0b. Staff ID: ☐☐☐
(To be completed by research staff member)

MEDICAL CONDITIONS UPDATE FORM (Mail Version)

PPT NAME: ________ (To be completed by research staff member)

FORM CODE: M | C | U

DATE: 10/08/2024
Version 2.0

ADMINISTRATIVE INFORMATION

Instructions: *Please tell us who is completing this form and today's date.*

Date of last contact with research team: ☐☐/☐☐/☐☐☐☐ (Month / Day / Year)
(To be completed by research staff member)

Full name of person completing this form: ______________ (first) (last)

Are you the study participant?

Yes ...... ☐ → *Skip to Question 0a.*
No .... ☐ → *Continue to next question.*

Are you a proxy for the study participant?

Yes ...... ☐
No .... ☐

0a. Today's Date: ☐☐/☐☐/☐☐☐☐ (Month / Day / Year)

QUESTIONS

Instructions: *Please answer the questions below to the best of your ability. Please answer the questions in the order they appear on the form and follow directions to skip questions, as applicable. Please note that some question numbers are not in order and some numbers are skipped.*

GENERAL MEDICAL CONDITIONS

Since we last contacted you, has a doctor said you have any of the following conditions? (Mark all that apply.)

1. High blood pressure.......... ☐
2. Diabetes or sugar in the blood.......... ☐
3. Chronic lung disease, such as bronchitis or emphysema.......... ☐
4. Asthma.......... ☐
5. Peripheral vascular disease or intermittent claudication.......... ☐

HEART FAILURE OR WEAK HEART

6. Since our last contact, has a doctor said that you had heart failure or congestive heart failure?

   Yes .... ☐→ *Skip to Question 8.*
   No...................... ☐→ *Continue to Question 7.*

7. Since our last contact, has a doctor said that your heart is weak, or does not pump as strongly as it should, or that you had fluid on the lungs?

   Yes .... ☐→ *Continue to Question 8.*
   No...................... ☐→ *Skip to Question 12.*

DOCTOR INFORMATION FOR HEART FAILURE/WEAK HEART

Instructions: *Please provide the name and contact information for the doctor you most recently visited for heart failure/weak heart. Please also provide the month and year of the doctor visit.*

8. Name and address of the doctor you saw:

   8a. Name: ____

   8b. Address: ____

   8c. City: ________________________________ 8d. State: ☐☐

   8e. Approximate date: ☐☐/☐☐☐☐
   Month Year

HOSPITAL INFORMATION FOR HEART FAILURE/WEAK HEART

Instructions: *Please answer the questions below about any time you have spent in the hospital for your heart failure/weak heart.*

10. At the time the doctor said you had heart failure/weak heart, were you hospitalized or did you stay in a hospital observation unit?

   Yes .... ☐→ *Continue to Question 11a.*
   No...................... ☐→ *Skip to Question 12.*

11a. Hospital/Medical Facility Name, City, State: ______________________

____

11b. Approximate date of admission: ☐☐/☐☐☐☐
Month Year

IRREGULAR HEARTBEAT

12. Since our last contact, has a doctor said you had an irregular heartbeat, called atrial fibrillation, or atrial fibrillation on a heart scan or electrocardiogram tracing?

    Yes .... ☐
    No...................... ☐

PERSONAL NEUROLOGIC HISTORY

Since our last contact, have you been told by a doctor or health professional that you have any of the following conditions? (Mark all that apply.)

13a. Alzheimer's Disease... ☐
13b. Parkinson's Disease... ☐
13c. Memory loss or cognitive impairment... ☐
13d. Dementia, vascular dementia, or hardening of the arteries of the brain......... ☐

Thank you for completing this form!
Please make sure you complete all forms before mailing them back to the ARIC Study Team.