

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:

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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: / /
(To be completed by research staff member) Month Day Year

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

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.*

HEART FAILURE OR WEAK HEART

6. Since our last contact, has a doctor said that the participant 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 the participant's heart is weak, or does not pump as strongly as it should, or that the participant 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 the participant 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 the participant 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 the participant has spent in the hospital for heart failure/weak heart.*

10. At the time the doctor said the participant had heart failure/weak heart, was the participant hospitalized or did the participant 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 the participant 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, has the participant been told by a doctor or health professional that he/she has 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.