerous, also called benign prostatic hypertrophy?

- No 0
Yes 1
Unsure / Refused 9

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34b. How old were you when you were first told that you had benign enlargement of the prostate gland?

Enter age in years

34c. Was the enlargement due to cancer?

No 0

Yes 1

Unsure / Refused 9

35. Have you ever had a blood test that your doctor told you was being used to check for prostate cancer, called PSA, or Prostate Specific Antigen?

No 0

Yes 1

Unsure / Refused 9

36. Have you ever had a rectal examination? A rectal exam is when a finger is inserted in the rectum or bottom to check for problems.

No 0 **→Go to question 37**

Yes 1

Unsure / Refused 9 **→Go to question 37**

36a. Was this done to check for prostate cancer?

No 0

Yes 1

Unsure / Refused 9

36b. Was this done to check for blood?

No 0

Yes 1

Unsure / Refused 9

37. Many men experience problems with sexual intercourse. How would you describe your ability to get and keep an erection adequate for satisfactory intercourse? Would you say that you are..

Verbal Instruction: Always able or almost always able to get and keep an erection? Usually able to get and keep an erection? Sometimes able to get and keep an erection? Never able to get and keep an erection?]

Always or almost always able 3

Usually able 2

Sometimes able 1

Never able 0

Unsure/ Refused 9