APPENDIX I

ARIC Recruitment and Follow-up Letters, and Appointment Reminder

Appendix I

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Appendix I

ARIC Form Letters, Brochure and Appointment Reminder

FORM 1: Introductory Letter

Date

Dear _____:

An important medical project directed by the [University of] is being conducted in [County]. It is called the Atherosclerosis Risk in Communities project and is sponsored by the National Institutes of Health. The object of the project is to understand factors related to atherosclerosis (hardening of arteries), heart attack, and stroke. Each year approximately 1,300 residents ages 45 to 64 years will be invited to take part.

Eligible people will be interviewed in their home at their convenience (each interview will take approximately 20 minutes) and will be invited to a free medical screening clinic where blood pressure, cholesterol, lung function, an electrocardiogram, and body size will be measured and interviews on many factors related to health will be conducted. A check for the presence of atherosclerosis in the arteries of the neck and leg will be performed using ultrasound, a painless test which measures reflected sound waves. Three years after entry into the study, participants will have another physical examination like the first.

The information collected will be held strictly confidential and used only for statistical, research purposes. The project will provide important information on your health status and will aid physicians in understanding the causes of heart attack and stroke. Your household is a valuable part of this effort.

[A trained field interviewer from our staff will call on you soon.] We thank you for your assistance in this project.

Sincerely,

[Field Center Director]

FORM 2: Brochure

ARIC Project

The Atherosclerosis Risk in Communities Study

- Forsyth County, North Carolina
- Jackson, Mississippi
- Minneapolis suburbs, Minnesota
- Washington County, Maryland

Sponsored by the National Heart, Lung, and Blood Institute of the U.S. National Institute of Health in conjunction with:

- The University of North Carolina
- The University of Mississippi
- The University of Minnesota
- The Johns Hopkins University

Purpose: The ARIC Study is a medical research project being conducted in four communities in the United States, seeking to learn more about factors associated with diseases of the heart and blood vessels. It is designed to investigate the causes of atherosclerosis, a form of hardening of the arteries in which cholesterol and other materials gradually close down the circulation of blood through the vessel. Researchers will study the relationships between characteristics of people and the way in which changes occur in their blood vessels.

Participants: In each of the four areas, residents between the ages of 45 and 65 will be randomly selected and invited to participate. A total of 4000 persons will be enrolled from each area over a three-year period.

Examination: Participants in the study will have an interview in their home. Then, in a clinic, they will complete a health interview and receive a free examination including an electrocardiogram (EKG) which records the functioning of the heart, lung function tests, measurement blood pressure and body size, and blood tests for blood fats, cholesterol and other properties of the blood. A picture of the arteries in the neck and leg will be taken by ultrasound, a painless procedure widely used in obstetrics which makes diagnoses based on the properties of reflected sound waves. These studies will be performed at no cost to you.

[Pictures of procedures about here]

Information from these procedures will be provided to you and your physician, if you choose.

Future Contacts: After the examination, participants will be contacted about once a year by phone or mail to ask about their health in the preceding year. The examination will be repeated after three years, and again yearly contacts will be made by phone or mail.

If participants are hospitalized during the study period, the researchers would like to check their hospital records to obtain information that may apply to this study. If a participant suffers a heart attack or stroke, their relatives or physician may be contacted for details about the illness.

Confidentiality: All of the information provided by participants to the ARIC Study will be kept confidential. The information will be used for statistical, research purposes without ever identifying individual participants.

For more information about the ARIC Study program, please contact the field centers in your area:

[List of centers, their addresses, and telephone numbers]

[Local pictures, population information]

ARIC

ATHEROSCLEROSIS RISK IN COMMUNITIES STUDY

FORSYTH CO. NORTH CAROLINA | JACKSON MISSISSIPPI | SUBURBAN MINNEAPOLIS MINNESOTA | WASHINGTON CO. MARYLAND

Thank you for agreeing to participate in the Atherosclerosis Risk in Communities (ARIC) Study. Your appointment has been scheduled for:

DAY_____ DATE_____TIME_____A.M.

A _____ taxi will pick you up at your home at approximately _____ a.m. and will return you to (your home/place of work) after the exam. Please read the following instructions carefully.

* FASTING:
  You should fast (NOTHING BY MOUTH EXCEPT WATER) for 12 hours before your appointment time. A snack will be provided during your visit.

* SMOKING AND PHYSICAL ACTIVITY:
  Please refrain from smoking or vigorous physical activity at least one hour before your appointment.

* CLOTHING:
  Please be prepared to change into a hospital gown after your arrival and bring or wear comfortable shoes or slippers that are easy to take on and off. Please wear loose fitting underwear and leave necklaces at home.

* MEDICATIONS:
  Please be sure to bring your medications in their original containers. You should put these containers in the ARIC medications bag.

* GLASSES:
  If you normally use glasses for reading, please bring them with you to the clinic.

* PHYSICIAN CONTACT:
  Please complete the form on back of the Medications Instructions and bring it with you to the clinic.

* TRACKING INFORMATION:
  Please complete the included form with names, addresses, and telephone numbers of two contact people to help us to locate you in the future.

* SOCIAL SECURITY/DRIVER'S LICENSE NUMBER:
  Please have your social security and driver's license number available. Provision of these numbers is voluntary and failure to do so will not have any affect upon the receipt of any benefits or programs of the U.S. Government. Remember that all information is confidential and will be used only for statistical purposes.

To help you to move through the clinic on schedule, it is most important that you be on time for your appointment. Here is a list of activities

(over)

for your clinic visit.

Reception
Blood Pressure Measurement
Blood Drawing
Anthropometry (Body Measurement)
Snack
Ultrasound
Interview
Pulmonary Function Tests
Physical Examination
Electrocardiogram
Medical Review

If you have any questions or a problem with your appointment, please call the clinic at 777-3040 between 7:30 a.m. and 4:30 p.m. Monday through Friday.

We look forward to meeting you.

ARIC STAFF

PLEASE BRING WITH YOU TO THE CENTER...

- Prescription Drugs from your physician
- Prescription Drugs you have been given by a friend or relative
- Non-prescription Drugs (over the counter) that you obtained from a drug store, supermarket, or by mail, such as aspirin, cold remedies, vitamins, or the like.

THAT YOU HAVE TAKEN FROM _____ TO _____.

In order to be sure you have included everything, think about the past few weeks when you were ill, when you visited a physician or dentist and might have been given medication.

Also, review this list of reasons why many people take medication.

GROUP A

Lung problems - such as asthma, lung disease, emphysema, shortness of breath, wheezing
Arthritis, joint pain, for example, cortisone-type medicine, anti-inflammatory drugs
Vascular problems, blood thinning, for example, dicumarol, coumadin
Heart problems, angina, for example, digitalis, nitroglycerin
Diabetes - insulin or pills
Cancer
Ulcers, stomach, digestion

GROUP B

Chest pain
High blood pressure
Seizures
Flu, pneumonia
Skin problems
Coughs and colds
Headaches
Nausea

GROUP C

WOMEN - oral contraceptives, pills for hot flashes or to regulate periods, relieve menstrual problems
Hormones
Steroid, cortisone
Shots or pills to lose water from your body
Thyroid
Allergies
Ear, eye, nose drops or ointments

GROUP D

Pain, for example, codeine, Darvon, Percodan, Demerol, Tylenol #3/#4
Infection, for example, penicillin, sulfas, other antibiotics
Muscle relaxants
To reduce fever

GROUP E

Weight reducing aids (appetite suppresants)
To combat anxiety, depression
To improve regularity, relieve constipation
Relaxation
Sleep

GROUP F

Iron or anemia medicine (don't forget Geritol)
Vitamins or mineral supplements
Herbs or folk remedies

ALL INFORMATION COLLECTED FOR THIS STUDY IS HELD IN CONFIDENCE AND USED ONLY FOR STATISTICAL RESEARCH PURPOSES.

Contact Information Sheet

We will provide your doctor with results of your tests if you would like us to. Will you please fill out the information below and bring it with you to the clinic so that we will not have to take time during the clinic visit to look up the information?

YOUR DOCTOR'S NAME

STREET ADDRESS

CITY STATE ZIP CODE

TELEPHONE NUMBER

SINCE WE WILL BE CONTACTING YOU FOR SEVERAL YEARS, WE WOULD LIKE TO OBTAIN SOME INFORMATION NOW WHICH WILL HELP US LOCATE YOU IN THE FUTURE. REMEMBER THAT ALL INFORMATION IS CONFIDENTIAL AND THAT ANYONE WE MIGHT CONTACT WILL BE TOLD ONLY THAT WE ARE TRYING TO LOCATE YOU FOR A HEALTH STUDY.
PLEASE BRING THE NAME, ADDRESS, AND TELEPHONE NUMBER OF TWO CLOSE FRIENDS OR RELATIVES WHO YOU ARE LIKELY TO KEEP IN TOUCH WITH BUT WHO DO NOT LIVE WITH YOU, AND WHO ARE NOT PLANNING TO MOVE ANYTIME SOON. THANK-YOU.

CONTACT PERSON 1

NAME

STREET ADDRESS

CITY STATE ZIP CODE

TELEPHONE NUMBER

CONTACT PERSON 2

NAME

STREET ADDRESS

CITY STATE ZIP CODE

TELEPHONE NUMBER

FORM 4: Draft Letter Explaining the ARIC Study for Employers

Dear Employer:

Your employee has been selected to participate in an important medical research project called the Atherosclerosis Risk in Communities (ARIC) Study. This project is sponsored by the National Heart, Lung, and Blood Institute in only four communities nationwide. In [County] it is being sponsored by [the University of]. The purpose of the study is to better understand characteristics which may predispose people to heart or blood vessel diseases.

The ARIC Study requires a three-and-one-half hour examination now and in three years to collect the medical information. We hope you will allow your employee time off to complete this examination. His/her participation is important to the study. If you have any further questions you may call me at [telephone number].

Thank you.

Sincerely,

[Principal Investigator]

FORM 5: Follow-Up Letter Before the Phone Interview

Dear (_____):

It has been almost one year since you were contacted by the National Institutes of Health study, the medical research project of the (University of) in which you are participating. As explained at your first examination, the ARIC Study maintains annual contacts to monitor the health of its participants.

In the next few days an ARIC Study interviewer will telephone you to obtain some brief information about your health in the past year. It would be helpful if you could have ready for the interviewer information about any hospitalizations or illnesses you may have had in the past year. The interview will take about 10 minutes.

If you think it will be difficult for us to reach you in the next week, please telephone the ARIC Study office at (telephone number) so that we can make special arrangements for your interview.

We thank you again for your assistance in this research project.

Sincerely,

(Principal Investigator)

FORM 6: Follow-Up Letter Before the Three-Year Exam

Dear (_____):

It has been almost three years since your physical examination by the ARIC Study, the medical research project of the (University of) in which you are participating. As explained at your first examination, the ARIC Study conducts examinations every three years to monitor the health of its participants.

The three year ARIC Study examination will be identical to your first one at (Memorial Hospital), involving health interviews, an electrocardiogram, lung function tests, blood pressure, blood tests, and an ultrasound picture of the arteries in your neck and thigh. There will be no interviews in your home. The exam will take about three hours.

In the next few days an ARIC Study interviewer will telephone you to set up an appointment time for the examination. It would be helpful if you could have your calendar ready for the interviewer to set up the appointment. If you think it will be difficult for us to reach you in the next week, please telephone the ARIC Study office at (telephone number) to schedule an appointment for the examination.

We thank you again for your assistance in this research project.

Sincerely,

(Principal Investigator)

APPENDIX II

ARIC Enumeration Form (Version B, 2/21/87)

Appendix II

Contents:

Household Enumeration Form

ARIC ATHEROSCLEROSIS RISK IN COMMUNITIES STUDY

OMB No. 0925-0281
Approval Expires 7-31-89

HOUSEHOLD ENUMERATION FORM	A. ASSIGNMENT INFORMATION
MD MN MS	

B. INTRODUCTION

Hello, I'm (NAME) with (NAME OF INSTITUTION). We are doing medical research for the National Institutes of Health and recently sent (NAME OF SAMPLE PERSON) a letter describing the study. Is (he/she) still living at this address?

Yes . . . . . Y

No. . . . . N → GO TO TRACING FORM AND ENTER CODE "12" BELOW.

I would like to talk with (him/her) for a few minutes. IF SAMPLE MEMBER NOT AVAILABLE, CONTINUE WITH ADULT HOUSEHOLD MEMBER 18 OR OLDER. Did you receive the letter we sent?

Yes . . . . . Y
No. . . . . N) Here is a copy of the letter that describes the study and assures
Unsure. . . . U) that everything you say will be kept private.

I would like to take a few minutes of your time to obtain information on members of your household and I will be pleased to answer any questions you may have. GO TO SECTION F ON BACK.

C. STUDY DESCRIPTION IF RESPONDENT REQUESTS ADDITIONAL INFORMATION, READ:

This medical research is designed to study factors related to heart disease in this country. As part of this important study, we are conducting a brief interview today and physical examination later with people in (NAME OF COMMUNITY). (NAME OF COMMUNITY) is one of only four communities being studied and we would appreciate your cooperation in this important effort. Here is a (letter/brochure) that explains the study and assures that everything you say will be kept private.

D. RECORD OF CALLS

Day of Week	MO/DA/YR Date	Time	Notes	Code*	FI ID
Y M T W R F S	/ /	A P			
Y M T W R F S	/ /	A P			
Y M T W R F S	/ /	A P			
Y M T W R F S	/ /	A P			
Y M T W R F S	/ /	A P			
Y M T W R F S	/ /	A P			
FINAL CODE OFFICE USE ONLY	/ /				

* RESULT CODES (CIRCLE THE FINAL FIELD SCREENING RESULT CODE.)

01 HEF complete	07 Vacant	13 Moved from study area
02 No one home	08 Demolished/merged/not a housing unit	14 Deceased
03 No eligible respondent home	09 Vacation/second home	17 HEF appointment pending
04 Refusal	10 Temporarily away	18 HEF appointment broken
05 Language barrier	11 HEF partially complete	20 Other (SPECIFY IN NOTES ABOVE)
06 Physically/mentally incompetent	12 Tracing required	26 Age/race ineligible

ENTER COMMENTS IN NOTES ABOVE FOR CODES 4, 5, 6, 10, 11, 17, AND 20.

E. SOURCE OF INFORMATION

ENTER THE SOURCE OF INFORMATION FOR RESULT CODES 06-10.

Source's Name _____ Number/Street/RFD _____

Telephone Number _____ City _____

F. HOUSEHOLD ROSTER

1. In order to find out who is eligible in your household for the study, would you please tell me how many people live here? ☐☐

2. How many persons are younger than 18? ☐☐

3. Please give me the names of all those eighteen years or older, including yourself, who consider this their permanent residence, starting with the oldest. GO TO ENUMERATION SUPPLEMENT IF MORE THAN 8.

4. CHECK (✓) ENUMERATION RESPONDENT. IF NOT VOLUNTEERED, ASK: And you are which one of these people?

5. WHEN LIST IS COMPLETE, ASK: Would you please tell me (PERSON NAME'S) month and year of birth? IF NONE ELIGIBLE, READ: Thank you very much for your help but only people who are 45 through 64 years old are eligible for our study.

6. Now I would like to know the race or ethnic identification, sex and marital status of each household member. (HAND RACE CARD TO RESPONDENT AND READ 6a AND 6b.) READ ALL MARITAL STATUS CODES. (S=Separated, N=Never Married.)

PID	3. First Name	MI	Last Name	4. ER	5. Date of Birth Month		Year		6a. Race	6b. H	6c. Sex	6d. Marital Status	7. Spouses
01									W B I A	Y N	M F	M W D S N	
02									W B I A	Y N	M F	M W D S N	
03									W B I A	Y N	M F	M W D S N	
04									W B I A	Y N	M F	M W D S N	
05									W B I A	Y N	M F	M W D S N	
06									W B I A	Y N	M F	M W D S N	
07									W B I A	Y N	M F	M W D S N	
08									W B I A	Y N	M F	M W D S N	

7. Please tell me if any of these people are married to each other. INDICATE SPOUSE PAIRS BY PLACING AN "S" NEXT TO EACH SPOUSE, AT Q7 ON TABLE ABOVE. RECORD MULTIPLE SPOUSE PAIRS BY S1, S2, ETC.

8. CIRCLE THE "PID" NUMBER OF ALL ELIGIBLE RESPONDENTS. HOW MANY ELIGIBLE? _____ GO TO HOUSEHOLD INTERVIEW FORM AND INTERVIEW ALL MEMBERS WHO ARE 45 THROUGH 64 YEARS OLD. EXPLAIN STUDY IF STUDY NOT YET EXPLAINED TO RESPONDENTS.

ARIC ATHEROSCLEROSIS RISK IN COMMUNITIES STUDY

OMB No. 0915-0281
Approval Expires 12-31-89

HOUSEHOLD ENUMERATION FORM	A. ASSIGNMENT INFORMATION
NC	

B. INTRODUCTION

Hello, I'm (NAME) with (NAME OF INSTITUTION). We are doing medical research for the National Institutes of Health and I would like to take a few minutes of your time to obtain information on members of your household. Are there any occupied or vacant living quarters besides your own . . .

(FOR SINGLE UNIT STRUCTURES). . . . . in this structure or on this property?
(FOR MULTI-UNIT STRUCTURES) . . . . . in this unit?

Yes . . . . . Y → (ADD TO LIST OF ADDED HOUSING UNITS IF INDICATED BY MISSED HU RULES AND THEN GO TO SECTION F.)
No. . . . . N → (SECTION F ON BACK).

C. STUDY DESCRIPTION IF RESPONDENT REQUESTS ADDITIONAL INFORMATION, READ:

This medical research is designed to study factors related to heart disease in this country. As part of this important study, we are conducting a brief interview today and physical examination at a clinic later with people in (NAME OF COMMUNITY). (NAME OF COMMUNITY) is one of only four communities being studied and we would appreciate your cooperation in this important effort. Here is a brochure that explains the study and assures that everything you say will be kept private. I will be pleased to answer any questions you may have.

D. RECORD OF CALLS

Day of Week	MO/DA/YR Date	Time	Notes	Code*	FI ID
Y M T W R F S	/ /	A P			
Y M T W R F S	/ /	A P			
Y M T W R F S	/ /	A P			
Y M T W R F S	/ /	A P			
Y M T W R F S	/ /	A P			
Y M T W R F S	/ /	A P			
Y M T W R F S	/ /	A P			
FINAL CODE OFFICE USE ONLY	/ /				

* RESULT CODES (CIRCLE THE FINAL FIELD SCREENING RESULT CODE.)

01 HEF complete	06 Physically/mentally incompetent	11 HEF partially complete
02 No one home	07 Vacant	17 HEF appointment pending
03 No eligible respondent home	08 Demolished/merged/not a housing unit	18 HEF appointment broken
04 Refusal	09 Vacation/second home	20 Other (SPECIFY IN NOTES ABOVE)
05 Language barrier	10 Temporarily away	

ENTER COMMENTS IN NOTES ABOVE FOR CODES 4, 5, 6, 10, 11, 17, AND 20.

E. SOURCE OF INFORMATION

ENTER THE SOURCE OF INFORMATION FOR RESULT CODES 06-10.

Source's Name

Number/Street/RFD

Telephone Number

City

State

ZIP Code

A-16

F. HOUSEHOLD ROSTER

1. In order to find out who is eligible in your household for the study, would you please tell me how many people live here? ☐☐

2. How many persons are younger than 18? ☐☐

3. Please give me the names of all those eighteen years or older, including yourself, who consider this their permanent residence, starting with the oldest. GO TO ENUMERATION SUPPLEMENT IF MORE THAN 8.

4. CHECK (✓) ENUMERATION RESPONDENT. IF NOT VOLUNTEERED, ASK: And you are which one of these people?

5. WHEN LIST IS COMPLETE, ASK: Would you please tell me (PERSON NAME'S) month and year of birth? IF NONE ELIGIBLE, READ: Thank you very much for your help but only people who are 45 through 64 years old are eligible for our study.

6. Now I would like to know the race or ethnic identification, sex and marital status of each household member. (HAND RACE CARD TO RESPONDENT AND READ 6a AND 6b.) READ ALL MARITAL STATUS CODES. (S=Separated, N=Never Married.)

PID	3. First Name	MI	Last Name	4. ER	5. Date of Birth Month		Year		6a. Race	6b. H	6c. Sex	6d. Marital Status	7. Spouses
01									W B I A	Y N	M F	M W D S N	
02									W B I A	Y N	M F	M W D S N	
03									W B I A	Y N	M F	M W D S N	
04									W B I A	Y N	M F	M W D S N	
05									W B I A	Y N	M F	M W D S N	
06									W B I A	Y N	M F	M W D S N	
07									W B I A	Y N	M F	M W D S N	
08									W B I A	Y N	M F	M W D S N	

7. Please tell me if any of these people are married to each other. INDICATE SPOUSE PAIRS BY PLACING AN "S" NEXT TO EACH SPOUSE, AT Q7 ON TABLE ABOVE. RECORD MULTIPLE SPOUSE PAIRS BY S1, S2, ETC.

8. CIRCLE THE "PID" NUMBER OF ALL ELIGIBLE RESPONDENTS. HOW MANY ELIGIBLE? _____ GO TO HOUSEHOLD INTERVIEW FORM AND INTERVIEW ALL MEMBERS WHO ARE 45 THROUGH 64 YEARS OLD. EXPLAIN STUDY IF STUDY NOT YET EXPLAINED TO RESPONDENTS.

APPENDIX III

Occupational Classification System

Appendix III

Contents:

Occupational Classification System

Occupational Classification System

Equivalent numeric codes follow the alphabetic code. Either code may be used, depending on the processing method. Numbers in parentheses following the occupation categories are the 1977 Standard Occupational Classification code equivalents. The abbreviation "pt" means "part" and "n.e.c." means "not elsewhere classified."

Occupation code	MANAGERIAL AND PROFESSIONAL SPECIALTY OCCUPATIONS
	Executive, Administrative, and Managerial Occupations
003	Legislators (112)
004	Chief executives and general administrators, public administration (111)
005	Administrators and officials, public administration (pt 113 and 119, except 1136)
006	Administrators, protective services (pt 113)
007	Financial managers (122)
008	Personnel and labor relations managers (123)
009	Purchasing managers (124)
013	Managers, marketing, advertising, and public relations (125)
014	Administrators, education and related fields (128)
015	Managers, medicine and health (131)
016	Managers, properties and real estate (1353)
017	Postmasters and mail superintendents (1344)
018	Funeral directors (pt 1359)
019	Managers and administrators, n.e.c. (1136, 121, 126, 127, 132-139, except 1344, 1353, pt 1359)
	Management related occupations
023	Accountants and auditors (1412)
024	Underwriters (pt 1419)
025	Other financial officers (pt 1419)
026	Management analysts (142)
027	Personnel, training, and labor relations specialists (143)
028	Purchasing agents and buyers, farm products (pt 144)
029	Buyers, wholesale and retail trade, except farm products (432)
033	Purchasing agents and buyers, n.e.c. (pt 144)
034	Business and promotion agents (145)
035	Construction inspectors (1171, 618)
036	Inspectors and compliance officers, exc. construction (1172, 147)
037	Management related occupations, n.e.c. (149)
	Professional Specialty Occupations
043	Architects (15)
	Engineers, surveyors and mapping scientists
044	Aerospace engineers (1622)
045	Metallurgical and materials engineers (1623)
046	Mining engineers (1624)
047	Petroleum engineers (1625)
048	Chemical engineers (1626)
049	Nuclear engineers (1627)
053	Civil engineers (1628)
054	Agricultural engineers (1632)
055	Electrical and electronic engineers (1633, 1636)

Occupation code	MANAGERIAL AND PROFESSIONAL SPECIALTY OCCUPATIONS—Con.
	Professional Specialty Occupations—Con.
	Engineers, surveyors and mapping scientists—Con.
056	Industrial engineers (1634)
057	Mechanical engineers (1635)
058	Marine engineers and naval architects (1637)
059	Engineers, n.e.c. (1639)
063	Surveyors and mapping scientists (1642)
	Mathematical and computer scientists
064	Computer systems analysts and scientists (171)
065	Operations and systems researchers and analysts (172)
066	Actuaries (1732)
067	Statisticians (1733)
068	Mathematical scientists, n.e.c. (1739)
	Natural scientists
069	Physicists and astronomers (1842, 1843)
073	Chemists, except biochemists (1845)
074	Atmospheric and space scientists (1846)
075	Geologists and geodesists (1847)
076	Physical scientists, n.e.c. (1849)
077	Agricultural and food scientists (1853)
078	Biological and life scientists (1854, 1859)
079	Forestry and conservation scientists (1852)
083	Medical scientists (1855)
	Health diagnosing occupations
084	Physicians (261)
085	Dentists (262)
086	Veterinarians (27)
087	Optometrists (281)
088	Podiatrists (283)
089	Health diagnosing practitioners, n.e.c., (289)
	Health assessment and treating occupations
095	Registered nurses (29)
096	Pharmacists (301)
097	Dietitians (302)
	Therapists
098	Inhalation therapists (pt 303)
099	Occupational therapists (pt 303)
103	Physical therapists (pt 303)
104	Speech therapists (pt 303)
105	Therapists, n.e.c. (pt 303)
106	Physicians' assistants (304)
	Teachers, postsecondary
113	Earth, environmental, and marine science teachers (2212)
114	Biological science teachers (2213)
115	Chemistry teachers (2214)
116	Physics teachers (2215)
117	Natural science teachers, n.e.c. (2216)
118	Psychology teachers (2217)

Occupation code — MANAGERIAL AND PROFESSIONAL SPECIALTY OCCUPATIONS—Con.

Professional Specialty Occupations—Con.

Teachers, postsecondary—Con.

- 119 Economics teachers (2218)
- 123 History teachers (2222)
- 124 Political science teachers (2223)
- 125 Sociology teachers (2224)
- 126 Social science teachers, n.e.c. (2225)
- 127 Engineering teachers (2226)
- 128 Mathematical science teachers (2227)
- 129 Computer science teachers (2228)
- 133 Medical science teachers (pt 2232)
- 134 Health specialties teachers (pt 2232)
- 135 Business, commerce, and marketing teachers (2233)
- 136 Agriculture and forestry teachers (2234)
- 137 Art, drama, and music teachers (2235)
- 138 Physical education teachers (2236)
- 139 Education teachers (2237)
- 143 English teachers (2238)
- 144 Foreign language teachers (2242)
- 145 Law teachers (2243)
- 146 Social work teachers (2244)
- 147 Theology teachers (2245)
- 148 Trade and industrial teachers (2246)
- 149 Home economics teachers (pt 2249)
- 153 Teachers, postsecondary, n.e.c. (pt 2249)
- 154 Postsecondary teachers, subject not specified

Teachers, except postsecondary

- 155 Teachers, prekindergarten and kindergarten (231)
- N (156) Teachers, elementary school (232)
- P (157) Teachers, secondary school (233)
- 158 Teachers, special education (235)
- 159 Teachers, n.e.c. (234, 239)
- 163 Counselors, educational and vocational (24)

Librarians, archivists, and curators

- 164 Librarians (251)
- 165 Archivists and curators (252)

Social scientists and urban planners

- 166 Economists (1912)
- 167 Psychologists (1915)
- 168 Sociologists (1916)
- 169 Social scientists, n.e.c. (1913, 1914, 1919)
- 173 Urban planners (192)

Social, recreation, and religious workers

- 174 Social workers (2032)
- 175 Recreation workers (2033)
- 176 Clergy (2042)
- 177 Religious workers, n.e.c. (2049)

Lawyers and judges

- 178 Lawyers (211)
- 179 Judges (212)

Writers, artists, entertainers, and athletes

- 183 Authors (pt 321)
- 184 Technical writers (pt 321)
- 185 Designers (322)
- 186 Musicians and composers (323)
- 187 Actors and directors (324)
- 188 Painters, sculptors, craft-artists, and artist printmakers (325, pt 7263)
- 189 Photographers (326)
- 193 Dancers (327)

Occupation code — MANAGERIAL AND PROFESSIONAL SPECIALTY OCCUPATIONS—Con.

Professional Specialty Occupations—Con.

Writers, artists, entertainers, and athletes—Con.

- 194 Artists, performers, and related workers, n.e.c. (328, 329)
- 195 Editors and reporters (331)
- 197 Public relations specialists (332)
- 198 Announcers (333)
- 199 Athletes (34)

TECHNICAL, SALES, AND ADMINISTRATIVE SUPPORT OCCUPATIONS

Technicians and Related Support Occupations

Health technologists and technicians

- 203 Clinical laboratory technologists and technicians (362)
- 204 Dental hygienists (363)
- 205 Health record technologists and technicians (364)
- 206 Radiologic technicians (365)
- 207 Licensed practical nurses (366)
- 208 Health technologists and technicians, n.e.c. (369)

Technologists and technicians, except health

Engineering and related technologists and technicians

- 213 Electrical and electronic technicians (3711)
- 214 Industrial engineering technicians (3712)
- 215 Mechanical engineering technicians (3713)
- 216 Engineering technicians, n.e.c. (3719)
- 217 Drafting occupations (3721)
- 218 Surveying and mapping technicians (3722)

Science technicians

- 223 Biological technicians (382)
- 224 Chemical technicians (3831)
- 225 Science technicians, n.e.c. (3832, 3833, 384, 389)

Technicians, except health, engineering, and science

- 226 Airplane pilots and navigators (645)
- 227 Air traffic controllers (391)
- 228 Broadcast equipment operators (392)
- 229 Computer programmers (3931, 3932)
- 233 Tool programmers, numerical control (3934)
- 234 Legal assistants (396)
- 235 Technicians, n.e.c. (399)

Sales Occupations

- 243 Supervisors and proprietors, sales occupations (40, pt 4518)

Sales occupations, business goods and services

- 253 Insurance sales occupations (4222)
- 254 Real estate sales occupations (4223)
- 255 Securities and financial services sales occupations (4224)
- 256 Advertising and related sales occupations (4253)
- 257 Sales occupations, other business services (4252)
- 258 Sales engineers (pt 16)
- 259 Sales representatives, mining, manufacturing, and wholesale (412, 413)

Occupation code	TECHNICAL, SALES, AND ADMINISTRATIVE SUPPORT OCCUPATIONS—Con.
	Sales Occupations—Con.
	Sales occupations, personal goods and services
263	Sales workers, motor vehicles and boats (4142, 4144)
264	Sales workers, apparel (pt 4146)
265	Sales workers, shoes (pt 4146)
266	Sales workers, furniture and home furnishings (4148)
267	Sales workers; radio, television, hi-fi, and appliances (4143, 4152)
268	Sales workers, hardware and building supplies (4153)
269	Sales workers, parts (4167)
274	Sales workers, other commodities (4145, 4147, 4154, 4156, 4159, pt 4162, 4169, 4259, 4665)
275	Sales counter clerks (pt 4162)
Q (276)	Cashiers (4683)
277	Street and door-to-door sales workers (4163)
278	News vendors (4165)
	Sales related occupations
283	Demonstrators, promoters and models, sales (435)
284	Auctioneers (pt 439)
285	Sales support occupations, n.e.c. (434, 436, pt 439)
	Administrative Support Occupations, Including Clerical
	Supervisors, administrative support occupations
303	Supervisors, general office (4511-4514, 4516, pt 4518, 4519, 4529, 4537)
304	Supervisors, computer equipment operators (4535)
305	Supervisors, financial records processing (4521, 4536)
306	Chief communications operators (4515)
307	Supervisors; distribution, scheduling, and adjusting clerks (4522-4528)
	Computer equipment operators
308	Computer operators (4852)
309	Peripheral equipment operators (4853)
	Secretaries, stenographers, and typists
R (313)	Secretaries (4612)
314	Stenographers (4613)
315	Typists (4622)
	Information clerks
316	Interviewers (4642)
317	Hotel clerks (4643)
318	Transportation ticket and reservation agents (4644)
319	Receptionists (4645)
323	Information clerks, n.e.c. (4649)
	Records processing occupations, except financial
325	Classified-ad clerks (4662)
326	Correspondence clerks (4663)
327	Order clerks (4664)
328	Personnel clerks, except payroll and timekeeping (4692)
329	Library clerks (4694)
335	File clerks (4696)
336	Records clerks (4693, 4699)
	Financial records processing occupations
S (337)	Bookkeepers, accounting, and auditing clerks (4712)
338	Payroll and timekeeping clerks (4713)

Occupation code	TECHNICAL, SALES, AND ADMINISTRATIVE SUPPORT OCCUPATIONS—Con.
	Administrative Support Occupations, Including Clerical—Con.
	Financial records processing occupations—Con.
339	Billing clerks (4715)
343	Cost and rate clerks (4716)
344	Billing, posting, and calculating machine operators (486)
	Duplicating, mail and other office machine operators
345	Duplicating machine operators (4872)
346	Mail preparing and paper handling machine operators (4873)
347	Office machine operators, n.e.c. (4879)
	Communications equipment operators
348	Telephone operators (4652)
349	Telegraphers (4623)
353	Communications equipment operators, n.e.c. (4659)
	Mail and message distributing occupations
354	Postal clerks, exc. mail carriers (4723)
355	Mail carriers, postal service (4733)
356	Mail clerks, exc. postal service (4722)
357	Messengers (4732)
	Material recording, scheduling, and distributing clerks, n.e.c.
359	Dispatchers (4741)
363	Production coordinators (4742)
364	Traffic, shipping, and receiving clerks (4743)
365	Stock and inventory clerks (4744)
366	Meter readers (4745)
368	Weighers, measurers, and checkers (4746)
369	Samplers (4747)
373	Expediters (4748)
374	Material recording, scheduling, and distributing clerks, n.e.c. (4749)
	Adjusters and investigators
375	Insurance adjusters, examiners, and investigators (4782)
376	Investigators and adjusters, except insurance (4783)
377	Eligibility clerks, social welfare (4784)
378	Bill and account collectors (4786)
	Miscellaneous administrative support occupations
379	General office clerks (4632)
383	Bank tellers (4682)
384	Proofreaders (4792)
385	Data-entry keyers (4624)
386	Statistical clerks (4717)
387	Teachers' aides (4695)
389	Administrative support occupations, n.e.c. (4787, 4799)
	SERVICE OCCUPATIONS
	Private Household Occupations
403	Launderers and ironers (533)
404	Cooks, private household (534)
405	Housekeepers and butlers (535)
406	Child care workers, private household (536)
T (407)	Private household cleaners and servants (532, 537, 539)

Occupation code	SERVICE OCCUPATIONS—Con.
	Protective Service Occupations
	Supervisors, protective service occupations
413	Supervisors, firefighting and fire prevention occupations (5011)
414	Supervisors, police and detectives (5012)
415	Supervisors, guards (5013)
	Firefighting and fire prevention occupations
416	Fire inspection and fire prevention occupations (5112)
417	Firefighting occupations (5113)
	Police and detectives
418	Police and detectives, public service (5122)
423	Sheriffs, bailiffs, and other law enforcement officers (5124)
424	Correctional institution officers (5133)
	Guards
425	Crossing guards (5132)
426	Guards and police, exc. public service (5134)
427	Protective service occupations, n.e.c. (5139)
	Service Occupations, Except Protective and Private Household
	Food preparation and service occupations
433	Supervisors, food preparation and service occupations (5021)
434	Bartenders (5212)
U (435)	Waiters and waitresses (5213)
436	Cooks, except short order (5214)
437	Short-order cooks (5215)
438	Food counter, fountain and related occupations (5216)
439	Kitchen workers, food preparation (5217)
443	Waiters'/waitresses' assistants (5218)
444	Miscellaneous food preparation occupations (5219)
	Health service occupations
445	Dental assistants (5232)
446	Health aides, except nursing (5233)
447	Nursing aides, orderlies, and attendants (5236)
	Cleaning and building service occupations, except private household
448	Supervisors, cleaning and building service workers (5024)
449	Maids and housemen (5242, 5249)
V (453)	Janitors and cleaners (5244)
454	Elevator operators (5245)
455	Pest control occupations (5246)
	Personal service occupations
456	Supervisors, personal service occupations (5025)
457	Barbers (5251)
458	Hairdressers and cosmetologists (5252)
459	Attendants, amusement and recreation facilities (5253)
463	Guides (5254)
464	Ushers (5255)
465	Public transportation attendants (5256)
466	Baggage porters and bellhops (5258)
467	Welfare service aides (5262)
468	Child care workers, except private household (5263)
469	Personal service occupations, n.e.c. (5257, 5269)

Occupation code	FARMING, FORESTRY, AND FISHING OCCUPATIONS
	Farm operators and managers
W (473)	Farmers, except horticultural (5512-5514)
474	Horticultural specialty farmers (5515)
475	Managers, farms, except horticultural (5522-5524)
476	Managers, horticultural specialty farms (5525)
	Other agricultural and related occupations
	Farm occupations, except managerial
477	Supervisors, farm workers (5611)
479	Farm workers (5612-5617)
483	Marine life cultivation workers (5618)
484	Nursery workers (5619)
	Related agricultural occupations
485	Supervisors, related agricultural occupations (5621)
486	Groundskeepers and gardeners, except farm (5622)
487	Animal caretakers, except farm (5624)
488	Graders and sorters, agricultural products (5625)
489	Inspectors, agricultural products (5627)
	Forestry and logging occupations
494	Supervisors, forestry and logging workers (571)
495	Forestry workers, except logging (572)
496	Timber cutting and logging occupations (573, 579)
	Fishers, hunters, and trappers
497	Captains and other officers, fishing vessels (582)
498	Fishers (583)
499	Hunters and trappers (584)
	PRECISION PRODUCTION, CRAFT, AND REPAIR OCCUPATIONS
	Mechanics and repairers
503	Supervisors, mechanics and repairers (66)
	Mechanics and repairers, except supervisors
	Vehicle and mobile equipment mechanics and repairers
X (505)	Automobile mechanics (6711)
506	Automobile mechanic apprentices (pt 6711)
507	Bus, truck, and stationary engine mechanics (6712)
508	Aircraft engine mechanics (6713)
509	Small engine repairers (6714)
514	Automobile body and related repairers (6715)
515	Aircraft mechanics, exc. engine (6716)
516	Heavy equipment mechanics (6717)
517	Farm equipment mechanics (6718)
518	Industrial machinery repairers (673)
519	Machinery maintenance occupations (674)
	Electrical and electronic equipment repairers
523	Electronic repairers, communications and industrial equipment (6751, 6753, 6755)
525	Data processing equipment repairers (6754)
526	Household appliance and power tool repairers (6756)
527	Telephone line installers and repairers (6757)
529	Telephone installers and repairers (6758)
533	Miscellaneous electrical and electronic equipment repairers (6752, 6759)

Occupation code	PRECISION PRODUCTION, CRAFT, AND REPAIR OCCUPATIONS—Con.
	Mechanics and repairers—Con.
	Mechanics and repairers, except supervisors—Con.
534	Heating, air conditioning, and refrigeration mechanics (676)
	Miscellaneous mechanics and repairers
535	Camera, watch, and musical instrument repairers (6771, 6772)
536	Locksmiths and safe repairers (6773)
538	Office machine repairers (6774)
539	Mechanical controls and valve repairers (6775)
543	Elevator installers and repairers (6776)
544	Millwrights (6778)
547	Specified mechanics and repairers, n.e.c. (6777, 6779)
549	Not specified mechanics and repairers
	Construction trades
	Supervisors, construction occupations
553	Supervisors; brickmasons, stonemasons, and tile setters (6012)
554	Supervisors, carpenters and related workers (6013)
555	Supervisors, electricians and power transmission installers (6014)
556	Supervisors; painters, paperhangers, and plasterers (6015)
557	Supervisors; plumbers, pipefitters, and steamfitters (6016)
558	Supervisors, n.e.c. (6011, 6018)
	Construction trades, except supervisors
563	Brickmasons and stonemasons (6112, 6113)
564	Brickmason and stonemason apprentices (pt 6112-6113)
565	Tile setters, hard and soft (6114, pt 6162)
566	Carpet installers (pt 6162)
Y (567)	Carpenters (6122)
569	Carpenter apprentices (pt 6122)
573	Drywall installers (6124)
575	Electricians (6132)
576	Electrician apprentices (pt 6132)
577	Electrical power installers and repairers (6133)
579	Painters, construction and maintenance (6142)
583	Paperhangers (6143)
584	Plasterers (6144)
585	Plumbers, pipefitters, and steamfitters (6150)
587	Plumber, pipefitter, and steamfitter apprentices (pt 6150)
588	Concrete and terrazzo finishers (6163)
589	Glaziers (6164)
593	Insulation workers (6165)
594	Paving, surfacing, and tamping equipment operators (6166)
595	Roofers (6168)
596	Sheetmetal duct installers (6172)
597	Structural metal workers (6173)
598	Drillers, earth (6174)
599	Construction trades, n.e.c. (6167, 6175, 6176, 6179)
	Extractive occupations
613	Supervisors, extractive occupations (602)
614	Drillers, oil well (622)
615	Explosives workers (623)

Occupation code	PRECISION PRODUCTION, CRAFT, AND REPAIR OCCUPATIONS—Con.
	Extractive occupations—Con.
616	Mining machine operators (624)
617	Mining occupations, n.e.c. (626)
	Precision production occupations
633	Supervisors, production occupations (pt 711, 712)
	Precision metal working occupations
634	Tool and die makers (7211)
635	Tool and die maker apprentices (pt 7211)
636	Precision assemblers, metal (7212)
637	Machinists (7213)
639	Machinist apprentices (pt 7213)
643	Boilermakers (7214)
644	Precision grinders, fitters, and tool sharpeners (7216)
645	Patternmakers and model makers, metal (7217)
646	Lay-out workers (7221)
647	Precious stones and metals workers (jewelers) (7222, 7266)
649	Engravers, metal (7223)
653	Sheet metal workers (7224)
654	Sheet metal worker apprentices (pt 7224)
655	Miscellaneous precision metal workers (7229)
	Precision woodworking occupations
656	Patternmakers and model makers, wood (7231)
657	Cabinet makers and bench carpenters (7232)
658	Furniture and wood finishers (pt 7234, pt 7756)
659	Miscellaneous precision woodworkers (pt 7234, 7239)
	Precision textile, apparel, and furnishings machine workers
666	Dressmakers (7251, pt 7752)
667	Tailors (7252)
668	Upholsterers (7253)
669	Shoe repairers (7254)
673	Apparel and fabric patternmakers (pt 7259)
674	Miscellaneous precision apparel and fabric workers (pt 7259, pt 7752)
	Precision workers, assorted materials
675	Hand molders and shapers, except jewelers (7261)
676	Patternmakers, lay-out workers, and cutters (7262)
677	Optical goods workers (7264, pt 7677)
678	Dental laboratory and medical appliance technicians (7265)
679	Bookbinders (pt 7249, pt 7449)
683	Electrical and electronic equipment assemblers (7267)
684	Miscellaneous precision workers, n.e.c. (7269)
	Precision food production occupations
686	Butchers and meat cutters (7271)
687	Bakers (7272)
688	Food batchmakers (7273, 7279)
	Precision inspectors, testers, and related workers
689	Inspectors, testers, and graders (7281)
693	Adjusters and calibrators (7282)
	Plant and system operators
694	Water and sewage treatment plant operators (791)
695	Power plant operators (pt 793)
696	Stationary engineers (pt 793, 7668)
699	Miscellaneous plant and system operators (792, 794, 795, 796)

Occupation code	OPERATORS, FABRICATORS, AND LABORERS
	Machine Operators, Assemblers, and Inspectors
	Machine operators and tenders, except precision
	Metalworking and plastic working machine operators
703	Lathe and turning machine set-up operators (7312)
704	Lathe and turning machine operators (7512)
705	Milling and planing machine operators (7313, 7513)
706	Punching and stamping press machine operators (7314, 7317, 7514, 7517)
707	Rolling machine operators (7316, 7516)
708	Drilling and boring machine operators (7318, 7518)
709	Grinding, abrading, buffing, and polishing machine operators (7322, 7324, 7522)
713	Forging machine operators (7319, 7519)
714	Numerical control machine operators (7326)
715	Miscellaneous metal, plastic, stone, and glass working machine operators (7329, 7529)
717	Fabricating machine operators, n.e.c. (7339, 7539)
	Metal and plastic processing machine operators
719	Molding and casting machine operators (7315, 7342, 7515, 7542)
723	Metal plating machine operators (7343, 7543)
724	Heat treating equipment operators (7344, 7544)
725	Miscellaneous metal and plastic processing machine operators (7349, 7549)
	Woodworking machine operators
726	Wood lathe, routing, and planing machine operators (7431, 7432, 7631, 7632)
727	Sawing machine operators (7433, 7633)
728	Shaping and joining machine operators (7435, 7635)
729	Nailing and tacking machine operators (7636)
733	Miscellaneous woodworking machine operators (7434, 7439, 7634, 7639)
	Printing machine operators
734	Printing machine operators (7443, 7643)
735	Photoengravers and lithographers (7242, 7444, 7644)
736	Typesetters and compositors (7241, 7442, 7642)
737	Miscellaneous printing machine operators (pt 7249, pt 7449, 7649)
	Textile, apparel, and furnishings machine operators
738	Winding and twisting machine operators (7451, 7651)
739	Knitting, looping, taping, and weaving machine operators (7452, 7652)
743.	Textile cutting machine operators (7654)
744	Textile sewing machine operators (7655, pt 7656)
745	Shoe machine operators (pt 7656, pt 7659)
747	Pressing machine operators (7657)
748	Laundering and dry cleaning machine operators (7255, 7658)
749	Miscellaneous textile machine operators (7453, 7653, pt 7659)
	Machine operators, assorted materials
753	Cementing and gluing machine operators (7661)
754	Packaging and filling machine operators (7462, 7662)
755	Extruding and forming machine operators (7463, 7663)
756	Mixing and blending machine operators (7664)
757	Separating, filtering, and clarifying machine operators (7476, 7666, 7676)
758	Compressing and compacting machine operators (7467, 7667)
759	Painting and paint spraying machine operators (7669)
763	Roasting and baking machine operators, food (7472, 7672)
764	Washing, cleaning, and pickling machine operators (7673)
765	Folding machine operators (7474, 7674)
766	Furnace, kiln, and oven operators, exc. food (7668, 7671, 7675)
768	Crushing and grinding machine operators (7477, pt 7677)
769	Slicing and cutting machine operators (7478, 7678)
773	Motion picture projectionists (pt 7679)
774	Photographic process machine operators (pt 7263, pt 7679)
777	Miscellaneous machine operators, n.e.c. (7479, 7665, pt 7679)
779	Machine operators, not specified
	Fabricators, assemblers, and hand working occupations
783	Welders and cutters (7332, 7532, 7714)
784	Solderers and brazers (7333, 7533, 7717)
785	Assemblers (772, 774)
786	Hand cutting and trimming occupations (7753)
787	Hand molding, casting, and forming occupations (7754, 7755)
789	Hand painting, coating, and decorating occupations (pt 7756)
793	Hand engraving and printing occupations (7757)
794	Hand grinding and polishing occupations (7758)
795	Miscellaneous hand working occupations (7759)
	Production inspectors, testers, samplers, and weighers
796	Production inspectors, checkers, and examiners (782, 786, 787)
797	Production testers (783)
798	Production samplers and weighers (784)
799	Graders and sorters, except agricultural (785)
	Transportation and Material Moving Occupations
	Motor vehicle operators
803	Supervisors, motor vehicle operators (6311)
Z (804)	Truck drivers, heavy (6412, 6413)
805	Truck drivers, light (6414)
806	Driver-sales workers (433)
808	Bus drivers (6415)
809	Taxi cab drivers and chauffeurs (6416)

Occupation code	OPERATORS, FABRICATORS, AND LABORERS—Con.
	Transportation and Material Moving Occupations—Con.
	Motor vehicle operators—Con.
813	Parking lot attendants (6417)
814	Motor transportation occupations, n.e.c. (6419)
	Transportation occupations, except motor vehicles
	Rail transportation occupations
823	Railroad conductors and yardmasters (6313)
824	Locomotive operating occupations (6432)
825	Railroad brake, signal, and switch operators (6433)
826	Rail vehicle operators, n.e.c. (6439)
	Water transportation occupations
828	Ship captains and mates, except fishing boats (6441, 6442)
829	Sailors and deckhands (6443)
833	Marine engineers (6444)
834	Bridge, lock, and lighthouse tenders (6445)
	Material moving equipment operators
843	Supervisors, material moving equipment operators (632)
844	Operating engineers (6512)
845	Longshore equipment operators (6513)
848	Hoist and winch operators (6514)
849	Crane and tower operators (6515)
853	Excavating and loading machine operators (6516)
855	Grader, dozer, and scraper operators (6517)
856	Industrial truck and tractor equipment operators (6518)
859	Miscellaneous material moving equipment operators (6519, pt 659)

Occupation code	OPERATORS, FABRICATORS, AND LABORERS—Con.
	Handlers, Equipment Cleaners, Helpers, and Laborers
863	Supervisors; handlers, equipment cleaners, and laborers, n.e.c. (pt 711)
864	Helpers, mechanics and repairers (679)
	Helpers, construction and extractive occupations
865	Helpers, construction trades (6191-6195, 6198)
866	Helpers, surveyor (6196)
867	Helpers, extractive occupations (629)
869	Construction laborers (81)
873	Production helpers (769, 779)
	Freight, stock, and material movers, hand
875	Garbage collectors (822)
876	Stevedores (823)
877	Stock handlers and baggers (824)
878	Machine feeders and offbearers (825)
883	Freight, stock, and material movers, hand, n.e.c. (649, 826)
885	Garage and service station related occupations (672)
887	Vehicle washers and equipment cleaners (83)
888	Hand packers and packagers (841)
889	Laborers, except construction (842, 846, pt 659)
999	OCCUPATION NOT REPORTED[1]

[1] Code used when not-reported cases are not allocated.

OCCUPATIONAL CLASSIFICATION SYSTEM: 1980 CENSUS
FIFTEEN MAJOR GROUPS IN SIX SUMMARY GROUPINGS

I.	MANAGERIAL AND PROFESSIONAL SPECIALTY OCCUPATIONS	(003-199)
	1. Executive, Administrative, and Managerial Occupations	Codes 003-037
	2. Professional Specialty Occupations	Codes 043-179
	3. Writers, artists, entertainers, and athletes	Codes 183-199
II.	TECHNICAL, SALES, AND ADMINISTRATIVE SUPPORT OCCUPATIONS	(203-389)
	4. Technicians and Related Support Occupations	Codes 203-235
	5. Sales Occupations	Codes 243-285
	6. Administrative Support Occupations, Including Clerical	Codes 303-389
III.	SERVICE OCCUPATIONS	(403-469)
	7. Private Household Occupations	Codes 403-407
	8. Protective Service Occupations	Codes 413-427
	9. Service Occupations, Except Protective and Private Household	Codes 433-469
IV.	FARMING, FORESTRY, AND FISHING OCCUPATIONS	(473-499)
	10. Farm operators and managers	Codes 473-476
	11. Other farming, forestry and fishing occupations	Codes 477-499
V.	PRECISION PRODUCTION, CRAFT, AND REPAIR OCCUPATIONS	(503-699)
	12. Mechanics and repairers, Construction trades, extractive occupations, precision production occupations	Codes 503-699
VI.	OPERATORS, FABRICATORS, AND LABORERS	(703-889)
	13. Machine Operators, Assemblers, and Inspectors	Codes 703-799
	14. Transporation and Material Moving Occupations	Codes 803-859
	15. Handlers, Equipment Cleaners, Helpers and Laborers	Codes 863-889

OCCUPATIONS FOR WHICH SPECIAL CARE IS NECESSARY

The following are examples of inadequate and adequate job entries.

Inadequate	Adequate
Accounting Accounting Work	Certified public accountant, accountant, accounting machine operator, tax auditor, accounts-payable clerk, etc.
Clerical work Clerk Clerical	Stock clerk, shipping clerk, sales clerk. A person who sells goods in a store is a salesperson or sales clerk—do not report him/her merely as a clerk.
Data processing	Computer programmer, data typist, key punch operator, computer operator, coding clerk, card tape converter operator
Doctor	Physician, dentist, veterinarian, osteopath, chiropractor
Engineer	Civil engineer, locomotive engineer, mechanical engineer, aeronautical engineer
Factory worker	Electric motor assembler, forge heater, turret lathe operator, weaver, loom fixer, knitter, stitcher, punch-press operator, spray painter, riveter
IBM Clerk IBM Machine Operator IBM Operator	IBM card puncher, IBM tabulator, sorting machine operator, proof machine operator, etc.
Laborer	Sweeper, charwoman, baggage porter, janitor, stevedore, window washer, car cleaner, section hand, hand trucker

Inadequate	Adequate
Maintenance worker	Groundskeeper, janitor, carpenter, electrician
Mechanic	Auto engine mechanic, dental mechanic, radio mechanic, airplane mechanic, office machine mechanic
Nun	Specify the type of work done, if possible, as grammar school teacher, housekeeper, art teacher, organist, cook, laundress, registered nurse
Nurse Nursing	Registered nurse, nursemaid, practical nurse, nurse's aide, student nurse, or professional nurse
Office clerk Office worker Office work	Typist, secretary, receptionist, comptometer operator, file clerk, bookkeeper, physician's attendant
Program Analyst	Computer systems analyst, procedure analyst, vocational director, manufacturing liason planner, etc.
Program Specialist	Program scheduler, data-processing-systems supervisor, metal-flow coordinator, etc.
Programmer	Computer programmer, electronics data programmer, radio or TV program director, senior computer programmer, production planner, etc.
Research Research and Development Research and Testing Research Assistant Research Associate Research Specialist Research Work	Specify field of research, as research physicist, research chemist, research mathematician, research biologist, etc. Also, if associate or assistant, research associate chemist, assistant research physicist, research associate geologist, etc.
Sales worker	Advertising sales, insurance sales, bond sales, canvasser, driver-sales (route selling), fruit peddler, newspaper sales
Scientist	Specify field, for example, political scientist, physicist, sociologist, home economist, oceanographer, soil scientist, etc.

Teacher

Teachers should report the level of school they teach and the subject. Those below high school who teach many subjects may just report level. College teachers should report title. Following are some illustrations:

Level	Subject
Preschool	-
Kindergarten	-
Elementary	-
Elementary	Music
Junior High	English
High School	Physical Ed.
College	Mathematics (Professor)

Technician

Medical laboratory technician, dental laboratory technician, X-ray technician

Trucker

Truck driver, trucking contractor, electric trucker, hand trucker

Caution on occupations of young persons

Professional, technical, and skilled occupations usually require lengthy periods of training or education which a young person normally cannot have. Upon further inquiry, you may find that the young person is really only a trainee, apprentice, or helper (for example, accountant trainee, electrician trainee, apprentice electrician, electrician's helper).

Unusual occupations

You may encounter occupations which sound strange to you. Accept such entries if the respondent is sure the title is correct. For example, "sand hog" is the title for a certain worker engaged in the construction of underwater tunnels, and "printer's devil" is sometimes used for an apprentice printer. Where these or any other unusual occupation titles are entered, add a few words of description if the combined entries do not clarify the response.

Apprentice versus trainee

An "apprentice" is under contract during his/her training period but a "trainee" is not. Include both the occupation and the word "apprentice" or "trainee," as the case may be, in the description--e.g., apprentice plumber, buyer trainee.

Baby sitter versus boarding children

A baby sitter usually cares for children in the home of his/her employer. Where the children are cared for in the worker's home, the occupation is "boarding children." (See page D6-28, on "Foster parent.")

From Current Population Survey Interviewer Reference Manual (CPS-250) 1968

APPENDIX IV

ARIC Informed Consent Form

Appendix IV

Contents:

Appendix IV

ARIC

(Atherosclerosis Risk in Communities)

Consent Form Information

ARIC is a medical research project sponsored by the National Institutes of Health, conducted in four communities in the United States. The purpose of the study is to learn more about the factors associated with heart diseases and hardening of the arteries. The (NAME OF INSTITUTION) is conducting the study in (FIELD CENTER LOCATION). You are one of 4,000 people between the ages of 45 and 65 who have been selected at random (by chance) from the community.

If you agree to take part in the study, you will be given a series of examinations. These include:

1. An interview to obtain informtion about your health, previous illnesses, diet, exercise, and hospitalizations. In addition you will be asked questions about your use of tobacco, alcohol, and medications.

2. A physical examination that will include measuring your blood pressure, listening to your heart and lungs, measuring your reflexes, testing your lungs, and recording height and weight.

3. An electrocardiogram (ECG) which records the functioning of your heart.

4. An ultrasound examination that will take pictures of the arteries in your neck and leg using sound waves.

5. We will take 2.5 ounces of blood from your arm for blood tests that will indicate whether you have anemia, high blood sugar, high cholesterol, and other conditions.

These examinations will take between 3 and 4 hours to complete. The ARIC examination procedures are considered safe. There may be some slight discomfort during the blood drawing; however, we will have a skilled technician draw your blood. You will not be exposed to any X-rays. Ultrasound is now widely used in the evaluation of pregnancy and in other clinical applications. Your exposure to ultrasound in this examination will be no greater than a typical clinical examination. In 25 years of clinical experience with ultrasound, no confirmed harmful effects have been reported. All of the tests are free of charge.

In the unlikely event that during the examination procedures you should require medical care, first aid will be available. If the examinations uncover any medical problems that require medical diagnosis or treatment, you will be so advised and that information will be provided to the physician or

clinic that you choose. In that case payment must be provided by you and your third party payer, if any (for example, health insurance or Medicare). It is important to note that the ARIC Study does not provide medical treatment, and that the examination you receive here does not substitute for a medical examination your doctor might give you. Similarly, the ultrasound examination you receive here is different from a medical ultrasound examination and does not provide the same information to a physician.

We will report to you or your physician those results from the examination that are of known medical value. Unless you or your physician requests, we will not be reporting results which are of research value only.

Following the examination we will contact you once a year by phone or mail to ask about your health during the past year. The physical examination will be repeated after three years. Following the second examination we will contact you again once a year by phone or mail to ask about your health.

If you are hospitalized for any reason, we would like to check your hospital records to obtain medical information that may apply to this study. If you have a heart attack or stroke during the study period, or if you were to die, we would like to ask your relatives and physician for details about your illness that apply to this study.

The information you provide will be strictly confidential. It will be used only for scientific purposes without revealing your name. Only selected study personnel will have access to the names of study participants. Your personal information will be released only with your explicit approval.

We anticipate that your participation in this study will help provide new and valuable information that will reduce the risk of heart disease in the U.S. and in other countries.

If you have any additional questions about the ARIC study, feel free to to ask our personnel, or contact any of the following persons:

Dr. (NAME OF CLINIC DIRECTOR) at (PHONE NUMBER)

Dr. (NAME OF PI), Principal Investigator at (PHONE NUMBER)

(Chair, Institutional Review Board, if required by institution)

CONSENT FORM
ARIC
(Atherosclerosis Risk in Communities)

I have read the above and understand that I am invited to participate in the ARIC study. I understand that the risks of participation are small. I understand that the benefits of taking part include possible early detection of heart and blood vessel problems that I may have. I also understand that my participation will add to our knowledge of risk factors for heart disease and may help to prevent premature deaths from heart attacks.

I agree to be contacted by ARIC study personnel once a year by phone or mail, and to answer questions about my health. I understand that in three years I will be invited to the ARIC field center for a repeat examination.

I authorize the ARIC study to obtain medical records from my physician and any hospitals where I might be admitted, and to contact my relatives if I die.

I understand that I am free to withdraw my consent and to stop taking part in this study at any time, without affecting any future relationship with (NAME OF THE INSTITUTION). The procedures involved have been explained to me and understanding them fully I hereby consent to enter the ARIC study.

_____ _____

Date Signature of Participant

_____

Printed Name of Participant

_____

Witness

APPENDIX V

Scoring for the ARIC Physical Activity Questionnaire

Appendix V

Contents:

Calculation of Scores for Habitual Physical Activity

APPENDIX V

Questionnaire, codes, and method of calculation of scores on habitual physical activity

---

1) What is your main occupation?.....1-3-5
2) At work I sit
   never/seldom/sometimes/often/always.....1-2-3-4-5
3) At work I stand
   never/seldom/sometimes/often/always.....1-2-3-4-5
4) At work I walk
   never/seldom/sometimes/often/always.....1-2-3-4-5
5) At work I lift heavy loads
   never/seldom/sometimes/often/very often.....1-2-3-4-5
6) After working I am tired
   very often/often/sometimes/seldom/never.....5-4-3-2-1
7) At work I sweat
   very often/often/sometimes/seldom/never.....5-4-3-2-1
8) In comparison with others of my own age I think my work is physically
   much heavier/heavier/as heavy/lighter/much lighter.....5-4-3-2-1
9) Do you play sport? yes/no If yes:
   --which sport do you play most frequently?.....Intensity 0.76-1.26-1.76
   --how many hours a week? <1/1-2/2-3/3-4/>4.....Time 0.5-1.5-2.5-3.5-4.5
   --how many months a year? <1/1-3/4-6/7-9/>9.....Proportion 0.04-0.17-0.42-0.67-0.92
   If you play a second sport:
   --which sport is it?.....Intensity 0.76-1.26-1.76
   --how many hours a week? <1/1-2/2-3/3-4/>4.....Time 0.5-1.5-2.5-3.5-4.5
   --how many months a year? <1/1-3/4-6/7-9/>9.....Proportion 0.04-0.17-0.42-0.67-0.92
10) In comparison with others of my own age I think my physical activity during
   leisure time is much more/more/the same/less/much less.....5-4-3-2-1
11) During leisure time I sweat
   very often/often/sometimes/seldom/never.....5-4-3-2-1
12) During leisure time I play sport
   never/seldom/sometimes/often/very often.....1-2-3-4-5
13) During leisure time I watch television
   never/seldom/sometimes/often/very often.....1-2-3-4-5
14) During leisure time I walk
   never/seldom/sometimes/often/very often.....1-2-3-4-5
15) During leisure time I cycle
   never/seldom/sometimes/often/very often.....1-2-3-4-5
16) How many minutes do you walk and/or cycle per day to and from work,
   school and shopping? <5/5-15/15-30/30-45/>45.....1-2-3-4-5

Calculation of the simple sport-score (I_9): (a score of zero is given to people who do not play a sport)

$I_9 = \sum_{i=1}^{2}$ (intensity x time x proportion) x 5/4.....1-2-3-4-5

= 0/0.01-<4/4-<8/8-<12/>12

Calculation of scores of the indices of physical activity:

Work index = $[I_1 + (6 - I_2) + I_3 + I_4 + I_5 + I_6 + I_7 + I_8]/8$

Sport index = $[I_9 + I_{10} + I_{11} + I_{12}]/4$

Reference: Baecke, et al.

APPENDIX VI

Body Size Measurements: Equipment, Quality Control Checklists, and Tables of Body Fatness

Appendix VI

Contents

Appendix VI

Equipment for Body Size Measurements

1. Scale to measure body weight in lbs.: Detecto Model #437

2. Metal anthropometric ruler in centimeters: 200 cm., aluminum.
   model #733, $47.50.
   Radiation Products Design
   RR #3, Box 132F
   Buffalo, MN 55313

3. Skinfold calipers: Lange type, model #300-919, $175.00.
   Cambridge Scientific Industries Mooselodge Road, P.O. Box 265
   Cambridge, MD 21613 Phone: (301) 228-5111

4. Sliding caliper to measure outside diameter (wrist breadth):
   dial wrist caliper, catalog #8504, $40.
   Quinton Instrument Co.
   2121 Terry Ave.
   Seattle, WA 98121
   Phone: (800) 425-0347

5. Steel or fiberglass anthropometric tape (in centimeters):
   fiberglass metric measuring tape, catalog #7650, $4.50.
   (Two needed)
   Quinton Instrument Co.
   2121 Terry Ave.
   Seattle, WA 09121
   Phone: (800) 426-0347

6. Metal carpenter's square (10") for use in measuring body height,
   or preferably a right angle made from balsa wood.

7. Step wedge to check calibration of skinfold calipers. Lange model
   #100613, $10.00. Cambridge Scientific Industries, Mooselodge Road,
   P.O. Box 265, Cambridge, MD 21613, Phone: (301) 228-5111

8. Weights to calibrate scale: 50 lbs., obtain through local scale
   supplier.

9. Foot stool for height station.

10. Metal centimeter ruler for persons > 200 cm tall.

11. All purpose stool by United Chair (flat masonite seat), height
    24"-32", $36.00, available from local office supply dealers.

PERCENT BODY FATNESS - MALES

Sum of Triceps and Subscapular Skinfolds (mm)	Age Range 40 to 49	50+	Sum of Triceps and Subscapular Skinfolds (mm)	Age Range 40 to 49	50+
10	10.6	11.2	59	37.5	39.0
11	11.9	12.6	60	37.8	39.3
12	13.2	13.9	61	38.0	39.6
13	14.3	15.1	62	38.3	39.8
14	15.4	16.2	63	38.6	40.1
15	16.4	17.2	64	38.8	40.4
16	17.4	18.2	65	39.1	40.6
17	18.3	19.1	66	39.3	40.9
18	19.1	20.0	67	39.6	41.1
19	19.9	20.8	68	39.8	41.4
20	20.7	21.6	69	40.0	41.6
21	21.4	22.4	70	40.3	41.9
22	22.1	23.1	71	40.5	42.1
23	22.8	23.8	72	40.7	42.3
24	23.5	24.5	73	41.0	42.6
25	24.1	25.1	74	41.2	42.8
26	24.7	25.7	75	41.4	43.0
27	25.3	26.3	76	41.6	43.2
28	25.8	26.9	77	41.8	43.5
29	26.4	27.5	78	42.0	43.7
30	26.9	28.0	79	42.2	43.9
31	27.4	28.5	80	42.5	44.1
32	27.9	29.0	81	42.7	44.3
33	28.3	29.5	82	42.9	44.5
34	28.8	30.0	83	43.1	44.7
35	29.3	30.5	84	43.3	44.9
36	29.7	30.9	85	43.4	45.1
37	30.1	31.4	86	43.6	45.3
38	30.5	31.8	87	43.8	45.5
39	30.9	32.2	88	44.0	45.7
40	31.3	32.6	89	44.2	45.9
41	31.7	33.0	90	44.4	46.1
42	32.1	33.4	91	44.6	46.3
43	32.5	33.8	92	44.8	46.5
44	32.8	34.2	93	44.9	46.7
45	33.2	34.5	94	45.1	46.9
46	33.5	34.9	95	45.3	47.1
47	33.9	35.2	96	45.5	47.2
48	34.2	35.6	97	45.6	47.4
49	34.5	35.9	98	45.8	47.6
50	34.9	36.3	99	46.0	47.8
51	35.2	36.6	100	46.1	47.9
52	35.5	36.9	101	46.3	48.1
53	35.8	37.2	102	46.5	48.3
54	36.1	37.5	103	46.6	48.4
55	36.4	37.8	104	46.8	48.6
56	36.7	38.1	105	47.0	48.8
57	37.0	38.4			
58	37.2	38.7			

Table adapted from regression equations in: Durnin, J.V.G.S., and Womersley, J., Brit. J. Nutr., (1974), 32, 77-97. Equations are found on pages 86-87.

PERCENT BODY FATNESS - FEMALES

Sum of Triceps and Subscapular Skinfolds (mm)	Age Range 40 to 49	50+	Sum of Triceps and Subscapular Skinfolds (mm)	Age Range 40 to 49	50+
10	18.4	20.4	59	41.0	43.3
11	19.6	21.6	60	41.2	43.6
12	20.6	22.7	61	41.4	43.8
13	21.6	23.7	62	41.6	44.0
14	22.5	24.6	63	41.8	44.2
15	23.4	25.5	64	42.0	44.5
16	24.2	26.3	65	42.3	44.7
17	24.9	27.0	66	42.5	44.9
18	25.6	27.8	67	42.7	45.1
19	26.3	28.4	68	42.9	45.3
20	27.0	29.1	69	43.1	45.5
21	27.6	29.7	70	43.2	45.7
22	28.2	30.3	71	43.4	45.9
23	28.7	30.9	72	43.6	46.1
24	29.3	31.4	73	43.8	46.3
25	29.8	32.0	74	44.0	46.4
26	30.3	32.5	75	44.2	46.6
27	30.8	33.0	76	44.4	46.8
28	31.2	33.4	77	44.5	47.0
29	31.7	33.9	78	44.7	47.2
30	32.1	34.3	79	44.9	47.3
31	32.5	34.8	80	45.0	47.5
32	32.9	35.2	81	45.2	47.7
33	33.3	35.6	82	45.4	47.9
34	33.7	36.0	83	45.5	48.0
35	34.1	36.4	84	45.7	48.2
36	34.5	36.7	85	45.9	48.3
37	34.8	37.1	86	46.0	48.5
38	35.2	37.5	87	46.2	48.7
39	35.5	37.8	88	46.3	48.8
40	35.8	38.1	89	46.5	49.0
41	36.2	38.5	90	46.6	49.1
42	36.5	38.8	91	46.8	49.3
43	36.8	39.1	92	46.9	49.4
44	37.1	39.4	93	47.1	49.6
45	37.4	39.7	94	47.2	49.7
46	37.7	40.0	95	47.4	49.9
47	37.9	40.3	96	47.5	50.0
48	38.2	40.6	97	47.7	50.2
49	38.5	40.8	98	47.8	50.3
50	38.8	41.1	99	48.0	50.5
51	39.0	41.4	100	48.1	50.6
52	39.3	41.6	101	48.2	50.7
53	39.5	41.9	102	48.4	50.9
54	39.8	42.1	103	48.5	51.0
55	40.0	42.4	104	48.6	51.2
56	40.3	42.6	105	48.8	51.3
57	40.5	42.9			
58	40.7	43.1			

Tables adapted from regression equations in: Durnin, J.V.G.S., and Womersley, J., Brit. J. Nutr., (1974), 32, 77-97. Equations are found on pages 86-87.

ARIC

ANTHROPOMETRY EQUIPMENT CALIBRATION LOG

Mail original to Coordinating Center on Friday afternoons. Keep photocopy in Field Center.

Week of _____ (Monday's date) Field Center _____

DAILY CHECKS (at beginning of day for questions 1 and 2)

	M	T	W	Th	F
1. a. Measurement of Stool Height:					
Measure (cm)	___	___	___	___	___
b. Adjustments to stool height requiring during day (Y or N)	___	___	___	___	___
c. Remeasurement after adjustment (check)	___	___	___	___	___
2. Scales Read Zero	___	___	___	___	___
3. Lange Calipers check at 10 mm	___	___	___	___	___
(before each participant)					
Backup calipers (if needed)	___	___	___	___	___
4. Sliding Calipers check at 50 mm (before each participant)	___	___	___	___	___

Note: If caliper checks are more than 1.0 mm off the standard, the calipers should be replaced.

WEEKLY CHECKS

1. Lange Calipers:

Check at each increment	Primary	Backup (if used)
_____ 10 mm	_____	_____
_____ 20 mm	_____	_____
_____ 30 mm	_____	_____
_____ 40 mm	_____	_____
_____ 50 mm	_____	_____

2. Scales

A. Calibration check of scales with 50 lb weight Date _____

Time _____

Reading of scales with 50 lb weight Heavy Arm _____

Low Weight Arm _____

If reading outside of 49.5 to 50.5 range, scale should be serviced.

If service is REQUESTED, give Time _____ Date _____,

RECALIBRATION by independent service technician Time _____ Date _____.

B. Repeat calibration because of moving of scales

Scales moved: 1. Date _____ 2. Date _____

Time _____ Time _____

Calibration: 1. Date _____ 2. Date _____

Time _____ Time _____

3. Height Rule

   a. Touches hard-surfaced platform on which measures are done _____

   b. Perpendicular to floor _____

MONTHLY CHECKS

1. Check of Measuring Tape: Date _____

   a. Excess wear or damage found(Y or N) _____

   b. Height above floor (to nearest cm) on height rule of the 30 cm mark of the tape when the zero mark of the tape is aligned with the 150 cm mark of the height rule. _____

      Note: If this measure is outside the 119.5-120.5 cm range, the tape should be replaced.

   c. Height above floor (to nearest cm) on height rule of the 100 cm mark of the tape, with the tape aligned as above. _____

      Note: If this measure is outside the 49.5-50.5 cm range, the tape should be replaced.

   d. Tape replaced (Y or N) ____ Date replaced _____
      Time replaced _____

Technician doing weekly check:

ID # _____ Signature _____ Date _____

ARIC

CHECKLISTS FOR ANTHROPOMETRY MEASUREMENTS

ARIC Field Center:_____

Participant's Name:_____

Date of Visit: ___/___/___
mon day year

Observer:_____ I.D. #:_____

Recorder:_____ I.D. #:_____

This booklet contains a checklist for each anthropometry measurement and equipment calibration. The purpose of these checklists is to help train technicians to take uniform and accurate measurements using calibrated measuring equipment. Each checklist leads you through a series of steps to obtain and to record a measurement.

Item	Yes	No
A. Anthropometry will be done BEFORE the snack.	___	___
B. Ready participant for anthropometry: (May be done by the receptionist or technician.)		
1) If the participant is wearing any nylon hose, instruct participant to remove hose.	___	___
2) Participant should wear lightweight non-constricting underwear.	___	___
3) Have participant put on scrub suit.	___	___
4) Have participant empty bladder	___	___

ARIC

CHECKLIST FOR HEIGHT MEASUREMENT

Item	Yes	No	Readings	Comments
A. Equipment				
1. Ruler touching floor	___	___		
2. Ruler vertical (use level)	___	___		
3. Firm and stable floor	___	___		
4. Triangle or measuring block and extra ruler available	___	___		
5. Height calibration log up to date (weekly)	___	___		
6. Centimeter to feet and inches conversion available	___	___		
7. Other_____	___	___		
B. Procedure				
1. Participant prepared and procedures explained	___	___		
2. Shoes and heavy clothing off	___	___		
3. Position of participant's spine, heels against wall, eye to ear horizontal	___	___		
4. Measurement with triangle or measuring block	___	___		
5. Recording completed	___	___		
6. Data recorded accurately to the centimeter, rounding down	___	___	____cm	
7. Other_____	___	___		

ARIC

CHECKLIST FOR SITTING HEIGHT MEASUREMENT

Item	Yes	No	Readings	Comments
A. Equipment				
1. Ruler touching floor	___	___		
2. Ruler vertical (use level	___	___		
3. Firm floor	___	___		
4. Measuring block or triangle available	___	___		
5. Height calibration log up-to-date (weekly)	___	___		
6. Hard surfaced chair against ruler	___	___		
7. Other_____	___	___		
B. Procedure				
1. Participant prepared and procedures explained	___	___		
2. Shoes and heavy clothing off	___	___		
3. Participant sits on chair/ stool with spine against wall, eye to ear horizontal	___	___		
4. Have subject relax gluteal muscles	___	___		
5. Take measurement with measuring block or triangle to the centimeter, rounding down	___	___		
6. Record measurement to the centimeter, rounding down	___	___	____cm	
7. Other_____	___	___		

ARIC

CHECKLIST FOR WEIGHT MEASUREMENT

Item	Yes	No	Readings	Comments
A. Equipment				
1. Scale on firm floor	___	___		
2. 50 lb. standard weight available	___	___		
3. Scale accurately calibrated	___	___		
4. Scale calibration log up-to-date	___	___		
5. Scale calibrated in past year by Bureau of Standards	___	___		
6. Other_____	___	___		
B. Procedure				
1. Participant prepared and procedures explained	___	___		
2. Shoes and heavy clothing off	___	___		
3. Position of participant on center of scale	___	___		
4. Balance achieved	___	___		
5. Recording completed	___	___		
6. Data recorded accurately to the pound, rounding down	___	___	____lbs	
7. Other_____	___	___		

ARIC

CHECKLIST OF TRICEPS SKINFOLD MEASUREMENT

Item	Yes	No	Readings	Comments
1. Locate and mark posterior tip of the acromial process on the right arm.	___	___		
2. Have subject flex right elbow 90 degrees.	___	___		
3. Mark olecranon and then straighten and relax arm.	___	___		
4. Measure with cloth tape the distance between the acromial process and the olecranon.	___	___		
5. Make a pen mark on the back of the right upper arm halfway between the tip of the acromial process and the olecranon.	___	___		
6. Have the subject place his or her right arm at their side.	___	___		
7. Check caliper on measuring block at 10 mm.	___	___		
8. Firmly grasp a fold of skin between thumb and first two forefingers in your left hand, 1 cm above the mark of the midpoint of the upper arm. Gently lift fold away from the muscle and then release fold.	___	___		
9. Repeat gently lifting fold 2 or 3 times to make sure no muscle is grasped.	___	___		
10. Again, firmly grasp a fold of skin, gently lifting fold away from the muscle.	___	___		

CHECKLIST OF TRICEPS SKINFOLD MEASUREMENT, cont.

Item	Yes	No	Readings	Comments
11. Place the contact surface of the caliper at the level of the mark.	___	___		
12. Keep a firm grip on the skinfold with the left hand during the entire measurement.	___	___		
13. Release the calipers, count silently 1-2-3 (approximately 2 seconds) and take the reading.	___	___		
14. Take the reading to the millimeter, rounding down, before the needle drifts.	___	___	____mm	
15. Repeat the skinfold measurement.	___	___	____mm	
16. Record both measurements	___	___		

ARIC

CHECKLIST FOR SUBSCAPULAR SKINFOLD MEASUREMENT

Item	Yes	No	Readings	Comments
1. Have the subject place right hand in middle of their back to help define the medial border of the right scapula.	___	___		
2. Locate the medial border of the right scapula with the fingers of your left hand.	___	___		
3. Move your fingers down the full length of the medial border of the scapula until the inferior angle is located.	___	___		
4. Have subject relax arm at his/her side.	___	___		
5. Make a pen mark 1 cm below the inferior angle of the right scapula on the diagonal line extending slightly downward from the medial border.	___	___		
6. Grasp the skinfold 1 cm above the mark with your left hand. The skinfold is grasped and lifted up along the diagonal line extending slightly downward from the medial border. Gently lift fold away from the muscle and then release fold.	___	___		
7. Repeat gently lifting fold 2 or 3 times to make sure no muscle is grasped.	___	___		
8. Again, firmly grasp a fold of skin, gently lifting fold away from the muscle.	___	___		
9. Place the contact surface of caliper at the level of the mark.	___	___		

CHECKLIST FOR SUBSCAPULAR SKINFOLD MEASUREMENT, cont.

Item	Yes	No	Readings	Comments
10. Keep a firm grip on the skinfold with left hand during entire measurement.	___	___		
11. Release caliper, count silently 1-2-3 (approximately 2 seconds) and take the reading.	___	___		
12. Take the reading to the millimeter, rounding down, before needle drifts down.	___	___	____mm	
13. Release the skinfold and repeat once.	___	___	____mm	
14. Record both measurements to the millimeter, rounding down.	___	___		

ARIC

CHECKLIST FOR MAXIMAL WAIST MEASUREMENT

Item	Yes	No	Readings	Comments
1. Have subject stand erect yet relaxed with weight equally distributed on both feet.	___	___		
2. Place cloth tape around the subject's waist at the level of the umbilicus (navel).	___	___		
3. Recorder or another observer verifies horizontal position of tape, both front and back of the subject or use mirror to check tape.	___	___		
4. Have subject take a normal breath and gently exhale holding breath in a relaxed manner at end of exhalation.	___	___		
5. Tape should be horizontal and snug, but not tight enough to compress tissue. (Invert tape, if needed, to insure reading edge of tape is snug to skin for measurement.)	___	___		
6. Take a reading to the centimeter, rounding down - at point of relaxed end exhalation.	___	___	____cm	

ARIC

CHECKLIST FOR MAXIMAL HIP CIRCUMFERENCE MEASUREMENT

Item	Yes	No	Readings	Comments
1. Have subject stand erect yet relaxed with weight equally distributed on both feet and feet together.	___	___		
2. The tape is placed horizontally level around the subject's gluteal muscles (hips) at the level of maximal protusion of the gluteal muscles. Verify this position by passing the tape above and below the observed maximum.	___	___		
3. Recorder or another observer verifies horizontal position of tape, both front and back of subject. A mirror may be used.	___	___		
4. Tape should be snug, but not tight enough to <u>compress</u> tissue. (Invert tape, <u>if needed</u>, to insure reading edge of tape is snug to the skin for measurement.)	___	___		
5. Tape is read to the centimeter, rounding down.	___	___	____cm	
6. The measurement should be made at the side of the participant.	___	___		

ARIC

CHECKLIST FOR MAXIMAL RIGHT CALF MEASUREMENT

Item	Yes	No	Readings	Comments
1. Have the subject sit high enough such that the right foot does not touch the floor.	___	___		
2. Have subject sit so that the knees and calves are relaxed. The foot must not be extended or flexed.	___	___		
3. The tape is placed horizontally level around the right calf at the point of maximal circumference. Verify this position by passing the tape above and below the observed maximum.	___	___		
4. Recorder verifies horizontal position of tape on subject.	___	___		
5. Tape should be snug but not tight enough to compress tissue.	___	___		
6. Tape is read to the centimeter, rounding down.	___	___	____cm	

ARIC

CHECKLIST FOR WRIST BREADTH MEASUREMENT

Item	Yes	No	Readings	Comments
1. Zero-out caliper.	___	___		
2. Checks caliper in measuring block at 50 mm.	___	___		
3. Participant extends right hand such that palm and wrist are parallel to floor and locked or straightened. Palm is facing ceiling.	___	___		
4. Mark the styloid process of radius	___	___		
5. Mark the styloid process of ulna	___	___		
6. With the body of the caliper above the wrist, place the immovable jaws of caliper on the styloid process of the ulna and gently slide the movable caliper jaw snugly to the styloid process of the radius, compressing the soft tissue.	___	___		
7. Read measurement on caliper to the millimeter, rounding down.	___	___	____mm	
8. Ask subject if either caliper jaw "slides off" position. If "yes", repeat caliper measurement.	___	___	____mm	

APPENDIX VII

Letters to Informants and Physicians

Appendix VII

This appendix contains sample letters to cohort members and their physicians, concerning the investigation of study endpoints.

APPENDIX VII

SAMPLE LETTERS TO INFORMANTS AND PHYSICIANS

FORMAT 1 LETTER

(To the informant for a cohort member who died out-of-hospital: telephone number known)

Dear _____:

I am writing on behalf of the National Heart, Lung, and Blood Institute's Atherosclerosis Risk in Community Study, a project of _____(name of institution)___ designed to study risk factors for atherosclerosis (hardening of the arteries) in __(name of community)__ to ask for your help. Your name was given to us by _____(name)_____, a participant in our study, who passed away on ___(date)___. In a few days, _____, a member of my staff will be calling to explain further about the project and seek your permission to ask a few medical questions. Mr./Ms. _____ gave us permission to contact a relative, should we need additional information (a copy of the consent form is attached), but of course your participation is entirely voluntary.

The information we need will be used for statistical purposes only, and will remain strictly confidential. It will contribute to our efforts to better understand heart disease and prevent its occurrence in the future.

Thank you very much in advance for your help in this important study. Best regards.

Sincerely,

FORMAT 2 LETTER

(To the informant of a cohort member who died out-of-hospital: informant telephone number unknown)

Dear _____:

I am writing on behalf of the National Heart, Lung, and Blood Institute's Atherosclerosis Risk in Communities study, a project of _____(name of institution)_____ designed to study risk factors for atherosclerosis (hardening of the arteries), in __(name of community)__, to ask for your help. Your name was (listed on the death certificate of _____(name)_____, a participant in our study who passed away on ___(date)___) given to us by _____. Mr./Ms _____name_____ gave us permission to contact a relative, should we need additional information (a copy of the release form is attached). We would like to call you to explain more about the project and to ask a few medical questions, but have been unable to find your telephone number.

Could you please take a few moments to fill out and mail the enclosed postcard? The information we will be calling about is used for statistical purposes only, and will remain strictly confidential. It will contribute to our efforts to better understand heart disease and prevent its occurrence in the future. Of course your participation in our research is entirely voluntary.

Thank you very much in advance for your help in this important study. Best regards.

Sincerely yours,

(ENCLOSE POSTCARD, RETURN ADDRESSED AND STAMPED. SEE FORM 3.)

FORMAT 3 POSTCARD

(To accompany Format 2 Letter)

POSTCARD SHOULD BE RETURN-ADDRESSED TO LOCAL SURVEILLANCE CENTER AND STAMPED.

Dear Dr. _____:

I will be able to help with your Atherosclerosis Risk in Communities Study.

I do have a telephone number which is (___) _____.
The best times to reach me are: _____ or _____.

An alternative number is: (___) _____.
The best times to reach me at this number are _____ and _____.

I do not have a telephone number, but I agree to be interviewed in person, and will be calling your local Surveillance Supervisor, Mr./Ms. _____ at (___) _____, to set up a time and a place for the interview.

Sincerely,

_____
(print in name)

FORMAT 4 LETTER

(To a neighbor of the cohort member who died out-of-hospital.)

Dear _____:

I am writing on behalf of the National Heart, Lung and Blood Institute's Atherosclerosis Risk in Communities Study, a project of (name of institution) designed to study risk factors for atherosclerosis (hardening of the arteries) in (name of community) to ask for your help. As you may know, (name) passed away on (date). As part of the study, we are systematically attempting to contact a next-of-kin or another person who lived with the decedent, in order to obtain some medical information that would help us to find out whether (name) died from a heart attack. Since we have not been able to locate such a person and since you were (name's) neighbor, we believe that you may be able to help us.

Could you take a few moments to fill out and mail the enclosed postcard? The information we wish to obtain from a next-of-kin or another person who lived with (name) will be used for research purposes only, and will remain strictly confidential. It will contribute to our efforts to better understand heart disease and prevent its occurrence in the future. Of course, your assistance in our research is entirely voluntary.

If you have any questions, please feel free to call me collect at ( ) _____, or our local Surveillance Center Supervisor, (name) at ( ) _____. Thank you very much in advance for your help in this important study.

Sincerely,

ENCLOSE POSTCARD, RETURN ADDRESSED AND STAMPED. SEE FORMAT 5.

FORMAT 5 POSTCARD

(To accompany Format 4 letter)

POSTCARD SHOULD BE RETURN-ADDRESSED AND STAMPED TO LOCAL SURVEILLANCE CENTER.

Dear Dr. _____:

The following individual(s) was (were) living with __name_____ at the time of his/her death:

Name	Relationship to deceased	Present Address	Telephone #
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

_____ I do not have any information on persons who were living with (name) at the time of his/her death.

Sincerely,

_____
(print name)

FORMAT 6 LETTER

(To M.D. identified by next-of-kin as nonhospital cohort decedent's M.D.)

Dear Doctor _____:

I am writing on behalf of the Atherosclerosis Risk in Communities Study, an epidemiologic project of _____(name of institution)_____ along with other centers in the United States. This longitudinal study is assessing risk factors for development of atherosclerosis. We need some information concerning _____(name)_____, who, according to the family, was your patient. The information is needed to supplement the death certificate in assigning a cause of death. Mr./Ms. _____ gave us consent to contact his/her physician should we need additional information (a copy of the consent form is included). Could your nurse or you take a few moments to provide the answers to the questions of the enclosed form from your records?

This information will be used for statistical purposes only, and will remain strictly confidential. If you have any questions, please feel free to call me collect at _____(A/C) (number)_____, or our local Surveillance Supervisor, _____(name)_____ at ___(A/C) (number)__.

Many thanks for your kind assistance and consideration of this request.

Sincerely,

FORMAT 7 LETTER

(To M.D. signatory of death certificate of out-of-hospital death in a cohort member)

Dear Dr. _____:

I am writing on behalf of the Atherosclerosis Risk in Communities Study, an epidemiologic project of _____(name of institution)_____ along with other centers in the United States. This longitudinal study is assessing risk factors for development of atherosclerosis. We need some information concerning _____(name)_____ , a participant in our study whose death certificate you signed on _____(date)_____. This information is needed to supplement the death certificate in assigning a cause of death. Mr./Ms. _____ gave us consent to contact his/her physician, should we need additional information. (A copy of the consent form is included.) Could your nurse or you take a few moments to provide the answers to the questions on the enclosed form from your records?

This information will be used for statistical purposes only, and will remain strictly confidential. If you have any questions, please feel free to call me collect at _____(A/C) (number)_____, or our local Field Center Supervisor, _____(name)_____ at __(A/C) (number)__.

Many thanks for your kind assistance and consideration of this request.

Yours sincerely,

APPENDIX VIII

Letters of Notification and Reports of Study Results

APPENDIX VIII

Contents:

SCHEDULE FOR REPORTING YOUR ARIC RESULTS

AT THE END OF YOUR CLINIC VISIT YOU WILL RECEIVE A SUMMARY OF:

Blood Pressure
Lung Function Test
Electrocardiogram (preliminary report)
Important Findings from your Physical Examination
Height and Weight

YOUR TESTS WILL BE SENT TO SPECIALIZED LABORATORIES FOR MEASUREMENT AND INTERPRETATION. APPROXIMATELY 3 MONTHS AFTER YOUR VISIT DATE, A FULL SUMMARY WILL BE REPORTED TO YOU AND YOUR PHYSICIAN. IT WILL INCLUDE THE FOLLOWING:

Blood Pressure
Electrocardiogram
Lung Function Test
Ultrasound Examination
Blood Tests: total cholesterol, LDL cholesterol, total HDL cholesterol, triglycerides, hematocrit, hemoglobin, white blood cell count, platelet count, total protein, albumin, calcium, phosphorous, magnesium, sodium, potassium, creatinine, urea nitrogen, uric acid, glucose.
Reports of important symptoms you may have

IF AN IMPORTANT ABNORMALITY IS DETECTED IN ANY TEST, YOU AND YOUR PHYSICIAN WILL BE NOTIFIED IMMEDIATELY.

Atherosclerosis Risk in Communities

SUMMARY OF RESULTS FOR ARIC PARTICIPANTS AND THEIR PHYSICIANS

Participant's name:

Date of visit to the ARIC center:

Birthdate: Our Reference (ARIC ID):

These are the results of your ARIC examination:

Height: feet inches

Weight: pounds

Blood pressure: / mm Hg (Average of 2 measurements).
systolic diastolic

*SBP<140, DBP<90: **"Your reading was normal."**

**SBP 140-199, DBP 90-104:

"Your reading was in the mild blood pressure elevation and should be checked within two months by a physician."

***SBP 200-239, DBP 105-114:

"Your reading was high. You should see a physician soon."

****SBP≥240 or DBP≥115:

"Your reading was quite high. You should see a physician at once."

- -

Electrocardiogram:

* **Normal or insignificant findings.** Your electrocardiogram has been sent to your physician with a copy of this report.
** **Please check your findings with your physician if you have not already done so.** Your electrocardiogram has been sent to your physician with a copy of this report.

- -

Pulmonary Function (Average of two best efforts):

Lung Function Test	Your Value	Usual Range
FEV1	%	80% & greater
FVC	%	80% & greater
FEV1/FVC	%	70% & greater

FEV1 is the amount of air you were able to blow out of your lungs in one second.
FVC is the total amount of air you could blow out of your lungs. Your results are reported as a percentage value which compares you to other individuals of your age, sex, height, and race.
FEV1/FVC is the ratio of these values.

*If FEV1 < 65%:

"Your lung function is reduced and you should see a physician if you have not already."

**If FEV1 is 65-79%, or FVC < 80%, or FEV1/FVC < 70%:

"Your lung function is somewhat below normal."

***If FEV1 $\geq$ 80% and FVC $\geq$ 80% and FEV1/FVC $\geq$ 70%:

"Your lung function is normal."

- -

Atherosclerosis Risk in Communities (ARIC) Study
SUMMARY OF RESULTS FOR ARIC PARTICIPANTS AND THEIR PHYSICIANS

Name: **EXAMPLE WITH GENDER- AND CENTER-SPECIFIC REFERENCE RANGES** Birthdate: 22DEC36

Date of visit at ARIC center: 31AUG88 Our Reference (ARIC ID):

These are the remaining results of your ARIC examination.
To assist in interpreting your values, see note at bottom of page.

Tests	Your Value	Interpretation	Usual Range
Blood Pressure (mmHg) Systolic....	102		less than 140
Blood Pressure (mmHg) Diastolic...	61		less than 90
Total Cholesterol (mg/dL).....	199		less than 240
LDL Cholesterol (mg/dL).....	120		less than 165
Total HDL Cholesterol (mg/dL).....	66		greater than 40
Triglycerides (mg/dL).....	65		less than 220
Hematocrit (%).....	40.2		36.0 - 48.0
Hemoglobin (g/dL).....	13.2		12.0 - 16.0
White Blood Cell Count (x1000/mm3)	18.8	B	4.0 - 10.5
Platelet Count (x1000/mm3).....	288		140 - 440
Total Protein (g/dL).....	8.9	A	6.0 - 8.3
Albumin (g/dL).....	3.5	B	3.8 - 5.3
Calcium (mg/dL).....	9.5		8.4 - 10.4
Phosphorous (mg/dL).....	3.6		2.0 - 5.0
Magnesium (meq/L).....	1.5		1.3 - 2.1
Sodium (mmol/L).....	136		136 - 147
Potassium (mmol/L).....	4.6		3.5 - 5.2
Creatinine (mg/dL).....	1.1		0.5 - 1.1
Urea Nitrogen (mg/dL).....	15		7 - 23
Uric Acid (mg/dL).....	5.1		2.6 - 6.0
Fasting Glucose (mg/dL).....	184	A	70 - 130

*A indicates a result clearly outside the normal range which should be confirmed by your physician.
*B indicates a Borderline result, only slightly outside the normal range.

(Version 7-88)

Total cholesterol, LDL cholesterol and triglyceride are the major fats in your blood stream. They have been identified as being responsible for increasing the risk of coronary heart disease. High density lipoprotein (HDL) cholesterol is a fat in the blood stream, and appears to protect against hardening of the arteries. It is sometimes called "the good cholesterol".

Hematocrit measures the volume of red cells compared with the volume of plasma (which is the fluid carrying red blood cells). It is an indicator of how well the blood can carry oxygen to the cells of the body. Hemoglobin is the substance that transports oxygen inside the red blood cells. The white blood cells are the primary defense against infection and disease. Platelets are blood cells involved in forming blood clots.

Total protein and albumin are some of the proteins in the blood, and are a reflection of the general state of nutrition. Calcium, phosphorus, and magnesium are some of the minerals in the blood. They are essential for the development and maintenance for healthy bones and teeth, and also important for adequate functioning of the muscles. Sodium is the major salt in the body fluids. It plays an important role in the body's water balance, electrical activity of nerves and muscles, and controlling the acid content of the body. Potassium is a salt in the cells of the body. It also plays a major role in regulating the electrical activity of muscles, including the heart and its rhythm, and together with sodium is important in controlling arterial blood pressure.

Creatinine and urea nitrogen are products of digestion eliminated from the body through the kidneys. They are used as indicators of kidney function. Uric acid may leave deposits in joints, leading to gout, which is the arthritis most often associated with an elevated uric acid. Fasting glucose is your blood sugar and is altered in conditions such as diabetes.

[Interpretation]

---

* All in usual range:

"Your blood test results are all normal."

*B Somewhat outside usual range: (B = borderline)

"Your results show a value slightly outside of the usual normal range. You may want to check with your physician about this."

*A Clearly outside usual range: (A = abnormal)

"Your results indicate a value clearly outside the usual range. You should have these results confirmed by your physician."

* Alert Values: (Abnormal values notified by Laboratory/Reading Center)

"Your results indicate a value clearly outside the usual range. You should have these results confirmed by your physician soon if you have not already done so."

- -

<u>B-Scan Ultrasound examination of the arteries</u>:

* No Alert value:

"Portions of the carotid arteries (blood vessels in the neck) were measured. We found no blockage in the artery segments examined."

*** Alert value: Wording of the letter as suggested by the Ultrasound Director after review of the video tape.

- -

Atherosclerosis Risk in Communities (ARIC) Study
SUMMARY OF RESULTS FOR ARIC PARTICIPANTS AND THEIR PHYSICIANS

FILE COPY: Original DATE: 04DEC88 DIABETES : Yes
FORMS WITH CHANGES: None HOURS FASTED: 13
Name: **EXAMPLE WITH GENDER- AND CENTER-SPECIFIC REFERENCE RANGES** Birthdate: 22DEC36
Date of visit at ARIC center: 31AUG88 Our Reference (ARIC ID):

These are the remaining results of your ARIC examination.
To assist in interpreting your values, see note at bottom of page.

Tests	Your Value	Interpretation	Usual Range
Blood Pressure (mmHg) Systolic....	102		less than 140
Blood Pressure (mmHg) Diastolic...	61		less than 90
Total Cholesterol (mg/dL).....	199		less than 240
LDL Cholesterol (mg/dL).....	120		less than 165
Total HDL Cholesterol (mg/dL).....	66		greater than 40
Triglycerides (mg/dL).....	65		less than 220
Hematocrit (%).....	40.2		36.0 - 48.0
Hemoglobin (g/dL).....	13.2		12.0 - 16.0
White Blood Cell Count (x1000/mm3)	18.8	B	4.0 - 10.5
Platelet Count (x1000/mm3).....	288		140 - 440
Total Protein (g/dL).....	8.9	A	6.0 - 8.3
Albumin (g/dL).....	3.5	B	3.8 - 5.3
Calcium (mg/dL).....	9.5		8.4 - 10.4
Phosphorous (mg/dL).....	3.6		2.0 - 5.0
Magnesium (meq/L).....	1.5		1.3 - 2.1
Sodium (mmol/L).....	136		136 - 147
Potassium (mmol/L).....	4.6		3.5 - 5.2
Creatinine (mg/dL).....	1.1		0.5 - 1.1
Urea Nitrogen (mg/dL).....	15		7 - 23
Uric Acid (mg/dL).....	5.1		2.6 - 6.0
Fasting Glucose (mg/dL).....	184	A	70 - 130

*A indicates a result clearly outside the normal range which should be confirmed by your physician.
*B indicates a Borderline result, only slightly outside the normal range.

(Version 7-88)

Referral Letter 2

URGENT REFERRAL LETTER

[Date]

Dear Dr. _____:

We saw your patient, _____, in the _____ _____ of the Atherosclerosis Risk in Communities (ARIC) Study clinic on _____.

The ARIC Study is an epidemiologic study of risk factors for heart disease and stroke. We do not provide diagnoses, medical advice, nor treatment. During the course of our evaluation, the following problems were identified which we believe need attention soon.

We suggested _____ contact you this week for further evaluation and management of this (these) problem(s). If you should have any questions, please feel free to contact us at ___ ___ ____ . A full report with results of our tests will be forwarded when available.

Sincerely,

Field Center Director

or

ARIC Physician

Referral Letter 3

ROUTINE REFERRAL LETTER

[Date]

Dear Dr. _____:

We saw your patient, _____, in the _____ _____ of the Atherosclerosis Risk in Communities (ARIC) Study clinic on _____.

The ARIC Study is an epidemiologic study of risk factors for heart disease and stroke. We do not provide diagnoses, medical advice, nor treatment. During the course of our evaluation, the following problems were identified which we believe need confirmation or follow-up.

We suggested _____ contact you for further evaluation and management of this (these) problem(s). If you should have any questions, please feel free to contact us at ___ ___ ____ . A full report with results of our tests will be forwarded when available.

Sincerely,

Field Center Director

or

ARIC Physician

Alert Value Referral Letter 4

URGENT OR ROUTINE REFERRAL TO RESPOND TO ALERT VALUES, FOR PARTICIPANT WITH M.D.

[Date]

Dear Mr./Ms. _____:

Since your ARIC examination on ___(Date)___ we have obtained some of the results of your studies.

Your ___(ultrasound exam/laboratory studies)___ revealed a finding which you should discuss with your physician. We suggest you contact him/her within _(day(s)/week(s)_. According to your instructions during the visit, a letter containing the specific results has already been forwarded to Dr. _____.

When the rest of your ARIC results are available, we will forward them to Dr. _____. If you should have any questions, please feel free to contact us at ___ ____ .

Sincerely,

Field Center Director

or

ARIC Physician

Alert Value Referral Letter 5

URGENT OR ROUTINE LETTER TO RESPOND TO ALERT VALUES, FOR PARTICIPANT WITHOUT M.D.

[Date]

Dear Mr./Ms. _____:

Since your ARIC examination on ___(Date)___ we have obtained some of the results of your studies.

Your ___(ultrasound exam/laboratory studies)___revealed a finding which you should discuss with your physician. A report of the results is attached. We urge you to contact your physician within _(day(s)/week(s)/month(s)_ to review the significance of this result.

If you do not have a physician and need help finding one, or if you should have any questions, please feel free to contact us at ___ ___ _____ .

Sincerely,

Field Center Director

or

ARIC Physician

Enclosure

Physician Letter 1

REPORT TO PARTICIPANT'S PHYSICIAN FOLLOWING ARIC VISIT 1

(No abnormal findings; results to M.D.)

[Date]

Dr. _____
Address

Dear Dr. _____:

Mr./Ms. _____, a patient of yours, is a participant in the ARIC Study and was seen at our ARIC Field Center on ___(date)___. Attached to this letter is a report of the results of this examination.

The ARIC Study routinely offers to send all clinically relevant data to the participant's physician. Mr./Ms. _____ has indicated that we should send these results to you. We also mailed a letter to Mr./Ms. _____ to report that no abnormalities were found for any items covered by the ARIC examination, and that the enclosed results were sent to you.

The ARIC examination procedures are designed exclusively for epidemiologic research. Our study procedures do not substitute for a clinical examination, nor does the study provide any diagnosis or treatment. If a condition or laboratory test result is found that requires diagnostic confirmation or possible treatment, the study participant is referred to his/her usual source of medical care.

As part of the ARIC follow-up protocol, Mr./Ms. _____ has agreed to be contacted by phone once a year. During this brief telephone interview we will inquire about his/her general health, as well as any cardiovascular symptoms and hospitali- zations during the year. A complete follow-up examination, similar to the one reported here, will take place in three years.

Thank you for your cooperation.

Sincerely,

[Clinic Director or ARIC Physician]

Enclosures

Physician Letter 2a

REPORT TO PARTICIPANT'S PHYSICIAN FOLLOWING ARIC VISIT 1

(Results to M.D.; participant advised of minor findings; no previous referrals; ARIC recommends that participant see M.D.)

[Date]

Dr. _____
Address

Dear Dr. _____:

Mr./Ms. _____, a patient of yours, is a participant in the ARIC Study and was seen at our ARIC Field Center on ___(date)___. Attached to this letter is a report of the results of this examination. We have indicated on the report the results we consider to be outside the normal range.

The ARIC Study routinely offers to send all clinically relevant data to the participant's physician. Mr./Ms. _____ has indicated that we should send these results to you. We have mailed a letter to Mr./Ms. _____ to report that one or more abnormal findings were noted during the ARIC examination and reported to you. We have also suggested that Mr./Ms. _____ contact you to determine if these findings need further study.

The ARIC examination procedures are designed exclusively for epidemiologic research. Our study procedures do not substitute for a clinical examination, nor does the study provide any diagnosis or treatment. If a condition or laboratory test result is found that requires diagnostic confirmation or possible treatment, the study participant is referred to his/her usual source of medical care.

As part of the ARIC follow-up protocol, Mr./Ms. _____ has agreed to be contacted by phone once a year. During this brief telephone interview we will inquire about his/her general health, as well as any cardiovascular symptoms and hospitalizations during the year. A complete follow-up examination, similar to the one reported here, will take place in three years.

Thank you for your cooperation.

Sincerely,

[Clinic Director or ARIC Physician]

Enclosure

Physician Letter 2b

REPORT TO PARTICIPANT'S PHYSICIAN FOLLOWING ARIC VISIT 1

(Results to M.D.; participant advised of minor finding; previous referrals by ARIC; ARIC recommends that participant see M.D.)

[Date]

Dr. _____
Address

Dear Dr. _____:

Mr./Ms. _____, a patient of yours, is a participant in the ARIC Study and was seen at our ARIC Field Center on ___(date)___. Attached to this letter is our final report of the results of this examination. We have indicated on the report the results we consider to be outside the normal range.

The ARIC Study routinely offers to send all clinically relevant data to the participant's physician. Mr./Ms. _____ has indicated that we should send these results to you, and we have already reported to you that __(insert previous referral)__. We are now sending a final report indicating possible abnormal findings to Mr./Ms. _____, reminding him/her to contact you if he/she has not already done so.

The ARIC examination procedures are designed exclusively for epidemiologic research. Our study procedures do not substitute for a clinical examination, nor does the study provide any diagnosis or treatment. If a condition or laboratory test result is found that requires diagnostic confirmation or possible treatment, the study participant is referred to his/her usual source of medical care.

As part of the ARIC follow-up protocol, Mr./Ms. _____ has agreed to be contacted by phone once a year. During this brief telephone interview we will inquire about his/her general health, as well as any cardiovascular symptoms and hospitalizations during the year. A complete follow-up examination, similar to the one reported here, will take place in three years.

Thank you for your cooperation.

Sincerely,

[Clinic Director or ARIC Physician]

Enclosure

Participant Letter 1

REPORT TO PARTICIPANT FOLLOWING ARIC VISIT 1

(Results to M.D.; no abnormal findings)

[Date]

Mr./Ms. _____
Address

Dear Mr./Ms. _____:

Thank you for taking part in the ARIC Study examination at our Field Center on _____(date)_____. We appreciate your willingness to join us in this important study.

The results of your laboratory tests are summarized on the attached sheet. We are glad to report that no abnormalities were found among these measurements.

Because the ARIC Study does not provide any clinical diagnosis nor treatment, we offer to send all relevant information to participants' usual sources of medical care. According to your instructions during the ARIC visit, we have mailed these results to _____, for his/her review.

We look forward to seeing you again during your next visit three years from now. In the meantime, our staff will call you once every year to stay in touch. Thank you again for becoming a member of the ARIC Study.

Sincerely,

[Clinic Director or ARIC Physician]

Enclosure

Participant Letter 2a

REPORT TO PARTICIPANT FOLLOWING ARIC VISIT 1

(Results to M.D.; Participant advised of minor finding; No previous ARIC referrals; ARIC recommends that participant see M.D.)

[Date]

Mr./Ms. _____
Address

Dear Mr./Ms. _____:

Thank you for taking part in the ARIC Study examination at our Field Center on _____(date)_____. We appreciate your willingness to join us in this important study.

The results of your examination are summarized on the attached sheet. One or more of the measurements, as shown on the sheet, ought to be reviewed by your physician to determine whether these findings should be studied further.

According to your instructions during the ARIC visit, we have mailed these results to Dr. _____. Because the ARIC Study does not provide any clinical diagnosis nor treatment, we suggest that you contact Dr. _____ to determine if the findings need further study.

We look forward to seeing you again during your next visit three years from now. In the meantime, our staff will call you once every year to stay in touch. Thank you again for becoming a member of the ARIC Study.

Sincerely,

[Clinic Director or ARIC Physician]

Enclosure

Participant Letter 2b

REPORT TO PARTICIPANT FOLLOWING ARIC VISIT 1

(Results to M.D.; Participant advised of minor finding; Previous referrals made by ARIC; ARIC recommends that participant see M.D.)

[Date]

Mr./Ms. _____
Address

Dear Mr./Ms. _____:

Thank you for taking part in the ARIC Study examination at our Field Center on _____(date)_____. We appreciate your willingness to join us in this important study.

The results of your examination are summarized on the attached sheet. One or more of the measurements, as shown on the sheet, ought to be reviewed by your physician to determine whether these findings should be studied further.

According to your instructions during the ARIC visit, we are mailing these results to Dr. _____, who has been notified earlier about __(insert previous referrals)___. Because the ARIC Study does not provide any clinical diagnosis nor treatment, we suggest that you contact Dr. _____, if you have not already, to determine if the findings need further study.

We look forward to seeing you again during your next visit three years from now. In the meantime, our staff will call you once every year to stay in touch. Thank you again for becoming a member of the ARIC Study.

Sincerely,

[Clinic Director or ARIC Physician]

Enclosure

Participant Letter 3a

REPORT TO PARTICIPANT FOLLOWING ARIC VISIT 1

(Results to Participant; no abnormal findings; no M.D. designated)

[Date]

Mr./Ms. _____
Address

Dear Mr./Ms. _____:

Thank you for taking part in the ARIC Study examination at our Field Center on _____(date)_____. We appreciate your willingness to join us in this important study.

Because the ARIC Study does not provide any clinical diagnosis nor treatment, we offer to send any relevant information to participants' usual sources of medical care. During your ARIC visit you indicated that we should send these results to you.

The results of your examination are summarized on the attached sheet. No abnormalities were found during the ARIC examination and the laboratory results are in the range considered normal. If you find that the attached report is not clear, please call us at ___(phone number)___.

We look forward to seeing you again during your next visit three years from now. In the meantime, our staff will call you once every year to stay in touch. Thank you again for becoming a member of the ARIC Study.

Sincerely,

[Clinic Director or ARIC Physician]

Enclosure

Participant Letter 3b

REPORT TO PARTICIPANT FOLLOWING ARIC VISIT 1

(Results to Participant; see M.D. to verify some findings; no M.D. designated)

[Date]

Mr./Ms. _____
Address

Dear Mr./Ms. _____:

Thank you for taking part in the ARIC Study examination at our Field Center on _____(date)_____. We appreciate your willingness to join us in this important study.

The results of your examination are summarized on the attached sheet. We have identified the results which are possibly abnormal. In most instances such a result does not mean that a medical problem exists. However, we believe that the enclosed report should be reviewed by a physician to determine whether these results should be confirmed or studied further.

Because the ARIC Study does not provide any clinical diagnosis nor treatment, we offer to send all relevant information to participants' usual sources of medical care. During your ARIC visit you indicated that we should send these results to you. We encourage you to consult your physician or usual source of medical care, to alert him/her to those results that we have highlighted for verification. If you do not have a personal physician or do not know where to find one we suggest that you call _____.

We look forward to seeing you again during your next visit three years from now. In the meantime, our staff will call you once every year to stay in touch. Thank you again for becoming a member of the ARIC Study.

Sincerely,

[Clinic Director or ARIC Physician]

Enclosure

APPENDIX IX

Study Forms

Appendix IX

Cohort Component Forms

Data Collection Forms

Home Interview Form
Identification Form
Fasting/Tracking Form
Sitting Blood Pressure Form
Venipuncture Form
Medication Survey
Medical History Form
Respiratory Symptoms/Physical Activity Form
Reproductive History Form
Dietary Intake Form (Food Frequency Questionnaire and Alcohol Consumption)
TIA/Stroke Form
Anthropometry Form
Physical Examination Form
Medical Data Review Printout
TIA/Stroke Summary Form
ARIC Cohort Annual Follow-up (TR)
Annual Follow-up Form
Hospital Record Abstraction Form
Hospital Stroke Form
Cohort Eligibility Form
Death Certificate Form
Informant Interview Form
Physician Questionnaire
Coroner/Medical Examiner Report
Autopsy Form
Cohort Event Investigation Summary

Management Forms

General Instructions for Paper Forms
Itinerary Form
Alert/Referral Log

OMB No. 0925-0281
Approval Expires: 07-31-89

Coordinating Center Participant ID Label	HOME INTERVIEW
ASSIGNMENT INFORMATION	ARIC ATHEROSCLEROSIS RISK IN COMMUNITIES STUDY

RECORD OF CALLS

Day of Week	MO/DA/YR Date	Time	Notes	Code*	FI ID
Y M T W R F S	/ /	A P			
Y M T W R F S	/ /	A P			
Y M T W R F S	/ /	A P			
Y M T W R F S	/ /	A P			
Y M T W R F S	/ /	A P			
Y M T W R F S	/ /	A P			
Y M T W R F S	/ /	A P			
Y M T W R F S	/ /	A P			
Y M T W R F S	/ /	A P			
Y M T W R F S	/ /	A P			
Y M T W R F S	/ /	A P			

CLINIC APPOINTMENT SET? Y N

OFFICE USE ONLY MONTH DAY YEAR

*RESULT CODES (CIRCLE THE FINAL FIELD RESULT CODE.)

01 Interview complete	06 Physically/mentally incompetent	11 Home Interview appointment set
02 No one home	07 Vacant	18 Home interview appointment broken
03 No eligible respondent home	08 Partial interview	20 Other (SPECIFY IN NOTES ABOVE)
04 Refusal	09 Vacation/second home	26 Age ineligible
05 Language barrier	10 Temporarily away	27 Moving from area

ENTER COMMENTS IN NOTES ABOVE FOR CODES 4, 5, 6, 10, 11 AND 20.

INTRODUCTION FOR FIRST CONTACT WITH ELIGIBLE RESPONDENT

Hello, I'm (NAME) with (NAME OF INSTITUTION). We are doing medical research for the National Institutes of Health to study factors related to heart disease in this county. As part of this important study, we are conducting a brief interview now and physical examination at a clinic later with people in (NAME OF COMMUNITY). (NAME OF COMMUNITY) is one of only four communities being studied. You are eligible for our study and we would appreciate your cooperation in this important effort. Would you like a brochure that explains the study and assures that everything you say will be kept private? I will be pleased to answer any questions you may have.

Let me record the date and time and we will begin this brief interview.

1. Date of Interview
   MONTH DAY YEAR
2. Time Interview Began:
   HOUR : MINUTE A P
3. Interviewer ID#

RMS 1, 2, 3
HOM 1, 3

01-21-87

4. I have the month and year of your birth. Please give me your complete date of birth. VERIFY ELIGIBILITY. IF INELIGIBLE, SAY: Thank you very much for your help but only people who are 45 through 64 years old are eligible for our study. TERMINATE INTERVIEW AND ENTER CODE 26 IN RECORD OF CALLS. *IDN*

☐☐	☐☐	☐☐
MONTH	DAY	YEAR

Since ARIC is a long-term study which will include a brief telephone interview with you each year and a second clinic examination three years from now, I would like to ask you about your future plans.

5. Do you have definite plans to move out of the area in the near future?

Yes.....Y
No.....N → GO TO BOX BELOW QUESTION 8

6. When do you plan to move? RECORD NUMBER OF UNITS IN "a" and CIRCLE CODES FOR WEEK OR MONTH IN "b."

a. ☐☐ b. W M

7. Where do you plan to move?

_____
CITY COUNTY STATE

8. What arrangements have you made for moving? _____

_____

REVIEW Qs. 6, 7, and 8
IF 6. Respondent plans to move within the next three months. AND 7. Respondent plans to move outside ARIC study area. AND 8. Moving arrangements are definite (movers hired, notice given on job, hired for job in new location, new/old residence rented, sold, etc.). SAY: Since the ARIC study is a long term study and you will be unable to participate in the follow-up because of your moving plans, we will not be able to include you in the study. Thank you for your help. If your plans should change and you should stay in (NAME OF STUDY COMMUNITY) will you call the ARIC study staff and we will discuss your participation in the study? GIVE RESPONDENT BROCHURE WITH ARIC TELEPHONE NUMBER CIRCLED AND TERMINATE INTERVIEW. ENTER CODE 27 IN RECORD OF CALLS.

I would like to ask you a few questions about your health and that of your parents.

9. Compared to other people your age, would you say that your health is excellent, good, fair, or poor?

Excellent.....E
Good.....G
Fair.....F
Poor.....P

10. Has a doctor ever said you had any of the following: READ EACH DISEASE NAME AND CODE "N" IF "NO" OR "NEVER TESTED".

a.	High blood pressure or hypertension (high blood)	Y	N	U (Unsure)
b.	High blood cholesterol	Y	N	U (Unsure)
c.	Heart attack	Y	N	U (Unsure)
d.	Stroke	Y	N	U (Unsure)
e.	Diabetes (sugar in the blood)	Y	N	U (Unsure)
f.	Cancer	Y	N	U (Unsure)
g.	Chronic lung disease, such as chronic bronchitis, or emphysema	Y	N	U (Unsure)
h.	Asthma	Y	N	U (Unsure)

11. Have you stayed overnight as a patient in a hospital during the past year?

Yes.....Y
No.....N

12. Is your natural mother living?

Yes.....Y → GO TO QUESTION 17
No.....N
Unknown.....U → GO TO QUESTION 20

13. Approximately how old was she when she died? ENTER "99" FOR AGES 99 OR OLDER.

AGE

14. What was the cause of your natural mother's death?

Cancer.....C
Heart attack.....A
Stroke.....S
Other (Specify).....O _____
Unknown.....U

15. Did your natural mother ever have any of the following diseases? READ EACH DISEASE NAME.

a. Cancer.....Y.....N.....U (Unsure)
b. Diabetes (sugar in the blood).....Y.....N.....U (Unsure)
c. High blood pressure or hypertension (high blood).....Y.....N.....U (Unsure)
d. Stroke.....Y.....N.....U (Unsure)
e. Heart Attack.....Y.....N.....U (Unsure)

IF ALL "NO" OR "UNSURE", GO TO QUESTION 20.

16. IF YES TO ANY DISEASE IN QUESTION 15, ASK FOR EACH DISEASE WITH A Y CODE: How old was she when she was first told she had (NAME OF DISEASE)? ENTER "99" FOR AGES 99 OR OLDER.

	AGE		AGE
a. (cancer)		d. (a stroke)	
b. (diabetes)		e. (a heart attack)	
c. (high BP)			

→ GO TO QUESTION 20.

17. How old is she? ENTER "99" FOR AGES 99 AND OLDER.

AGE

18. Did your natural mother ever have or does she now have any of the following diseases? READ EACH DISEASE NAME.

a.	Cancer	Y	N	U (Unsure)
b.	Diabetes (sugar in the blood)	Y	N	U (Unsure)
c.	High blood pressure or hypertension (high blood)	Y	N	U (Unsure)
d.	Stroke	Y	N	U (Unsure)
e.	Heart attack	Y	N	U (Unsure

IF ALL "NO" OR "UNSURE", GO TO QUESTION 20.

19. IF YES TO ANY DISEASE IN QUESTION 18, ASK FOR EACH DISEASE WITH A Y CODE: How old was she when she was first told she had (NAME OF DISEASE)? ENTER "99" FOR AGES 99 OR OLDER.

	AGE		AGE
a. (cancer)	☐☐	d. (a stroke)	☐☐
b. (diabetes)	☐☐	e. (a heart attack)	☐☐
c. (high BP)	☐☐		

20. Is your natural father living?

Yes	Y →	GO TO QUESTION 25
No	N	
Unknown	U →	GO TO QUESTION 28

21. Approximately how old was he when he died? ENTER "99" FOR AGES 99 OR OLDER.

☐☐
AGE

22. What was the cause of your natural father's death?

Cancer	C
Heart attack	A
Stroke	S
Other (Specify)	O
Unknown	U

_____

23. Did your natural father ever have any of the following diseases? READ EACH DISEASE NAME.

a. Cancer.....Y.....N.....U (Unsure)
b. Diabetes (sugar in the blood).....Y.....N.....U (Unsure)
c. High blood pressure or hypertension (high blood).....Y.....N.....U (Unsure)
d. Stroke.....Y.....N.....U (Unsure)
e. Heart attack.....Y.....N.....U (Unsure)

IF ALL "NO" OR "UNSURE", GO TO QUESTION 28.

24. IF YES TO ANY DISEASE IN QUESTION 23, ASK FOR EACH DISEASE WITH A Y CODE: How old was he when he was first told he had (NAME OF DISEASE)? ENTER "99" FOR AGES 99 OR OLDER.

	AGE		AGE
a. (cancer)	☐☐	d. (a stroke)	☐☐
b. (diabetes)	☐☐	e. (a heart attack)	☐☐
c. (high BP)	☐☐		

→ GO TO QUESTION 28.

25. How old is he? ENTER "99" FOR AGES 99 AND OLDER.

☐☐
AGE

26. Did your natural father ever have or does he now have any of the following diseases READ EACH DISEASE NAME.

a. Cancer.....Y.....N.....U (Unsure)
b. Diabetes (sugar in the blood).....Y.....N.....U (Unsure)
c. High blood pressure or hypertension (high blood).....Y.....N.....U (Unsure)
d. Stroke.....Y.....N.....U (Unsure)
e. Heart attack.....Y.....N.....U (Unsure)

IF ALL "NO" OR "UNSURE", GO TO QUESTION 28.

27. IF YES TO ANY DISEASE IN QUESTION 26, ASK FOR EACH DISEASE WITH A Y CODE: How old was he when he was first told he had (NAME OF DISEASE)? ENTER "99" FOR AGES 99 OR OLDER.

	AGE		AGE
a. (cancer)	☐☐	d. (a stroke)	☐☐
b. (diabetes)	☐☐	e. (a heart attack)	☐☐
c. (high BP)	☐☐		

28. Now I have a few questions about you. Have you ever smoked cigarettes? (CODE "NO" IF LESS THAN 400 CIGARETTES IN A LIFETIME.)

Yes.....Y
No.....N → GO TO QUESTION 37

29. How old were you when you first started regular cigarette smoking? ENTER "00" IF NEVER SMOKED REGULARLY.

☐☐
AGE

30. Do you now smoke cigarettes?

Yes.....Y → GO TO QUESTION 32
No.....N

31. How old were you when you stopped?

☐☐ → GO TO QUESTION 33
AGE

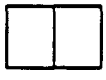
32. How many cigarettes do you smoke per day now? (CODE "00" IF LESS THAN ONE PER DAY.)

CIGARETTES

33. During the years that you have smoked, was there ever a period of one year or more that you did not smoke cigarettes?

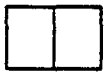
Yes.....Y
No.....N → GO TO QUESTION 35

34. For how many years did you not smoke cigarettes?



YEARS

35. On the average of the entire time you smoked, how many cigarettes did you usually smoke per day? (CODE "00" IF LESS THAN ONE PER DAY.)



CIGARETTES

36. (Do/did) you inhale the cigarette smoke? READ RESPONSE CATEGORIES.

Not at all.....N
Slightly.....S
Moderately.....M
Deeply.....D

37. Have you ever smoked a pipe regularly? (CODE "NO" IF LESS THAN 12 OZ IN A LIFETIME.)

Yes.....Y
No.....N → GO TO QUESTION 44

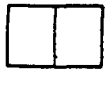
38. How old were you when you started to smoke a pipe regularly?

AGE

39. Do you now smoke a pipe?

Yes.....Y → GO TO QUESTION 41
No.....N

40. How old were you when you stopped?

 → GO TO QUESTION 42

AGE

41. How much pipe tobacco are you smoking now? (RECORD OZ PER WEEK: A STANDARD POUCH OF TOBACCO CONTAINS 1 1/2 OZ. CODE "00" IF LESS THAN ONE OZ. PER WEEK.)

OZ

42. On the average over the entire time you smoked a pipe, how much pipe tobacco did you smoke per week? (RECORD OZ PER WEEK: A STANDARD POUCH OF TOBACCO CONTAINS 1 1/2 OZ. CODE "00" IF LESS THAN ONE OZ. PER WEEK.)

OZ

43. (Do/Did) you ever inhale the pipe smoke? READ RESPONSE CATEGORIES.

Not at all.....N
Slightly.....S
Moderately.....M
Deeply.....D

44. Have you ever smoked cigars or cigarillos regularly? (CODE "NO" IF LESS THAN 1 CIGAR/ CIGARILLO A WEEK FOR A YEAR).

Yes.....Y
No.....N → GO TO QUESTION 51

45. How old were you when you started smoking (cigars/cigarillos) regularly?

AGE

46. Do you now smoke (cigars/cigarillos)?

Yes.....Y → GO TO QUESTION 48
No.....N

47. How old were you when you stopped?

		→ GO TO QUESTION 49

AGE

48. How many (cigars/cigarillos) do you smoke per week now? (CODE "00" IF LESS THAN ONE PER WEEK.)

CIGARS/CIGARILLOS

49. On the average, over the entire time you smoked (cigars/cigarillos), how many (cigars/ cigarillos) did you smoke per week? (CODE "00" IF LESS THAN ONE PER WEEK.)

CIGARS/CIGARILLOS

50. (Do/Did) you inhale the (cigar/cigarillo) smoke? READ RESPONSE CATEGORIES.

Not at all.....N
Slightly.....S
Moderately.....M
Deeply.....D

51. Please tell me if you are currently using or have ever used chewing tobacco, snuff, or nicotine gum prescribed by a doctor; for example, Nicorette. IF "YES," PROBE FOR CURRENT OR PAST USE.

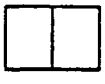
a. Chewing tobacco....Currently.....C.....Never.....N.....Past Use.....P
b. Snuff.....Currently.....C.....Never.....N.....Past Use.....P
c. Nicotine gum.....Currently.....C.....Never.....N.....Past Use.....P

52. ASK NON-SMOKERS ONLY: During the past year, about how many hours per week, on the average, were you in close contact with people when they were smoking? For example, in your home, in a car, at work or other close quarters.

HOURS

Now I have a few last general questions about you.

53. How long have you lived in (NAME OF COMMUNITY)?



YEARS

54. What is the highest grade or year of school you have ever completed, including trade or vocational school or college? RECORD NUMBER OF YEARS FOR GRADES 1-12 _____ OR:

CIRCLE RESPONSE FOR HIGHEST NUMBER BELOW:

GED.....13

VOCATIONAL.....

1 Year.....14
2 Years.....15
3 Years.....16

COLLEGE

1 Year.....17
2 Years.....18
3 Years.....19
4 Years.....20
Graduate School or Professional School.....21
Don't know.....99

55. I would like you to look at this card while I read it all to you. Please tell me the letter of the one which best describes your current occupation. HAND CARD TO RESPONDENT AND READ EACH RESPONSE CATEGORY.

Homemaking, not working outside the home.....A → GO TO QUESTION 62
Employed at a job for pay, either full or part-time.....B
Employed, but temporarily away from my regular job.....C → GO TO QUESTION 57
Unemployed, looking for work.....D
Unemployed, not looking for work.....E
Retired from my usual occupation and not working.....F
Retired from my usual occupation but working for pay.....G

56. Did you retire because of health reasons?

Yes.....Y
No.....N
Partially.....P

57. What (is/was) your (current/most recent) occupation? IF MORE THAN ONE JOB, RECORD OCCUPATION FOR JOB FOR MOST HOURS WORKED PER WEEK.

ENTER "N" [ ] IF "NEVER WORKED", AND GO TO QUESTION 62

58. (Are/Were) you self employed for this occupation?

Yes.....Y
No.....N

59. Please give me the name and address of your company. It will help us categorize (your/your former) occupation.

a.

COMPANY NAME

STREET ADDRESS

b.

c. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

CITY

d. ☐☐ STATE

e. ☐☐☐☐☐ ZIP CODE

60. What type business is this? READ RESPONSE CATEGORIES.

Manufacturing.....M	Retail.....R
Wholesale.....W	Service.....S
Other (Specify).....O	_____

61. What (are/were) your most important activities or duties? For example: selling cars, keeping account books or sweeping floors.

a. _____

b. _____

c. _____

62. Please look at this card. Which of these income groups represents your total combined family income for the past 12 months? Include income from all sources such as wages, salaries, social security or retirement benefits, help from relatives, rent from property, and so forth. (HAND CARD TO RESPONDENT). Please tell me the number only.

Under $5,000.....1
$5,000 - $7,999.....2
$8,000 - $11,999.....3
$12,000 - $15,999.....4
$16,000 - $24,999.....5
$25,000 - $34,999.....6
$35,000 - $49,999.....7
Over $50,000.....8

63. FOR MARYLAND AND MISSISSIPPI ONLY: Do you have a driver's license with an address in (NAME OF COMMUNITY)?

Yes.....Y
No.....N

64. FOR MINNESOTA ONLY: Do you have a driver's license with an address in (NAME OF COMMUNITY)?

Yes.....Y→ GO TO BOX ABOVE QUESTION 66.
No.....N

65. FOR MINNESOTA ONLY: Are you registered to vote in (NAME OF COMMUNITY) or do you have a Minnesota state identification card?

Yes.....Y
No.....N

Now I would like to obtain some information which will help us contact you later.

66. a. Please tell me what title you use before your name, for example: Mr., Mrs., Ms., Doctor, Reverend, or something else. *RMS IDN*

TITLE

b. Would you please spell your last name for me? *RMS IDN*

LAST NAME

c. Please spell your first name for me. *RMS IDN*

FIRST NAME

d. Please spell your middle name for me. *RMS IDN*

MIDDLE NAME

67. Would you please tell me your complete mailing address? *IDN*

STREET ADDRESS

a.

b. *IDN*

CITY

c. STATE

d. ZIP CODE *IDN*

68. What is your home telephone number, starting with your area code? *RMS IDN*

						-				

☐ CHECK (✓) IF NO HOME TELEPHONE AND GO TO QUESTION 70.

69. What is the best time for us to contact you at home? *RMS*

_____

70. Can you provide me with a telephone number other than your home where we can contact you? *RMS IDN*

						-				

SPECIFY: _____

71. What is the best time for us to contact you at that telephone number? *RMS*

_____

(IF RESPONDENT IS NOT PLANNING TO COME TO THE CLINIC, GO TO QUESTION 80.)

There are several points we would like to cover to make your clinic visits easier.

For your visit we ask that you fast, taking nothing by mouth but water and essential medication for 12 hours before your appointment. You will be given a snack shortly after your arrival, after we have drawn your blood sample.

72. Some medicines, such as insulin for diabetes, cannot be taken while fasting. Do you take insulin for diabetes? *RMS*

Yes.....Y		Continue to take insulin the way you normally do. You should not fast before you come to the clinic. GO TO QUESTION 77.
No.....N		

73. Do you have any medical reason why you must not fast for 12 hours?

Yes (SPECIFY).....Y	_____	*RMS*
No.....N →	GO TO QUESTION 75.	

74. Is it possible for you to arrange with your doctor a way to fast before you come to the clinic? *RMS*

Yes.....Y	Good. Please do so.
No.....N	Then it will be o.k. for you to eat before the visit as you normally do.

75. Some medications can be taken fasting or delayed until the snack at the clinic. Do you have a medicine you must take for which you must not fast for 12 hours? *RMS*

Yes.....Y _____
No.....N → GO TO QUESTION 77.

76. Is it possible for you to arrange with your doctor a way to take this medicine without fasting or fasting for a shorter time before you come to the clinic? *RMS*

Yes.....Y Good. Please do so.
No.....N Then it will be o.k. for you to take it before the visit as you normally do.

77. Do you have any special diet we should consider for the clinic snack? *RMS*

Yes (SPECIFY).....Y _____
No.....N

78. Will you need any assistance climbing steps or getting around the clinic? *RMS*

Yes (SPECIFY).....Y _____
No.....N

79. Do you have any other special needs for the clinic visit that we should know about? *RMS*

Yes (SPECIFY).....Y _____
No.....N

80. TIME INTERVIEW ENDED ☐☐ : ☐☐ A P *RMS*
HOUR MINUTES

81. SCHEDULE APPOINTMENT. (GO TO f. IN BOX BELOW IF RESPONDENT IS NOT GOING TO COME TO THE CLINIC.)

IF INTERVIEW SCHEDULED WITH ANOTHER HOUSEHOLD MEMBER, READ: Now I would like to interview (NAME OF RESPONDENT), then we will make the appointment for your clinic examinations together.

IF INTERVIEWS COMPLETED FOR THIS VISIT, READ: Now I would like to set your appointment for the clinic examination. May I use your telephone to call for a good appointment time for you?

CALL (TELEPHONE NUMBER) FOR APPOINTMENT INFORMATION AND RECORD BELOW.

a. ☐☐ ☐☐ ☐☐ b. M T W R F S c. ☐☐:☐☐ A P *RMS*

MONTH DAY YEAR HOUR MINUTES

REVIEW APPOINTMENT SCHEDULE, PROCEDURES.

IF RESPONDENT IS UNABLE TO SCHEDULE APPOINTMENT AT THIS TIME, SPECIFY:

d. REASON: _____

e. RECONTACT PROCEDURES _____

f. RECORD REASON RESPONDENT IS NOT COMING TO THE CLINIC: *RMS*

Language barrier 01
Physically unable to attend clinic 02
Doesn't want blood drawn 03
Doesn't want to take time off work 04
Other refusal (specify)_____ 05
Other (specify) _____ 06

NOW GO TO MEDICATIONS INSTRUCTIONS NEXT PAGE.

READ THE FOLLOWING MEDICATIONS INSTRUCTIONS:

"During your visit to the Clinic we would like to record any medicines you are taking, because they tell us about a person's health and may have effects on the tests which we will perform.

We are interested in ALL medicines that you take for ANY reason in the TWO WEEKS before your visit to the ARIC clinic, not just in heart medicines.

The best way to get this information is for you to bring in this carrying bag (HAND MEDICATIONS BAG TO PARTICIPANT) the containers of any medicines used in the two weeks before your visit, including:

- Prescription drugs from your physician or dentist;
- Prescription drugs you may have received from other people, such as friends or relatives:
- Over-the-counter medicines you may have bought at the drug store or a supermarket, such as medicines for colds, constipation, allergies, vitamins, minerals, and the like.

We ask that you bring the containers so that we can copy the information from the label. If you don't have the container, please bring the prescription or any other information that has the name of the drugs. Even if you only have loose pills or capsules, please bring them to the clinic so that we can identify them.

At the clinic we will handle all your medicines and containers very carefully and will return them in this same bag before you leave. Like all the other information we collect, your use of medicines will be kept in strict confidence."

DOES PARTICIPANT HAVE: (CHECK ALL THAT APPLY FOR YOUR FIELD CENTER)	PARTICIPANT INFORMATION SHEET	☐ YES
	MEDICATION BAG	☐ YES
	BROCHURE	☐ YES
	MEDICATION INSTRUCTIONS	☐ YES
	INTRODUCTORY LETTER	☐ YES
	CONSENT FORM	☐ YES
	CLINIC MAP	☐ YES

INTERVIEWER REMARKS

82. RESPONDENT'S COOPERATION WAS:

Very Good . . . . V Good . . . . G Fair . . . . F Poor . . . . P *RMS*

83. THE QUALITY OF THE INTERVIEW IS: (CIRCLE THE FOLLOWING CODE.) *RMS*

High Quality.....H
Generally Reliable.....R
Questionable.....Q
Unsatisfactory.....U

IF CODE Q OR U, CODE REASON USING CODES BELOW. ☐☐ *RMS*

REASON CODES FOR QUESTIONABLE OR UNSATISFACTORY INFORMATION (ENTER CODE ABOVE):

THE MAIN REASON FOR UNSATISFACTORY OR QUESTIONABLE QUALITY OF INFORMATION WAS BECAUSE THE RESPONDENT:

Did not want to be more specific.....01
Did not understand or speak English well.....02
Was bored or uninterested.....03
Was upset, depressed, or angry.....04
Had poor hearing or speech.....05
Was confused or distracted by frequent interruptions.....06
Was inhibited by others around him/her.....07
Was embarrassed by the subject matter.....08
Was emotionally unstable.....09
Was physically ill.....10
Other (SPECIFY).....11

_____

_____

84. Is the respondent able to read and write? *RMS*

Yes.....Y
No.....N
Unsure.....U

COMMENTS:

O.M.B. 0925-0281
exp. 7-31-89

A-99

ARIC IDENTIFICATION FORM

ID NUMBER: | | | | | | | | CONTACT YEAR: | 0 | 1 | FORM CODE: | I | D | N | VERSION: A 11/1.

LAST NAME: | | | | | | | | | | | | | INITIALS: | | |

INSTRUCTIONS:

Information on this form should be completed prior to the clinic visit, using the Home Interview Form. (Corresponding item numbers from the Home Interview Form are given for each item.) This form should be used at the beginning of the visit to verify information and make any necessary changes. Changes should be made on this form, using the usual procedures for correcting data items. Regardless of whether any items require revision, item 13 (code number) must always be completed by the person verifying or revising the information...
ID Number and Name must be entered above. When name and address information is required, code the response beginning in the leftmost box using capital letters. Whenever numerical responses are required (except in the address section), enter the number so that the last digit appears in the rightmost box. Enter leading zeroes where necessary to fill all boxes. If a number is entered incorrectly, mark through the incorrect entry with an "X". Code the correct entry clearly above the incorrect entry.

IDENTIFICATION FORM (IDNA screen 1 of 2)

A. VERIFICATION OF IDENTIFYING INFORMATION

"We need to verify some of the information you gave us at your home. I will read it back to you, and you tell me if it is correct. I will also check that we have spelled your name correctly."

1. Title (HOM 66a): | | | | |

2. Last Name (HOM 66b): | | | | | | | | | | | | | | | | | | | | |

3. First Name (HOM 66c): | | | | | | | | | | | | |

4. Middle Name (HOM 66d): | | | | | | | | | | | | |

5. Mailing Address (HOM 67a): | | | | | | | | | | | | | | | | | | | | | | | | |

| | | | | | | | | | | | | | | | | | | | | | | | | |

| | | | | | | | | | | | | | | | | | | | | | | | | |

6. City (HOM 67b): ..... | | | | | | | | | | | | | | | | | | | | |

7. State (HOM 67c): | | | 8. Zip Code (HOM 67d): | | | | | |

IDENTIFICATION FORM (IDNA screen 2 of 2)

9. Home Phone Number (HOM 68): ..... [ ][ ][ ] - [ ][ ][ ] - [ ][ ][ ][ ]

10. Other Phone Number (HOM 70): ..... [ ][ ][ ] - [ ][ ][ ] - [ ][ ][ ][ ]

11. Date of Birth (HOM 4): ..... [ ][ ] - [ ][ ] - [ ][ ]
Month Day Year

B. ADMINISTRATIVE INFORMATION

12. Method of data collection: ..... Computer C
Paper Form P

13. Code number of person verifying/changing this form: ..... [ ][ ][ ]

{When entering this information from Home Interview Form (prior to visit), do not complete item 13 (code number).}

VERSION A 11/1/86

IDENTIFICATION FORM INSTRUCTIONS

I. GENERAL INSTRUCTIONS

The Identification Form is used at the beginning of the participant's clinic visit. It serves the purpose of verifying and/or revising certain information collected in the Home Interview. The procedure associated with the Identification Form is unlike that of other forms, as explained below. Prior to completing this form, the interviewer should be familiar with and understand the document titled "General Instructions For Completing Paper Forms". ID Number, Contact Year, and Name should be completed as described in that document.

The intended procedure for completing the Identification Form is the following: The relevant information (name, address, phone number, date of birth) is first located in the already-completed Home Interview Form (a paper form). Prior to the participant's visit, this information is used to complete the computerized version of the Identification Form on the data entry system. Then, when the participant arrives at the field center, the form is called up on the computer in "CHANGE" mode, and the information on it is reviewed with the participant. If any information is found to be incorrect, misspelled, or requires updating, the changes are made directly on the form at that time.

If the data entry system is not available, the paper version of the Identification Form must be used. In this case, the paper Identification Form should be completed before the visit. Then, when the participant arrives at the field center, information on the form is reviewed with him. If any information is found to be incorrect, misspelled, or requires updating, the changes are made directly on the Identificaton Form at that time, using the usual procedures for correcting items on paper forms (see "General Instructions for Completing Paper Forms"). When the data entry system becomes available, the entire Identification Form is entered. It is possible that the form had already been entered using information from the Home Interview. In this case, simply access it in "CHANGE" mode and make any necessary changes. Even if no changes are necessary, the verifier's code number must be entered on this form.

II. DETAILED INSTRUCTIONS FOR EACH ITEM

A. Verification of Identifying Information

(Note: Corresponding item numbers from the Home Interview Form are given for each item below.)

1-4. Title and Name (HOM 66 a-d): It is extremely important that the participant's name be spelled correctly and verified. Record title and name information beginning in the leftmost box. Special characters (e.g., apostrophes, hyphens) may be used. For example, Mr. Peter James O'Brien would be entered as shown below.

1. Title (HOM 66a): MR

2. Last Name (HOM 66b): O'BRIEN

3. First Name (HOM 66c): PETER

4. Middle Name (HOM 66d): JAMES

Residential Address:

5. Mailing Address (HOM 67 a): Enter the subject's mailing address in the boxes on the three lines provided, exactly as one would address an envelope. Use standard abbreviations such as "S" for South, "W" for West, "ST" for Street, "AVE" for Avenue, etc. where necessary to conserve space. Include house number, apartment number, lot or box number, street name, apartment complex, mobile court name, or rural route. Use punctuation where necessary.

6. City (HOM 67 b): Enter the name of the city in which the participant receives his mail. See examples given below.

7. State (HOM 67 c): Enter appropriate abbreviation for the state where the participant resides. Abbreviations are given below:

Maryland	MD
Minnesota	MN
Mississippi	MS
North Carolina	NC

8. Zip Code (HOM 67 d): Enter the five digit zip code for the mailing address.

Examples for coding subject's address in items 5-8:

Example 1. If the address is: Route 5
P. O. Box 495
Winston-Salem, N.C. 54321

It should be entered as:

5. Mailing Address (HOM 67a):

R	O	U	T	E		5															
P	O		B	O	X		4	9	5												

6. City (HOM 67b): ..... W I N S T O N - S A L E M

7. State (HOM 67c): N C 8. Zip Code (HOM 67d): 5 4 3 2 1

Example 2. If the address is: Apartment C-12
Kings Apartments
77 Seventh Avenue
Hagerstown, Maryland 56789

It should be entered as:

5. Mailing Address (HOM 67a):

A	P	T		C	-	1	2														
K	I	N	G	S		A	P	A	R	T	M	E	N	T	S						
7	7		S	E	V	E	N	T	H		A	V	E								

6. City (HOM 67b): ..... H A G E R S T O W N

7. State (HOM 67c): M D 8. Zip Code (HOM 67d): 5 6 7 8 9

9. Home Phone Number (HOM 68): Enter the participant's home telephone number, including area code.

10. Other Phone Number (HOM 70): Enter the telephone number (other than the home phone number given above) where the participant is most likely to be contacted during the day. If applicable, enter the participant's telephone number at work. Include area code.

Example:

9. Home Phone Number (HOM 68): ..... 3 0 1 - 5 5 5 - 1 2 3 4

10. Other Phone Number (HOM 70): ..... 3 0 1 - 5 5 5 - 6 7 8 9

11. Date of Birth (HOM 4): Enter the month, day, and year of birth, coded in numbers. Right-justify using leading zeroes where appropriate.

Example: The participant's date of birth is May 8, 1936. It should be entered as:

11. Date of Birth (HOM 4): ..... 0 5 - 0 8 - 3 6
Month Day Year

B. Administrative Information

12. Method of data collection: Record "C" if the form was completed on the computerized data entry system, or "P" if the paper form was used.

13. Code number of person verifying/changing this form: The person at the clinic who has reviewed the information on this form with the participant must enter his/her code number in the boxes provided, regardless of whether any changes were made.

O.M.B. 0925-0281
exp. 7-31-89

ARIC FASTING / TRACKING FORM

ID NUMBER: | | | | | | | | CONTACT YEAR: | 0 | 1 | FORM CODE: | F | T | R | VERSION: A 11/1/8

LAST NAME: | | | | | | | | | | | | | INITIALS: | | |

INSTRUCTIONS:
This form should be completed at the beginning of the participant's visit. ID Number and Name must be entered above. When name and address information is required, code the response beginning in the leftmost box using capital letters. Whenever numerical responses are required (except in address sections), enter the number so that the last digit appears in the rightmost box. Enter leading zeroes where necessary to fill all boxes. If a number is entered incorrectly, 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.

FASTING / TRACKING FORM (FTRA screen 1 of 8)

A. FASTING INFORMATION

1. a. Date of Visit: .... | | | - | | | - | | |
Month Day Year

b. Time: ..... | | | : | | | c. AM or PM: ..... AM A
PM P

2. When was the last time you ate or drank anything except water?

a. Day last consumed: ..... Today T
Yesterday Y
Before Yesterday B

Go to Item 4, Screen 2

b. Time last consumed: ..... | | | : | | | c. AM or PM: ..... AM A
PM P

3. Computed fasting time: ___ ___ hours

FASTING / TRACKING FORM (FTRA screen 2 of 8)

"Since we will be contacting you for several years, we would like to obtain some information now which will help us locate you in the future. Remember that all information is confidential and that anyone we might contact will be told only that we are trying to locate you for a health study...
Please give me the name, address, and telephone number of two close friends or relatives who you are likely to keep in touch with but who do not live with you, and who are not planning to move anytime soon."

B. CONTACT PERSON 1

4. Title: 5. First Name:

6. Last Name: .....

7. Mailing Address:

8. City: .....

9. State: 10. Zip Code:

11. Telephone: ..... - -

12. Relationship: .....

FASTING / TRACKING FORM (FTRA screen 3 of 8)

C. CONTACT PERSON 2

13. Title: [ ][ ][ ][ ] 14. First Name: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

15. Last Name: ..... [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

16. Mailing Address:

[ ]

[ ]

[ ]

17. City: ..... [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

18. State: [ ][ ] 19. Zip Code: [ ][ ][ ][ ][ ]

20. Telephone: ..... [ ][ ][ ] - [ ][ ][ ] - [ ][ ][ ][ ]

21. Relationship: ..... [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

FASTING / TRACKING FORM (FTRA screen 4 of 8)

D. PARTICIPANT INFORMATION

22. Sex: ..... Male M
Female F

23. Race: ..... White W
Black B
American Indian or Alaskan Indian I
Asian or Pacific Islander A

24. How many people live in your household? ..... | | |

25. How many of them are between the ages of 45 and 64? .... | | |

26. In what state were you born? ..... | | |

27. {Ask of females only.} What is your father's last name (your maiden name)? .....

28. What name or nickname do most people know you by? .....

FASTING / TRACKING FORM (FTRA screen 5 of 8)

{Interviewer hands participant the disclosure statement.}

"We would like your Social Security number. This statement explains that it is voluntary, and the reasons we are requesting it."

29. Social Security Number: ..... | | | | - | | | - | | | | |

If Social Security Number is not given, mark through the boxes with two horizontal lines and complete item 30 below. If Social Security Number is given, complete boxes and skip to item 31.

30. Reason Social Security Number not given: ..... Refused R
SSN not known K
Has no SSN H

31. What is your driver's license number? ..... | | | | | | | | | | | | | |

32. What state is your driver's license registered in? ..... | | |

FASTING / TRACKING FORM (FTRA screen 6 of 8)

E. PHYSICIAN INFORMATION

33. Do you have a personal physician or clinic? ..... Yes Y

No N

Go to Item 42, Screen 7

34. First Name: | | | | | | | | | | | | |

35. Middle Initial: | |

36. Last Name: ..... | | | | | | | | | | | | | | | | | | | |

37. Clinic/Building:

| | | | | | | | | | | | | | | | | | | | | | | | |

38. Mailing Address:

| | | | | | | | | | | | | | | | | | | | | | | | |

| | | | | | | | | | | | | | | | | | | | | | | | |

39. City: ..... | | | | | | | | | | | | | | | | | | | |

40. State: | | | 41. Zip Code: | | | | | |

FASTING / TRACKING FORM (FTRA screen 7 of 8)

F. NOTIFICATION OF TEST RESULTS

42. {Show and explain Results Reporting Sheet.}

"Our usual procedure is to send results to you and your physician as shown on this sheet."

{Circle "U" unless participant volunteers that this procedure is not satisfactory or has no personal physician. If no personal physician, circle "I". If participant requests another procedure, offer those given below.} .....

Usual procedure (detailed results to physician, summary to participant)	U
Detailed results to participant, but not to physician	T
Detailed results to both participant and physician	B

FASTING / TRACKING FORM (FTRA screen 8 of 8)

43. Are you currently participating in any other medical research projects? ..... Yes Y

No N

{If "Yes", record details below}

Project Name: _____

Sponsor: _____

Purpose: _____

G. ADMINISTRATIVE INFORMATION

44. Method of Data Collection: ..... Computer C

Paper Form P

45. Code number of person completing this form: ..... | | | |

FASTING / TRACKING FORM INSTRUCTIONS

I. GENERAL INSTRUCTIONS

The Fasting / Tracking Form should be completed at the beginning of the participant's clinic visit. The interviewer should be familiar with and understand the document titled "General Instructions For Completing Paper Forms" prior to completing this form. ID Number, Contact Year, and Name should be completed as described in that document.

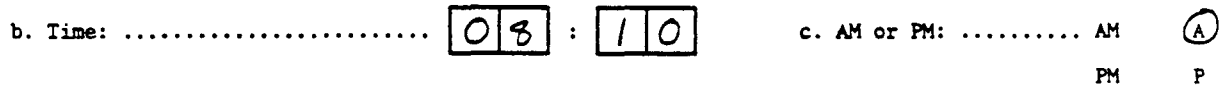
Some of the items in this form involve addresses and phone numbers which the participant may not recall immediately. Therefore, the interviewer should have access to a local telephone book to assist the participant in obtaining the necessary information. In addition, it may be necessary to ask the participant to phone the field center with the information after he/she returns home.

II. DETAILED INSTRUCTIONS FOR EACH ITEM

A. Fasting Information

1. a. Date of Visit: Enter the date on which the subject was seen in the clinic. Code in numbers using leading zeroes where necessary to fill all boxes. For example, May 3, 1986 would be entered as:

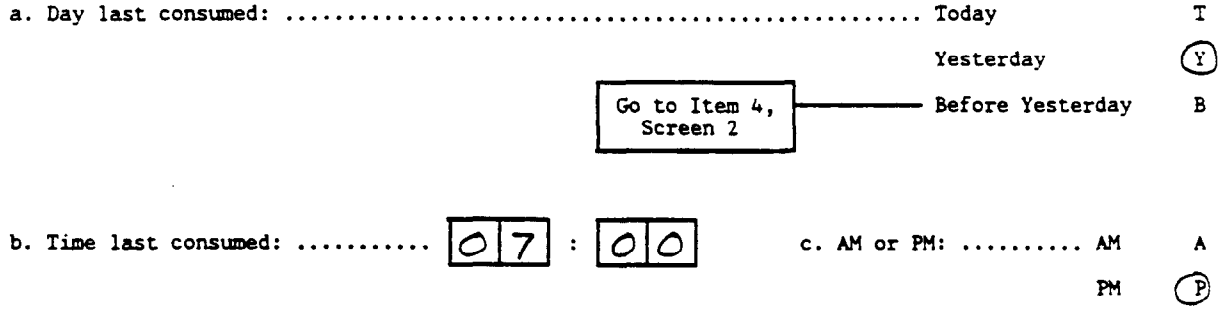
b-c. Time: Enter the time of the reception, i.e., time now. For example, 8:10 a.m. would be coded as:



2. Ask the question verbatim. Record the appropriate day in item (a), time in item (b), and AM or PM in item (c). Use midnight (12:00 AM) as the strict cutoff between days. Note: If "Before Yesterday" is chosen in (a), skip to item 4.

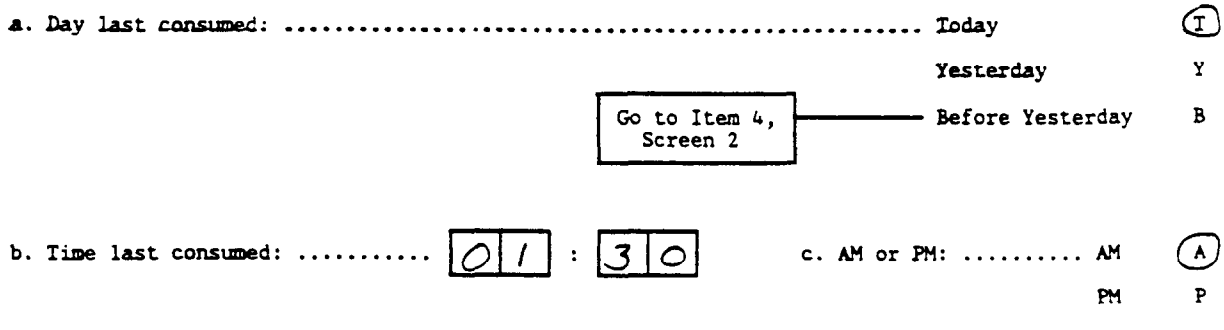
Example 1. The participant states that he/she last consumed something yesterday at 7:00 PM. Record as follows:

2. When was the last time you ate or drank anything except water?



Example 2. The participant states that he/she last consumed something last night at 1:30 AM. Record as follows:

2. When was the last time you ate or drank anything except water?



3. Computed fasting time: This item is calculated automatically when the Fasting/Tracking form is entered directly on the computer. (As a way of denoting this on the paper form, lines are provided rather than boxes for recording the result.) To calculate the fasting time when using the paper version of the form, use the "Fasting Time Computation Table", which can be found on the last page of these instructions, to determine the time. To use the table, look up the Time Last Consumed on the left hand column, and the current time (Time of Visit) along the top. The value in the body of the table corresponding to those two times is the number of hours fasted. Note that the "Time Last Consumed" is separated into "Yesterday" and "Today", and that all times are separated by "AM" and "PM". In addition, times are given in one-hour intervals. The top line in the table may be used whenever the Time Last Consumed is earlier than 7:00 PM. This is acceptable because, although the fasting time may not be accurate, it will not be less than the critical time of 12 hours.

Note: Computing fasting time using the table does not always provide the same result as the computer (due to a reduction in accuracy). However, any effect arising from this fact is believed to be negligible because (1) only a small number of cases would cross over the 12-hour critical time, and (2) even in such cases, ARIC procedures call for the completion of the visit regardless of fasting time.

For example, if the Time Last Consumed is 7:30 PM yesterday (in 7-7:59 PM interval) and the Time of Visit is 8:15 AM (in 8-8:59 AM interval), the fasting time is 13 hours.

3. Computed fasting time: 13 hours

B & C. Contact Person 1, Contact Person 2

4-21. The following paragraph should be read to the participant:

"Since we will be contacting you for several years, we would like to obtain some information now which will help us locate you in the future. Remember that all information is confidential and that anyone we might contact will be told only that we are trying to locate you for a health study...
Please give me the name, address, and telephone number of two close friends or relatives who you are likely to keep in touch with but who do not live with you, and who are not planning to move anytime soon."

If the participant has trouble identifying a contact, suggest someone he/she works with, a neighbor, or a landlord who would be given a forwarding address in the event of a move. While it is preferable to identify someone locally, it would be acceptable to name someone who lives elsewhere (e.g., an out-of-town relative) as a contact person. A family physician is not an acceptable contact person (physician information is collected elsewhere). If the participant knows of an acceptable contact but cannot recall the address and/or phone number, offer to look it up in the phone book at this time. If the contact is not in the phone bock, make a note of this and ask the participant to call back with the information (or if he/she is willing to be telephoned by someone at the field center) after returning home.

4-6,13-15. Title and Name: Record title and name information beginning in the leftmost box. Special characters (e.g., apostrophes, hyphens) may be used.

7,16. Mailing Address: Enter the contact's mailing address in the boxes on the three lines provided, exactly as one would address an envelope. Use standard abbreviations such as "S" for South, "W" for West, "ST" for Street, "AVE" for Avenue, etc. where necessary to conserve space. Include house number, apartment number, lot or box number, street name, apartment complex, mobile court name, or rural route. Use punctuation where necessary.

8,17. City: Enter the name of the city in which the contact receives his mail. See examples given below.

9,18. State: Enter appropriate abbreviation for the state where the contact resides. Abbreviations are given in the table following these instructions.

10,19. Zip Code: Enter the five digit zip code for the mailing address.

11,20. Telephone: Enter the contact's home telephone number, including area code.

Example 1. The first contact person is Mrs. Patricia Tabler, the participant's sister-in-law. Her address is:

712A South Brown Street
Minneapolis, Minnesota 12321

Her phone number is 612-555-1234.

This should be be entered as follows:

B. CONTACT PERSON 1

4. Title: MRS 5. First Name: PATRICIA

6. Last Name: ..... TABLER

7. Mailing Address:

712A S BROWN ST

8. City: ..... MINNEAPOLIS

9. State: MN 10. Zip Code: 12321

11. Telephone: ..... 612 - 555 - 1234

12. Relationship: ..... SISTER-IN-LAW

Example 2. The second contact person is Miss Francis White, the participant's friend. His address is:

Pine Grove Mobile Court
Lot C-1
Route 2
Jackson, Mississippi 34567

His phone number is 601-555-1234.

This should be be entered as follows:

C. CONTACT PERSON 2

13. Title: MISS 14. First Name: FRANCIS

15. Last Name: ..... WHITE

16. Mailing Address:

PINE GROVE MOBILE COURT

LOT C-1

ROUTE 2

17. City: ..... JACKSON

18. State: MS 19. Zip Code: 39567

20. Telephone: ..... 601 - 555 - 1234

21. Relationship: ..... FRIEND

D. Participant Information

22. Sex: Record "M" (male) or "F" (female) for the participant's sex.

23. Race: Record the participant's race as White, Black, American Indian or Alaskan Indian, or Asian or Pacific Islander. This may require asking the question verbally if it is not obvious.

24. Number of people in household: This refers only to those people residing in the same household as the participant on a permanent basis. If the participant lives alone, record "1".

25. Number of people aged 45-64 in household: This is a subset of the previous response.

26. State of Birth: Enter the appropriate abbreviation for the state in which the participant was born. Abbreviations are given in the table following these instructions.

27. Father's last name (maiden name): This item should only be asked of female participants.

28. Nickname: Any nickname or familiar version of a name (e.g., Bob for Robert) is sought.

29. Social Security Number: The interviewer must first hand the disclosure statement (located following these instructions) to the participant, reading it aloud if necessary. The interviewer then states: "We would like your Social Security number. This statement explains that it is voluntary, and the reasons we are requesting it." Enter the Social Security number in the boxes provided, and go to item 31. If the participant does not report a Social Security number, mark through the boxes with two horizontal lines and complete item 30.

30. Reason Social Security Number not given: Indicate the reason the participant did not report a Social Security number. If it is not already clear, probe to determine which response is most approprate, "Refused", "SSN not known", or "Has no SSN".

31. Driver's license number: If the participant has his/her license available, it is preferable to ask for it and copy the number directly. If no driver's license, skip items 31 and 32 (use "Next Field" or "Next Screen" key on computer.)

32. State driver's license is registered in: Enter the appropriate abbreviation for the state in which the license is registered. Again, it is preferable to get this information directly from the license itself. Abbreviations are given in the table following these instructions.

E. Physician Information

33. "Do you have a personal physician or clinic?": If the participant isn't sure, ask about a physician he may have seen recently for general purposes (check-ups, etc.).

34-36. Name of Physician: Record information beginning in the leftmost box. Special characters (e.g., apostrophes, hyphens) may be used.

37. Clinic/Building: Probe to determine whether this is applicable by indicating that we need the physician's address, and offer to help the participant look it up.

38. Mailing Address: Enter the physician's mailing address in the boxes on the three lines provided, exactly as one would address an envelope. Use standard abbreviations such as "S" for South, "W" for West, "ST" for Street, "AVE" for Avenue, etc. where necessary to conserve space. Include house number, apartment number, lot or box number, street name, apartment complex, mobile court name, or rural route. Use punctuation where necessary.

39 City: Enter the name of the city. See examples given below.

40. State: Enter appropriate abbreviation for the state. Abbreviations are given in the table following these instructions.

41. Zip Code: Enter the five digit zip code for the mailing address.

Example: The physician's name and address are: Kenneth R. Schrom, M.D.
Clinic A-106
Memorial Hospital
1100 Oak Street
Cleveland, Ohio 98765

It would be entered as:

34. First Name: KENNETH 35. Middle Initial: R

36. Last Name: ..... SCHROM

37. Clinic/Building:
CLINIC A-106

38. Mailing Address:
MEMORIAL HOSPITAL
1100 OAK ST

39. City: ..... CLEVELAND

40. State: OH 41. Zip Code: 98765

F. Notification of Test Results

42. Recipient of test results: Show the participant the Results Reporting Sheet (shown following these instructions), and briefly explain what it means. Make the statement as written (see below). Note that it is not to be phrased as a question. Unless the participant voices an objection, record "U" (if he/she has a personal physician) or "T" (if no personal physician). If the participant objects, offer any of the three alternatives given.

Example: The participant requests that results be sent to himself and his physician. Complete as shown:

42. {Show and explain Results Reporting Sheet.}

"Our usual procedure is to send results to you and your physician as shown on this sheet."

{Circle "U" unless participant volunteers that this procedure is not satisfactory or has no personal physician. If no personal physician, circle "T". If participant requests another procedure, offer those given below.} .....

Usual procedure (detailed results to physician, summary to participant)	U
Detailed results to participant, but not to physician	T
Detailed results to both participant and physician	(B)

43. Participation in other medical research projects: If the participant is also taking part in another project, answer "Yes" and write down the project name, sponsor (if known), and purpose (if known) in the space provided. When completing this form on the computer, use a note log to record this information.

G. Administrative Information

44. Method of data collection: Record "C" if the form was completed on the computerized data entry system, or "P" if the paper form was used.

45. The person at the clinic who has completed this form must enter his/her code number in the boxes provided.

ABBREVIATIONS FOR STATES

State	Abbrev.	State	Abbrev.	State	Abbrev.
Alabama	AL	Maryland	MD	South Carolina	SC
Alaska	AK	Massachusetts	MA	South Dakota	SD
Arizona	AZ	Michigan	MI	Tennessee	TN
Arkansas	AR	Minnesota	MN	Texas	TX
California	CA	Mississippi	MS	Utah	UT
Colorado	CO	Missouri	MO	Vermont	VT
Connecticut	CT	Montana	MT	Virginia	VA
Delaware	DE	Nebraska	NB	Washington	WA
District of Columbia	DC	Nevada	NV	West Virginia	WV
Florida	FL	New Hampshire	NH	Wisconsin	WI
Georgia	GA	New Jersey	NJ	Wyoming	WY
Hawaii	HI	New Mexico	NM		
Idaho	ID	New York	NY	Others	
Illinois	IL	North Carolina	NC	Puerto Rico	PR
Indiana	IN	North Dakota	ND	Virgin Islands	VI
Iowa	IA	Ohio	OH	Guam	GU
Kansas	KS	Oklahoma	OK	Canada	CN
Kentucky	KY	Oregon	OR	Cuba	CU
Louisiana	LA	Pennsylvania	PA	Mexico	MX
Maine	ME	Rhode Island	RI	Remainder of World	RW

DISCLOSURE STATEMENT FOR SOCIAL SECURITY NUMBER

Provision of the social security number is voluntary and failure to do so will not have any effect upon the receipt of any benefits or programs of the United States Government. The information we receive will be used only for statistical purposes. Data from this study will be linked with data supplied by the National Center for Health Statistics. This information is collected under the authority of Section 287 of the Public Health Service Act.

FASTING TIME COMPUTATION TABLE

Time Last Consumed	Time of Visit: 7-7:59 (AM)	8-8:59 (AM)	9-9:59 (AM)	10-10:59 (AM)	11-11:59 (AM)	12-12:59 (PM)	1-1:59 (PM)	2-2:59 (PM)	3-3:59 (PM)	4-4:59 (PM)	5-5:59 (PM)	6-6:59 (PM)
Yesterday...												
Earlier	13	14	15	16	17	18	19	20	21	22	23	24
7-7:59	12	13	14	15	16	17	18	19	20	21	22	23
8-8:59 (PM)	11	12	13	14	15	16	17	18	19	20	21	22
9-9:59	10	11	12	13	14	15	16	17	18	19	20	21
10-10:59	9	10	11	12	13	14	15	16	17	18	19	20
11-11:59	8	9	10	11	12	13	14	15	16	17	18	19
Today...												
12-12:59	7	8	9	10	11	12	13	14	15	16	17	18
1-1:59	6	7	8	9	10	11	12	13	14	15	16	17
2-2:59	5	6	7	8	9	10	11	12	13	14	15	16
3-3:59	4	5	6	7	8	9	10	11	12	13	14	15
4-4:59	3	4	5	6	7	8	9	10	11	12	13	14
5-5:59 (AM)	2	3	4	5	6	7	8	9	10	11	12	13
6-6:59	1	2	3	4	5	6	7	8	9	10	11	12
7-7:59	0	1	2	3	4	5	6	7	8	9	10	11
8-8:59		0	1	2	3	4	5	6	7	8	9	10
9-9:59			0	1	2	3	4	5	6	7	8	9
10-10:59				0	1	2	3	4	5	6	7	8
11-11:59					0	1	2	3	4	5	6	7
12-12:59						0	1	2	3	4	5	6
1-1:59							0	1	2	3	4	5
2-2:59								0	1	2	3	4
3-3:59 (PM)									0	1	2	3
4-4:59										0	1	2
5-5:59											0	1

ARIC RESULTS REPORTING

THE FOLLOWING RESULTS WILL BE REPORTED TO YOU:

Summarized today:

- Height, weight
- Blood pressure
- Lung function test (preliminary report)

Reported by mail in about six weeks:

- Ultrasound findings of arteries in the neck
- Blood tests: hematocrit, white blood cell count, glucose, potassium, triglycerides, total cholesterol, high density lipoprotein (HDL) cholesterol
- Electrocardiogram

THE FOLLOWING RESULTS WILL BE REPORTED TO YOUR PHYSICIAN:

- Height, weight
- Blood pressure
- Electrocardiogram (copy)
- Lung function test (copy)
- Ultrasound findings on carotid arteries
- Reports of important symptoms you may have
- Blood tests: the tests reported to you, protein, albumin, calcium, creatinine, magnesium, phosphorous, insulin, sodium, urea nitrogen, uric acid, platelet count, low density lipoprotein (LDL) cholesterol

THE FOLLOWING RESULTS WILL NOT BE REPORTED UNLESS AN ABNORMALITY IS DETECTED:

- Blood tests of research value only
- Ultrasound measurements of research value only
- Skinfold measurements

O.M.B. 0925-0281
exp. 7-31-89

ARIC SITTING BLOOD PRESSURE FORM

ID NUMBER: [ ][ ][ ][ ][ ][ ][ ] CONTACT YEAR: [0][1] FORM CODE: [S][B][P] VERSION: A 11/1/

LAST NAME: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ] INITIALS: [ ][ ]

INSTRUCTIONS:
This form should be completed during the participant's visit. ID Number 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 zeroes where necessary to fill all boxes. If a number is entered incorrectly, 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.

SITTING BLOOD PRESSURE FORM (SBPA screen 1 of 4)

A. TEMPERATURE

1. Room Temperature (degrees centigrade): ... [ ][ ]

B. TOBACCO AND CAFFEINE USE

"Smoking can change the results of the exams and laboratory tests we will do today. Because of this we would like to ask you ...

2. Have you smoked or used chewing tobacco or snuff within the last 4 hours? ..... Yes Y

Go to Item 4 ← No N

3. How long ago did you last smoke or last use chewing tobacco or snuff? ...

[ ] hours, [ ][ ] minutes

"We are going to ask you not to smoke until you have completed your visit with us today. We do this so that your test results are not affected by smoking. If you must smoke, please tell us that you did before you leave."

4. Have you had any coffee, tea, or chocolate within the last 4 hours? ..... Yes Y

Go to Item 6, Screen 2 ← No N

SITTING BLOOD PRESSURE FORM (SBPA screen 2 of 4)

5. How long ago did you last have any coffee, tea, or chocolate? ...

[ ] hours, [ ][ ] minutes

C. PRELIMINARY MEASUREMENTS

6. Right Arm Circumference (cm) ..... [ ][ ]

7. Cuff Size: ..... {arm circumference in brackets}

Pediatric {under 24 cm}	P
Regular Arm {24-32 cm}	R
Large Arm {33-41 cm}	L
Other	O

SITTING BLOOD PRESSURE FORM (SBPA screen 3 of 4)

8. a. Time of Day: ..... [ ][ ] : [ ][ ]

8. b. AM or PM: ..... AM A

PM P

9. Pulse Obliteration Pressure: ..... [ ][ ][ ]

10. Maximum Zero: ..... [ ][ ]

+30

11. Peak Inflation Level {Computation-- Item #9 + Item #10 + 30}: ..... ___ ___ ___

D. FIRST BLOOD PRESSURE MEASUREMENT

12. Systolic: ..... [ ][ ][ ]

13. Diastolic: ..... [ ][ ][ ]

14. Zero Reading: ..... [ ][ ]

SITTING BLOOD PRESSURE FORM (SBPA screen 4 of 4)

E. SECOND BLOOD PRESSURE MEASUREMENT

15. Systolic: ..... ☐☐☐

16. Diastolic: ..... ☐☐☐

17. Zero Reading: ..... ☐☐

F. THIRD BLOOD PRESSURE MEASUREMENT

18. Systolic: ..... ☐☐☐

19. Diastolic: ..... ☐☐☐

20. Zero Reading: ..... ☐☐

G. COMPUTED NET AVERAGE OF SECOND AND THIRD BLOOD PRESSURE MEASUREMENTS

21. Systolic: ..... ___ ___ ___

22. Diastolic: ..... ___ ___ ___

H. ADMINISTRATIVE INFORMATION

23. Date of data collection: ... ☐☐ - ☐☐ - ☐☐
Month Day Year

24. Method of Data Collection: ..... Computer C
Paper Form P

25. Code number of person completing this form: ... ☐☐☐

WORKSHEET FOR COMPUTING AVERAGE OF 2ND AND 3RD READINGS (ITEMS 21 AND 22)

	SYSTOLIC	DIASTOLIC
Second Measurement	___ ___ ___ (#15)	___ ___ ___ (#16)
2nd Zero Reading	- ___ ___ (#17)	- ___ ___ (#17)
Second Corrected	___ ___ ___	___ ___ ___
Third Measurement	___ ___ ___ (#18)	___ ___ ___ (#19)
3rd Zero Reading	- ___ ___ (#20)	- ___ ___ (#20)
Third Corrected	___ ___ ___	___ ___ ___
Average Corrected	___ ___ ___ (#21)	___ ___ ___ (#22)

VERSION A 11/1/86

SITTING BLOOD PRESSURE FORM INSTRUCTIONS

I. GENERAL INSTRUCTIONS

The Sitting Blood Pressure Form should be completed during the participant's clinic visit. The technician must be certified and should have a working knowledge of the ARIC Blood Pressure Manual of Procedures. He/she should also be familiar with and understand the document titled "General Instructions For Completing Paper Forms" prior to completing this form. ID Number, Contact Year, and Name should be completed as described in that document.

There should be no exertion, eating, smoking, or exposure to cold for half an hour before recording blood pressure. It is also important that the subject have no change of posture for five minutes before recording blood pressure.

Blood pressure is measured three times using a random zero sphygmomanometer. The detailed instructions below should be reviewed in combination with the Blood Pressure Manual of Procedures.

II. DETAILED INSTRUCTIONS FOR VARIOUS QUESTIONS

A. TEMPERATURE

1. Room Temperature (degrees centigrade): ... ☐☐

A. Temperature

1. Record the room temperature in degrees centigrade. A thermometer need not be read each time the procedure is initiated, but should be consulted two or three times during the day to note fluctuations.

B. TOBACCO AND CAFFEINE USE

"Smoking can change the results of the exams and laboratory tests we will do today. Because of this we would like to ask you ...

2. Have you smoked or used chewing tobacco or snuff within the last 4 hours? ..... Yes Y

No N

Go to Item 4

B. Tobacco and Caffeine Use

2. Ask the question as stated. Any type of smoking, chewing tobacco, snuff, nicotine gum, etc. should be noted if within the last 4 hours. If there was none, skip to item 4.

3. How long ago did you last smoke or last use chewing tobacco or snuff? ...

☐ hours, ☐☐ minutes

3. Ask about the most recent time. The question is phrased "How long ago..." instead of "At what time..." in order to make it easier for the participant to answer. Record the answer in the same way, noting it must be 4 hours or less. If unknown, mark through the boxes with two horizontal lines.

"We are going to ask you not to smoke until you have completed your visit with us today. We do this so that your test results are not affected by smoking. If you must smoke, please tell us that you did before you leave."

4. Have you had any coffee, tea, or chocolate within the last 4 hours? ..... Yes Y

No N

Go to Item 6, Screen 2

4-5. Ask the questions as stated, following the same procedures given for items 2 and 3 above.

5. How long ago did you last have any coffee, tea, or chocolate? ...

☐ hours, ☐☐ minutes

C. PRELIMINARY MEASUREMENTS

6. Right Arm Circumference (cm) ..... ☐☐

7. Cuff Size: ..... (arm circumference in brackets)

Pediatric (under 24 cm)	P
Regular Arm (24-32 cm)	R
Large Arm (33-41 cm)	L
Other	O

8. a. Time of Day: ..... ☐☐:☐☐

8. b. AM or PM: ..... AM A / PM P

9. Pulse Obliteration Pressure: ..... ☐☐☐

10. Maximum Zero: ..... ☐☐

+30

11. Peak Inflation Level (Computation-- Item #9 + Item #10 + 30): ..... ___ ___ ___

D. FIRST BLOOD PRESSURE MEASUREMENT

12. Systolic: ..... ☐☐☐

13. Diastolic: ..... ☐☐☐

14. Zero Reading: ..... ☐☐

E. SECOND BLOOD PRESSURE MEASUREMENT

15. Systolic: ..... ☐☐☐

16. Diastolic: ..... ☐☐☐

17. Zero Reading: ..... ☐☐

C. Preliminary Measurements

6. Measure right arm circumference once according to the Manual of Procedures. Record to the nearest centimeter.

7. Cuff size should be determined by the arm circumference measurement in item 6. The appropriate size for a given arm circumference is given below, and also appears on the form itself.

Arm Circumference	Cuff Size
under 24 cm	Pediatric
24-32 cm	Regular Arm
33-41 cm	Large Arm
over 41 cm	Thigh (record as "other")

8. Record the time. A five minute wait with no change of posture must precede the first blood pressure measurement.

9-10. Record as described in the Manual of Procedures.

11. Calculate peak inflation level as "pulse obliteration pressure" + "maximum zero" + 30. This item is calculated automatically when the form is entered on the computer. (As a way of denoting this on the paper form, lines are provided rather than boxes for recording the result.)

D. First Blood Pressure Measurement

12-13. Measure and record systolic and diastolic blood pressures as described in the Manual of Procedures. Right justify, using leading zeroes if necessary.

14. Record the zero reading.

NOTE: Do not calculate net blood pressure at this time.

E & F. Second and Third Blood Pressure Measurements

15-20. Repeat as in 12-14 above.

F. THIRD BLOOD PRESSURE MEASUREMENT

18. Systolic: ..... [ ][ ][ ]

19. Diastolic: ..... [ ][ ][ ]

20. Zero Reading: ..... [ ][ ]

G. COMPUTED NET AVERAGE OF SECOND AND THIRD BLOOD PRESSURE MEASUREMENTS

21. Systolic: ..... ___ ___ ___

22. Diastolic: ..... ___ ___ ___

H. ADMINISTRATIVE INFORMATION

23. Date of data collection: ... [ ][ ] - [ ][ ] - [ ][ ]
Month Day Year

24. Method of Data Collection: ..... Computer C
Paper Form P

25. Code number of person completing this form: ... [ ][ ][ ]

G. Computed Net Average of Second and Third Blood Pressure Measurements

21-22. These items are calculated automatically when the form is entered on the computer. (As a way of denoting this on the paper form, lines are provided rather than boxes for recording the result.) When the paper form is being used, these must be calculated using a hand calculator. A worksheet is provided at the end of the form to accomplish this. Items 15-20 are transcribed onto that worksheet in the specified spaces. The "corrected" readings are calculated as the measurement itself minus the corresponding zero reading. These (second and third corrected) are then averaged for systolic and diastolic. An example is given below.

H. Administrative Information

23. Record the date on which the measurements were performed.

24. Record "C" if the form was completed on the computerized data entry system, or "P" if the paper form was used.

25. The person at the clinic who has completed the form must enter his/her code number in the boxes provided.

EXAMPLE:

WORKSHEET FOR COMPUTING AVERAGE OF 2ND AND 3RD READINGS (ITEMS 21 AND 22)

	SYSTOLIC	DIASTOLIC
Second Measurement	148 (#15)	110 (#16)
2nd Zero Reading	- 26 (#17)	- 26 (#17)
Second Corrected	122	84
Third Measurement	140 (#18)	98 (#19)
3rd Zero Reading	- 22 (#20)	- 22 (#20)
Third Corrected	118	76
Average Corrected	120 (#21)	80 (#22)

O.M.B. 0925-0281 A-126
exp. 7-31-89

ARIC VENIPUNCTURE FORM

ID NUMBER: [ ][ ][ ][ ][ ][ ][ ] CONTACT YEAR: [0][1] FORM CODE: [V][E][N] VERSION: A 11-01-

LAST NAME: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ] INITIALS: [ ][ ]

INSTRUCTIONS:
This form should be completed during the participant's visit. 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 zeroes where necessary to fill all boxes. If a number is entered incorrectly, 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.

VENIPUNCTURE FORM (VENA screen 1 of 2)

A. BLOOD DRAWING

1. Do you have any bleeding disorders?.....YES Y
NO N
DON'T KNOW D

2. Date of blood drawing:..... [ ][ ] - [ ][ ] - [ ][ ]
month day year

3. Time of blood drawing:..... [ ][ ] : [ ][ ]
AM A
PM P

4. Was blood drawn before the snack?.....YES Y
NO N

5. Number of venipuncture attempts:..... [ ]

6. Filling time of tube 1:..... [ ][ ] seconds

7. Code number of phlebotomist completing this section:..... [ ][ ][ ]

B. BLOOD PROCESSING

8. Time specimen tubes 2,4-7 were spun:..... [ ][ ] : [ ][ ]
AM A
PM P

9. Time specimen tubes 1,3 were spun:..... [ ][ ] : [ ][ ]
AM A
PM P

VENIPUNCTURE FORM (VENA screen 2 of 2)

10. Was the specimen visibly hemolyzed?.....YES Y
NO N

11. Time specimen was placed in freezer:... [ ][ ] : [ ][ ]
AM A
PM P

12. Comments: _____

_____

_____

C. ADMINISTRATIVE INFORMATION

13. Code number of technician processing the blood:..... [ ][ ][ ]

O.M.B. 0925-0281
exp. 7-31-89

ARIC MEDICATION SURVEY FORM

ID NUMBER: | | | | | | | | CONTACT YEAR: | 0 | 1 | FORM CODE: | M | S | R | VERSION: A 11/1/86

LAST NAME: | | | | | | | | | | | | | INITIALS: | | |

INSTRUCTIONS:

This form should be completed in three stages. Section A should be completed at the Reception station. The transcription portion of Section B should be completed while the participant proceeds with the visit. The interview portion of Section B, as well as Sections C & D, should then be completed during the physical exam. The paper form is to be used for data collection and keyed into the data entry system as soon as possible following its completion. ID Number 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 zeroes where necessary to fill all boxes. If a number is entered incorrectly, 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.

A. RECEPTION

1. Did you bring the containers of all medications you used in the past two weeks? ..... Yes, all Y
   Some of them S
   No N

If "Yes, all", go to Section B and begin transcription while participant proceeds with clinic visit.
If "Some of them", go to Item 3; transcribe those medications which were brought at this time.

2. Is this because you forgot, because you have not taken any medications at all in the last two weeks, or because you could not bring your medications? ..... Took no medications T

Go to Item 9, Page 4

Forgot or was unable to bring medications F

"That's all right. Since the information on medications is so important we would still like to ask you about it during the interview."

3. Could we follow up on this after the visit so that we can get the information from the (other) medication labels? (Explain follow-up options.) ..... Yes Y
   No or not applicable N

(Attempt to convert refusals; indicate on Itinerary Form)

Describe method of follow-up to be used: _____

MEDICATION SURVEY FORM (MSRA page 2 of 4)

B. MEDICATION RECORDS

I. Transcription (Copy the NAME followed by the CONCENTRATION of each medication in the spaces below. Continue on second line if needed.):

II. Interview (For each medication, circle the appropriate response to the following questions.):

4. RECORD NUMBER	a. MEDICATION NAME & CONCENTRATION	b. CODE NO.	c. "Was this medication prescribed for you, over-the-counter, or shared?" RX (R)/ OTC (O)/ SHARED (S)/ UNKNOWN (U)	d. "Did you take this medication in the past 24 hours?" YES (Y)/ NO (N)/ UNKNOWN (U)
M1.			R O S U	Y N U
M2.			R O S U	Y N U
M3.			R O S U	Y N U
M4.			R O S U	Y N U
M5.			R O S U	Y N U
M6.			R O S U	Y N U
M7.			R O S U	Y N U
M8.			R O S U	Y N U
M9.			R O S U	Y N U
M10.			R O S U	Y N U
M11.			R O S U	Y N U

MEDICATION SURVEY FORM (MSRA page 3 of 4)

B. MEDICATION RECORDS (continued)

I. Transcription (Copy the NAME followed by the CONCENTRATION of each medication in the spaces below. Continue on second line if needed.):

II. Interview (For each medication, circle the appropriate response to the following questions.):

4. RECORD NUMBER	a. MEDICATION NAME & CONCENTRATION	b. CODE NO.	c. "Was this medication prescribed for you, over-the-counter, or shared?" RX (R)/ OTC (O)/ SHARED (S)/ UNKNOWN (U)	d. "Did you take this medication in the past 24 hours?" YES (Y)/ NO (N)/ UNKNOWN (U)
M12.			R O S U	Y N U
M13.			R O S U	Y N U
M14.			R O S U	Y N U
M15.			R O S U	Y N U
M16.			R O S U	Y N U
M17.			R O S U	Y N U

5. Total number of medications in bag: ..... [ ][ ]

6. Number of medications unable to transcribe: ..... [ ][ ]

7. Transcriber Code Number: ..... [ ][ ][ ]

MEDICATION SURVEY FORM (MSRA page 4 of 4)

C. INTERVIEW

"Now I would like to ask about a few specific medications."

8. Were any of the medications you took during the past two weeks for:
{If "Yes", verify that medication name is on medication record.}

	Yes	No	Unknown
a. High Blood Pressure	Y	N	U
b. Angina or Chest Pain	Y	N	U
c. Control of Heart Rhythm	Y	N	U
d. Heart Failure	Y	N	U
e. Blood Thinning	Y	N	U
f. Diabetes or High Blood Sugar	Y	N	U
g. Stroke	Y	N	U
h. Leg pain when walking	Y	N	U

9. During the past two weeks, did you take any Aspirin, Alka-Seltzer, a cold medicine, or a headache powder? ..... Yes Y
No N
Unknown U

10. During the past two weeks, did you take any [other] medication for arthritis, fever, or muscle aches and pains, (or menstrual cramps)? ..... Yes Y
No N
Unknown U

{Read bracketed "other" unless no meds were reported; include parenthetical portion for females only.}

D. ADMINISTRATIVE INFORMATION

11. Date of medications interview: ..... [ ][ ] - [ ][ ] - [ ][ ]
Month Day Year

12. Interviewer Code Number: ..... [ ][ ][ ]

VERSION A 11/1/86

MEDICATION SURVEY FORM INSTRUCTIONS

I. GENERAL INSTRUCTIONS

The purpose of this component of the ARIC baseline examination is to assess medication usage in the two weeks preceding the examination date. Both prescription and non-prescription drugs are ascertained. To obtain this information the participant is asked during the home interview to bring to the field center all medications taken in the two-week period prior to the baseline examination.

The interviewer and transcriber should be familiar with and understand the document titled "General Instructions For Completing Paper Forms" prior to completing this form. ID Number, Contact Year, and Name should be completed as described in that document.

If the paper form is used for data collection, the header information of the Medication Survey Form should be completed prior to the arrival of the participant at the field center and the information keyed into the data entry system as soon as possible following its completion.

II. DETAILED INSTRUCTIONS FOR EACH ITEM

A. Reception

1. **Did you bring the containers of all medications you used in the past two weeks? ..... Yes, all Y**

Some of them S

No N

If "Yes, all", go to Section B and begin transcription. This can take place while participant proceeds with clinic visit. As the participant delivers the medications, indicate that they will be returned at this same station before he/she leaves. Mention that medication names will be copied from the labels, and that if required, medications will be taken out their container only in the presence of, and with approval of the participant. Finally, indicate that the Nurse or P.A. may later ask a few questions about each medication. Verify that the medications bag is clearly identified with the participant's name. Do not open the medications bag or transcribe medications until the participant has signed the informed consent.

If "Some of them", go to Item 3 to make arrangements for those medications which were not brought; transcribe those medications which were brought at this time.

If the participant has not brought any medications, question 2 is asked:

2. Is this because you forgot, because you have not taken any medications at all in the last two weeks, or because you could not bring your medications? ... Took no medications T

Go to Item 9, Page 4	Forgot or was unable to bring medications F

If the participant took no medications in the past two weeks, Section A ends here. Return the form to the participant's folder. In such cases, the interview portion of the form begins with item 9.

Question 3 is asked if the participant did take some medications in the past two weeks, but did not bring them to the field center (or only brought some of them):

"That's all right. Since the information on medications is so important we would still like to ask you about it during the interview."

3. Could we follow up on this after the visit so that we can get the information from the (other) medication labels? {Explain follow-up options.} ..... Yes Y

No or not applicable N

If the participant agrees to follow-up, arrangements are made for obtaining the information over the telephone or through a visit by a field interviewer. Describe the method of follow-up after item 3 on the form. If the participant did bring some of his/her medications, complete as much of the form as possible using them at this time.

In case of deliberate omission to bring medications to the field center, this is indicated on the Itinerary Sheet and conversion is attempted at a later stage during the medical review of results with the participant. Even if the participant refuses to cooperate, attempt to complete as much of the form as possible, especially items 8 through 10.

B. Medication Transcription

Open the medications carrier and remove all medications, prescriptions, and containers. Complete the transcription section, copying each medication name found on containers, prescriptions, or lists. Transcribe medication names in full (block letters if using the paper form). Include all parts of the medication name as well as numbers and/or letters that identify the strength. Copy the name first, followed by the concentration or strength of the medication, if a single concentration is listed. Examples: Chlor-Trimethon 12 mg; Teldrin 8mg; Ascorbic Acid 250 mg; Nostril 1/2%; Anacin Maximum Strength. Copy also any numbers and codes that appear to follow, or be part of the name. Examples: Anacin-3; Acerola C (100 mg); Triaminic-12; Ovral-28; Ortho-Novum 10/11-28; Stuartnatal 1 + 1; Iletin I NPH; S-K Ampicillin; Caltrate 600 + Vitamin D. If in doubt, it is preferable to add information that may be significant and help later in identifying (and coding) a medication.

Do not record information in the interview section at this time.

Example:

I. Transcription (Copy the NAME followed by the CONCENTRATION of each medication in the spaces below. Continue on second line if needed.):

II. Interview (For each medication, circle the appropriate response to the following questions.):

4. RECORD NUMBER	a. MEDICATION NAME & CONCENTRATION	b. CODE NO.	c. "Was this medication prescribed for you, over-the-counter, or shared?" RX (R)/ OTC (O)/ SHARED (S)/ UNKNOWN (U)	d. "Did you take this medication in the past 24 hours?" YES (Y)/ NO (N)/ UNKNOWN (U)
M1.	_____ _____	[ ][ ][ ][ ][ ][ ]	R O S U	Y N U
M2.	_____ _____	[ ][ ][ ][ ][ ][ ]	R O S U	Y N U

When listing medications, record prescription medications first; then aspirin, aspirin-containing medications, and anti-inflammatory preparations (aspirin, Alka-Seltzer, headache powders, cold medicine, medication for arthritis); then list over-the-counter preparations; list vitamins and food supplements last.

Once all names are transcribed, count the total number of different medications (including those which could not be transcribed) and enter this number in item 5. Set aside any containers which have no clear label or identification, as well as medications without containers. Names should be left blank on the form for these medications. Add the number of these medications which you were unable to transcribe, and enter this number in item 6. For example, if there were 7 medications in the bag, and you were able to transcribe 5 of them, items 5 and 6 would be completed as follows:

5. Total number of medications in bag: ..... [ ][ ]

6. Number of medications unable to transcribe: ..... [ ][ ]

Open containers to examine medications only in the presence of the participant. If necessary, make a note on the form, and let the participant know that the Nurse/P.A. will identify these medications with the participant. Enter your ARIC code number in item 7, return the medications into the medications bag, attach the MSR form to the bag, and proceed to the medication survey, or take them to the station identified for the medication survey. At no time should the medications be left unattended at the Reception area.

C. Interview

To begin the medications survey, retrieve the appropriate bag and form, verifying the participant's name. Place all medications from the bag on the desk or counter so that the participant can see each one.

Take each medication, one at a time, and verify its name and concentration transcribed on the form. Correct discrepancies following the procedure for all paper forms. Next, show the medication to the participant and ask the two questions to the right of the transcribed medication names:

c. Was this medication prescribed for you, over-the-counter, or shared?

For the purposes of this study, a prescription medicine is one for which the participant has received from his or her physician a prescription that is filled by a pharmacist. An over-the-counter medication is one that may be purchased without a prescription from a physician. Physicians sometimes do write prescriptions for over-the-counter medicines. For example, the participant may take one aspirin a day. If the physician wrote a prescription for the aspirin, then it counts as a prescription medicine. If the physician recommended the use of an over-the-counter medicine such as aspirin but did not write a prescription for it, then the aspirin does not count as a prescription medication.

d. Did you take this medication in the past 24 hours?

The first question (c.) is intended to clarify whether the medication was a perscription written specifically for the participant (RX), which may be obvious from the container or a prescription, a prescription written for another individual (SHARED), or a product purchased over the counter (OTC). If this cannot be determined from the container or the participant, mark the "unknown" response (UNKNOWN). Be sure to ask the participant if a product was prescribed. Even if it is normally an OTC product, or not labelled as prescription, it may have been prescribed. If the participant has indicated s/he took no medications, or only such products as vitamins, it is permissible to preface the question with an explanation. "I know you said you took no medications, but we use these questions as a memory jogger."

The second question (d.) is self-explanatory. To assist the participant in remembering, one may state the question specifying a time on the previous day. For example, "Have you taken this medication since 10:00 AM yesterday?"

Example:

I. Transcription (Copy the NAME followed by the CONCENTRATION of each medication in the spaces below. Continue on second line if needed.):

II. Interview (For each medication, circle the appropriate response to the following questions.):

c. "Was this medication prescribed for you, over-the-counter, or shared?"

d. "Did you take this medication in the past 24 hours?"

4. RECORD NUMBER	a. MEDICATION NAME & CONCENTRATION	b. CODE NO.	RX (R)/ OTC (O)/ SHARED (S)/ UNKNOWN (U)	YES (Y)/ NO (N)/ UNKNOWN (U)
M1.	_____ _____	| | | | | | |	R O S U	Y N U

Repeat this process (verify name, ask the questions) for all medications. Determine from item 6 at the end of the medication transcription page whether there were any medications in the bag for which the transcriber was unable to transcribe a name. These may include unmarked containers, loose pills, and containers with more than one medication. Ask the participant to open any unmarked containers, and to handle loose pills. With the participant's help and using a PDR, attempt to identify these medications. If possible, enter the names and concentrations, and ask the two questions as above. If no unequivocal identification is possible, write UNKNOWN for the medication name and draw two horizontal lines through the boxes for the medication code number. If additional meds can be transcribed, adjust the total for item 6, "number of medications unable to transcribe" accordingly. After this has been completed for all containers, prescriptions, and medications in the bag, probe the participant on whether all medications taken in the previous two weeks are included. For any additional medications recalled by the participant, record the names and answer the questions with as much detail as possible. If there is any doubt, arrange for a phone call during which the participant can provide accurate information.

Often during an interview, the participant will recall other medications or vitamins s/he took during the past two weeks. These should be added to the list at this time, just as if they had been in the bag. The prescription or OTC nature, and whether they were used in the previous 24 hours are then recorded. However, the number of medications in the bag is not changed at this time, to alert us to the fact that the participant has provided these names from memory and ARIC staff have not transcribed these names from a written record.
Item 8 is to be asked of anyone who took any medications during the past two weeks, regardless of whether or not they were brought to the clinic. In addition to the listing of individual medication names, we want to know why people may be taking medications. Ask if medications were taken in the past two weeks for the eight listed reasons. If answered affirmatively, be sure that the

name was listed, but it is not necessary to indicate which medication corresponds to which reason. Acceptable synonyms are given below:

a. High Blood Pressure = hypertension
b. Angina or Chest Pain = heart pains
c. Control of Heart Rhythm = medicine for fast or irregular heart rate or heartbeats
d. Heart Failure = congestive heart failure, not heart attack
e. Blood Thinning = anticoagulation
h. Leg pain when walking = claudication

For example, if the participant had taken medication for high blood pressure and claudication, record as follows:

8. Were any of the medications you took during the past two weeks for:
{If "Yes", verify that medication name is on medication record.}

	Yes	No	Unknown
a. High Blood Pressure	Y	N	U
b. Angina or Chest Pain	Y	N	U
c. Control of Heart Rhythm	Y	N	U
d. Heart Failure	Y	N	U
e. Blood Thinning	Y	N	U
f. Diabetes or High Blood Sugar	Y	N	U
g. Stroke	Y	N	U
h. Leg pain when walking	Y	N	U

Items 9 and 10 are to be asked of all participants, regardless of whether they reported taking any medications during the past two weeks. The same preamble to question 8 about "jogging the memory" may also be used before questions 9 and/or 10: "I know you said you took no medications, but we use these questions as a memory jogger."

9. During the past two weeks, did you take any Aspirin, Alka-Seltzer, a cold medicine, or a headache powder? ..... Yes Y
No N
Unknown U

In item 9, we ask about aspirin or aspirin containing medications because these may affect some of the hemostasis tests. Again, confirm whether the names are on the medication record.

10. During the past two weeks, did you take any [other] medication for arthritis, fever, or muscle aches and pains, (or menstrual cramps)? ..... Yes Y

{Read bracketed "other" unless no meds were reported; include parenthetical portion for females only.}

No N

Unknown U

In item 10, we ask about analgesic and anti-inflammatory medications that are not aspirin-based, because they also affect the hemostasis tests. Confirm whether the names are on the medication list. Follow the instructions provided after the question.

Review the form for completeness, and place your code in the spaces provided in item 12. Secure all medications in the bag and explain to the participant that he/she should pick it up from the Receptionist before leaving. Place the form in the participant's folder, and escort the participant to the next station. Return the medications bag to a secure place at the Reception work station.

Medication Coding at the Field Center

Each medication name is coded by trained field center personnel. This may be done after the participant has left. A (hard copy) translation dictionary is used at the field center, or matching software if done at the Coordinating Center. Only exact matches and specific spelling variants listed in the dictionary are coded, by entering the corresponding numeric code in the boxes provided on the form.

O.M.B. 0925-0281
exp. 7-31-89

A-135

ARIC MEDICAL HISTORY FORM

ID NUMBER: | | | | | | | | CONTACT YEAR: | 0 | 1 | FORM CODE: | M | H | X | VERSION: A 11/1/86

LAST NAME: | | | | | | | | | | | | | INITIALS: | | |

INSTRUCTIONS:
This form should be completed during the interview portion of the participant's visit. ID Number 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 zeroes where necessary to fill all boxes. If a number is entered incorrectly, 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.

MEDICAL HISTORY FORM (MHXA screen 1 of 10)

A. MEDICAL CARE

1. How long has it been since you last saw a doctor for any reason?

		Years,			Months

2. How often do you have a routine physical examination, that is, not for a particular illness, but for a general check-up? .....

{Read choices slowly}

At least once a year	Y
At least once every five years	F
Less than once every five years	L
Do not have routine physical examinations	N
Unknown	U

3. Do you have health insurance, such as Medicare, or a medical plan, such as an HMO, which pays part of a hospital, doctor's, or surgeon's bill? ..... Yes Y

No N

Unknown U

MEDICAL HISTORY FORM (MHXA screen 2 of 10)

B. CHEST PAIN ON EFFORT

4. Have you ever had any pain or discomfort in your chest? ..... Yes Y

No N

Go to Item 28, Screen 6

5. Do you get it when you walk uphill or hurry? ..... Yes Y

Go to Item 25, Screen 6 — No N

Never hurries or walks uphill H

6. Do you get it when you walk at an ordinary pace on the level? ..... Yes Y

No N

7. What do you do if you get it it while you are walking? ... Stop or slow down S

Carry on C

{Record "Stop or slow down" if subject carries on after taking nitroglycerin}

Go to Item 25, Screen 6

8. If you stand still, what happens to it? ..... Relieved R

Not relieved N

Go to Item 25, Screen 6

MEDICAL HISTORY FORM (MHXA screen 3 of 10)

9. How soon? ..... 10 minutes or less L

More than 10 minutes M

Go to Item 25, Screen 6

10. Will you show me where it was? {Circle Y or N for all areas}

	Yes	No
a. Sternum (upper or middle)	Y	N
b. Sternum (lower)	Y	N
c. Left anterior chest	Y	N
d. Left arm	Y	N
e. Other	Y	N
f. Specify:		

11. Do you feel it anywhere else? ..... Yes Y

{If "Yes", record above}

No N

12. Did you see a doctor because of this pain or discomfort? ..... Yes Y

No N

Go to Item 14, Screen 4

13. What did he say it was? ... Angina A

Heart Attack H

Other Heart Disease D

Other O

MEDICAL HISTORY FORM (MHXA screen 4 of 10)

14. Have you been hospitalized because of this pain? ..... Yes Y
No N

15. How long ago did you start getting this pain?

Within the past: ..... 1 month A
6 months B
1 year C
2 years D
Over 2 years ago E

"The next 3 questions on chest pain refer to 3 aspects: how often it occurs, how severe it is, and how long it lasts."

16. Within the past 2 months, has your chest discomfort occurred more often? ... Yes Y
No N

Go to Item 18

17. Has it occurred at least twice as often as before? ..... Yes Y
No N

18. Within the past 2 months, has the pain become more severe? ..... Yes Y
No N

MEDICAL HISTORY FORM (MHXA screen 5 of 10)

19. Within the past 2 months, has the pain lasted longer when it occurs? ..... Yes Y
No N

20. Do you ever use nitroglycerin to relieve the pain? ..... Yes Y
No N

Go to Item 22

21. Within the past 2 months, has the pain required more nitroglycerin to relieve it? ..... Yes Y
No N

22. Within the past 2 months, have you started getting the pain with less exertion? ..... Yes Y
No N

23. Within the past 2 months, have you started getting the pain when sitting still? ..... Yes Y
No N

24. Within the past 2 months, have you started getting the pain when sleeping? ..... Yes Y
No N

MEDICAL HISTORY FORM (MHXA screen 6 of 10)

C. POSSIBLE INFARCTION

25. Have you ever had a severe pain across the front of your chest lasting for half an hour or more? ..... Yes Y

No N

Go to Item 28

26. Did you see a doctor because of this pain? ..... Yes Y

No N

Go to Item 28

27. What did he say it was? ..... Heart Attack H

Other Disorder O

Go to Item 29

28. Have you ever had a heart attack for which you were hospitalized one week or more? ..... Yes Y

No N

Unknown U

Go to Item 31, Screen 7

29. How many such heart attacks have you had? .... ☐

30. How old were you when you had your (first) heart attack? ..... ☐☐

MEDICAL HISTORY FORM (MHXA screen 7 of 10)

31. Have you ever had a test in which you were asked to exercise while an electrocardiogram was taken? ..... Yes Y

No N

Go to Item 33

32. Were you told that the results were normal or abnormal? ..... Normal N

Abnormal A

Unknown U

D. INTERMITTENT CLAUDICATION

33. Do you get pain in either leg on walking? ..... Yes Y

No N

Go to Item 43, Screen 9

34. Does this pain ever begin when you are standing still or sitting? ..... Yes Y

No N

Go to Item 42, Screen 9

MEDICAL HISTORY FORM (MHXA screen 8 of 10)

35. In what part of your leg do you feel it? .....
{If calves not mentioned, ask: Anywhere else?}

Pain includes calf/calves C

Pain does not include calf/calves N

Go to Item 42, Screen 9

36. Do you get it if you walk uphill or hurry? ..... Yes Y

Go to Item 42, Screen 9 — No N

Never hurries or walks uphill H

37. Do you get it if you walk at an ordinary pace on the level? ..... Yes Y

No N

38. Does the pain ever disappear while you are walking? ..... Yes Y

Go to Item 42, Screen 9

No N

39. What do you do if you get it when you are walking? ... Stop or slow down S

Carry on C

Go to Item 42, Screen 9

MEDICAL HISTORY FORM (MHXA screen 9 of 10)

40. What happens to it if you stand still? ..... Relieved R

Not relieved N

Go to Item 42

41. How soon? ..... 10 minutes or less L

More than 10 minutes M

42. Were you hospitalized for this problem in your legs? ..... Yes Y

No N

E. CONGESTIVE HEART FAILURE

43. Have you ever had to sleep on 2 or more pillows to help you breathe? ..... Yes Y

No N

44. Have you ever been awakened at night by trouble breathing? ..... Yes Y

No N

45. Have you ever had swelling of your feet or ankles (excluding during pregnancy)? ..... Yes Y

{Include parenthetical comment for females only} No N

Go to Item 47 Screen 10

MEDICAL HISTORY FORM (MHXA screen 10 of 10)

46. Did it tend to come on during the day and go down overnight? ..... Yes Y

No N

F. VASECTOMY

47. {Sex of participant}: ..... Male M

Female F

Go to Item 50

48. Have you had a vasectomy (sperm tubes tied)? ..... Yes Y

No N

Go to Item 50

49. At approximately what age did you have this operation? ..... ☐☐

G. ADMINISTRATIVE INFORMATION

50. Date of data collection: ... ☐☐ - ☐☐ - ☐☐

Month Day Year

51. Method of data collection: ..... Computer C

Paper Form P

52. Code number of person completing this form: ... ☐☐☐

VERSION A 11/1/86

MEDICAL HISTORY FORM INSTRUCTIONS

I. GENERAL INSTRUCTIONS

The Medical History Form should be completed during the interview portion of the participant's clinic visit. The interviewer must be certified and should be familiar with and understand the document titled "General Instructions For Completing Paper Forms" prior to completing this form. ID Number, Contact Year, and Name should be completed as described in that document.

The first section of the form provides information on the availability and utilization of medical care. It is also intended to serve as a lead-in for the health-related questions which follow.

The next three sections of the form have been largely adapted from the London School of Hygiene Cardiovascular Questionnaire. Section B deals with chest pain on effort, Section C with the severe and prolonged pain of possible myocardial infarction, and Section D with intermittent claudication. Additional questions have been inserted following the standard ones in sections B and C.

Other sections of the form provide information on congestive heart failure and (for males) vasectomy status.

Items on the form enclosed in braces are instructions to the interviewer, and should not be stated verbally during the interview.

The purpose of the questionnaire is to standardize the identification of each condition as defined. The questionnaire will fail to identify some subjects whose symptoms are regarded by the physician as genuine. It may categorize other cases as due to a quite different cause. Any special effort, however, to alter the conduct of the interview in such instances would destroy the basic purpose of the questionnaire technique, which is to insure uniformity in the eliciting of defined symptoms. Interviewers' comments may be recorded separately, but should not appear in the spaces provided for recording answers.

Questions must be put to the subject exactly as they are printed; small changes may make unexpectedly large differences in responses. Unequivocal answers must be recorded as such, whether they seem reasonable or not. Probing questions should rarely be needed. When they have to be asked, they should depart as little as possible from the wording of the initial question, and must not be such as to suggest any one particular answer to the subject.

If serious doubt arises about the correct interpretation of a particular answer, it should be recorded in such a way as to exclude the suspected condition -- e.g., "Do you get it when you walk uphill or hurry?" "Well, I think I might, but I can't really remember." This answer should be recorded as "No". An exception should be made to this rule only if the subject gives an equivocal answer to the initial question -- e.g., "Have you ever had any pain or discomfort in your chest?" "No. Only indigestion." This answer should be recorded as "Yes". In other words, the subject's interpretation of his symptoms should be disregarded.

A. MEDICAL CARE

1. How long has it been since you last saw a doctor for any reason?

☐☐ Years, ☐☐ Months

2. How often do you have a routine physical examination, that is, not for a particular illness, but for a general check-up? .....

{Read choices slowly}

At least once a year	Y
At least once every five years	F
Less than once every five years	L
Do not have routine physical examinations	N
Unknown	U

3. Do you have health insurance, such as Medicare, or a medical plan, such as an HMO, which pays part of a hospital, doctor's, or surgeon's bill? ..... Yes Y

No N

Unknown U

B. CHEST PAIN ON EFFORT

4. Have you ever had any pain or discomfort in your chest? ..... Yes Y

No N

→ Go to Item 28, Screen 6

5. Do you get it when you walk uphill or hurry? ..... Yes Y

→ Go to Item 25, Screen 6 — No N

Never hurries or walks uphill H

6. Do you get it when you walk at an ordinary pace on the level? ..... Yes Y

No N

II. DETAILED INSTRUCTIONS FOR VARIOUS QUESTIONS

A. Medical Care

1. The question refers to any type of interaction, whether it be a general check-up or a specific problem. Family doctors, specialists, hospitals, and clinics all apply. Round off as necessary; if less than two weeks, record as zero years, zero months. Complete boxes for both years and months, even if one or the other is zero.

2. Choose the first response category that applies. If necessary, probe to determine whether the participant has routine examinations, but do not probe to determine the frequency.

3. The information is sought as of today; if enrollment is pending at the time of the interview, record "no" unless the participant says he/she is caught in a temporary lapse in coverage (not more than 90 days) due to a job change, etc.

If necessary, explain "HMO" as follows: "Health Maintenance Organization, a plan where you pay a set monthly fee and all hospital, doctor, and surgeon fees are covered. Usually you must use a particular hospital and group of doctors for your care."

If probing is necessary, (1) remind the participant that many people are covered by health insurance plans through their employer or their spouse's employer, or (2) ask if they might be carrying a health insurance or Medicare wallet card.

B. Chest Pain on Effort

4. If "No", circle "N" and skip to item 28, which is found on screen 6.

5. The answer must be interpreted strictly. If pain is experienced only during some other form of exertion (e.g., cycling, stairclimbing, lawn mowing), it must be recorded "No".

5-10. These questions refer to the usual characteristics of the pain or discomfort. Unequivocal answers need not be probed; but answers such as "occasionally" or "sometimes" should be probed by a question of the type: "Does this happen on most occasions?" Skip rules must be adhered to.

7. What do you do if you get it it while you are walking? ... Stop or slow down S

Carry on C

{Record "Stop or slow down" if subject carries on after taking nitroglycerin}

→ Go to Item 25, Screen 6

8. If you stand still, what happens to it? ..... Relieved R

Not relieved N

→ Go to Item 25, Screen 6

9. How soon? ..... 10 minutes or less L

More than 10 minutes M

→ Go to Item 25, Screen 6

10. Will you show me where it was? {Circle Y or N for all areas}

	Yes	No
a. Sternum (upper or middle)	Y	N
b. Sternum (lower)	Y	N
c. Left anterior chest	Y	N
d. Left arm	Y	N
e. Other	Y	N

f. Specify: | | | | | | | | | | |

11. Do you feel it anywhere else? ..... Yes Y

{If "Yes", record above}

No N

11. Record any additional areas in item 10.

12. Did you see a doctor because of this pain or discomfort? ..... Yes Y

No N

→ Go to Item 14, Screen 4

13. What did he say it was? ... Angina A
Heart Attack H
Other Heart Disease D
Other O

14. Have you been hospitalized because of this pain? ..... Yes Y
No N

15. How long ago did you start getting this pain?

Within the past: ..... 1 month A
6 months B
1 year C
2 years D
Over 2 years ago E

15. Indicate the shortest applicable time interval, but not one which is less than the actual span of time. For example, "7 months ago" should be recorded as "within the past 1 year."

"The next 3 questions on chest pain refer to 3 aspects: how often it occurs, how severe it is, and how long it lasts."

16. Within the past 2 months, has your chest discomfort occurred more often? ... Yes Y
No N

Go to Item 18

16-24. All questions apply only to the past 2 months. Therefore, this phrase is repeated with each question (except items 17 and 20, for smoothness).

17. Has it occurred at least twice as often as before? ..... Yes Y
No N

18. Within the past 2 months, has the pain become more severe? ..... Yes Y
No N

19. Within the past 2 months, has the pain lasted longer when it occurs? ..... Yes Y
No N

20. Do you ever use nitroglycerin to relieve the pain? ..... Yes Y
No N

Go to Item 22

21. Within the past 2 months, has the pain required more nitroglycerin to relieve it? ..... Yes Y
No N

22. Within the past 2 months, have you started getting the pain with less exertion? ..... Yes Y
No N

23. Within the past 2 months, have you started getting the pain when sitting still? ..... Yes Y
No N

24. Within the past 2 months, have you started getting the pain when sleeping? ..... Yes Y
No N

C. POSSIBLE INFARCTION

25. Have you ever had a severe pain across the front of your chest lasting for half an hour or more? ..... Yes Y
No N

Go to Item 28

26. Did you see a doctor because of this pain? ..... Yes Y
No N

Go to Item 28

27. What did he say it was? ..... Heart Attack H
Other Disorder O

Go to Item 29

28. Have you ever had a heart attack for which you were hospitalized one week or more? ..... Yes Y
No N
Unknown U

Go to Item 31, Screen 7

29. How many such heart attacks have you had? .... ☐

30. How old were you when you had your (first) heart attack? ..... ☐☐

C. Possible Infarction

25-30. Ask questions exactly as printed. Skip rules must be observed for the questions to make sense.

29-30. Both questions refer only to heart attacks for which the participant was hospitalized one week or more (as stated in item 28). If not known, draw 2 horizontal lines through the box(es).

31. Have you ever had a test in which you were asked to exercise while an electrocardiogram was taken? ..... Yes Y

No N

Go to Item 33

32. Were you told that the results were normal or abnormal? ..... Normal N

Abnormal A

Unknown U

D. INTERMITTENT CLAUDICATION

33. Do you get pain in either leg on walking? ..... Yes Y

No N

Go to Item 43, Screen 9

34. Does this pain ever begin when you are standing still or sitting? ..... Yes Y

Go to Item 42, Screen 9

No N

35. In what part of your leg do you feel it? .....
{If calves not mentioned, ask: Anywhere else?}

Pain includes calf/calves C

Pain does not include calf/calves N

Go to Item 42, Screen 9

36. Do you get it if you walk uphill or hurry? ..... Yes Y

Go to Item 42, Screen 9

No N

Never hurries or walks uphill H

37. Do you get it if you walk at an ordinary pace on the level? ..... Yes Y

No N

38. Does the pain ever disappear while you are walking? ..... Yes Y

Go to Item 42, Screen 9

No N

31. The question refers to an exercise test; therefore, a resting ECG would not apply.

D. Intermittent Claudication

33-42. Ask questions exactly as they are printed; interpret answers strictly.

35-37,39-41. These questions refer to the usual characteristics of the pain or discomfort. Unequivocal answers need not be probed; but answers such as "occasionally" or "sometimes" should be probed by a question of the type: "Does this happen on most occasions?" Skip rules must be adhered to.

39. What do you do if you get it when you are walking? ... Stop or slow down S

Carry on C

Go to Item 42, Screen 9

40. What happens to it if you stand still? ..... Relieved R

Not relieved N

Go to Item 42

41. How soon? ..... 10 minutes or less L

More than 10 minutes M

42. Were you hospitalized for this problem in your legs? ..... Yes Y

No N

E. CONGESTIVE HEART FAILURE

43. Have you ever had to sleep on 2 or more pillows to help you breathe? ..... Yes Y

No N

44. Have you ever been awakened at night by trouble breathing? ..... Yes Y

No N

45. Have you ever had swelling of your feet or ankles (excluding during pregnancy)? ..... Yes Y

{Include parenthetical comment for females only} No N

Go to Item 47 Screen 10

46. Did it tend to come on during the day and go down overnight? ..... Yes Y

No N

E. Congestive Heart Failure

43-45. These questions are prefaced by the phrase, "Have you ever ...", thus it is not necessary that the condition be habitual.

45. For female participants only, include the phrase: "excluding during pregnancy."

46. The question refers to the swelling of feet or ankles established in question 45.

F. VASECTOMY

47. (Sex of participant): ..... Male M
Female F

Go to Item 50

48. Have you had a vasectomy (sperm tubes tied)? ..... Yes Y
No N

Go to Item 50

49. At approximately what age did you have this operation? ..... ☐☐

G. ADMINISTRATIVE INFORMATION

50. Date of data collection: ... ☐☐ - ☐☐ - ☐☐
Month Day Year

51. Method of data collection: ..... Computer C
Paper Form P

52. Code number of person completing this form: ... ☐☐☐

F. Vasectomy

47. Record the participant's sex. If the participant is female, skip to item 50.

48. The phrase, "sperm tubes tied", should only be used when an explanation of "vasectomy" is needed.

49. If not known, draw 2 horizontal lines through the boxes.

G. Administrative Information

50. Record the date on which the interview took place.

51. Record "C" if the form was completed on the computerized data entry system, or "P" if the paper form was used.

52. The person at the clinic who has performed the interview and completed the form must enter his/her code number in the boxes provided.

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A-149

ARIC RESPIRATORY SYMPTOMS/ PHYSICAL ACTIVITY FORM

ID NUMBER: | | | | | | | | CONTACT YEAR: | 0 | 1 | FORM CODE: | R | P | A | VERSION: A 11-01-86

LAST NAME: | | | | | | | | | | | | | INITIALS: | | |

INSTRUCTIONS:
This form should be completed during the participant's visit. 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 zeroes where necessary to fill all boxes. If a number is entered incorrectly, 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.

RESPIRATORY SYMPTOMS/PHYSICAL ACTIVITY FORM (RPAA screen 1 of 17)

"These questions pertain mainly to your chest."

A. COUGH

1. Do you usually have a cough?.....YES Y
   NO N
   [Count a cough with first smoke or on first going out-of-doors Exclude clearing throat.]

   Go to Item 3

2. Do you usually cough as much as 4 to 6 times a day, 4 or more days out of the week?.....YES Y
   NO N

3. Do you usually cough at all on getting up, or first thing in the morning?.....YES Y
   NO N

4. Do you usually cough at all during the rest of the day or at night?.....YES Y
   NO N

If any of questions 1, 3, and 4 are answered "Yes" answer questions 5 and 6, if not, go to item 7

PESPIRATORY SYMPTOMS/PHYSICAL ACTIVITY FORM (RPAA screen 2 of 17)

5. Do you usually cough like this on most days for 3 consecutive months or more during the year?.....YES Y

NO N

6. For how many years have you had this cough?..... ☐☐

B. PHLEGM

7. Do you usually bring up phlegm from your chest?.....YES Y

[Count phlegm with the first smoke or on first going out-of-doors. Exclude phlegm from the nose. Count swallowed phlegm.] NO N

Go to Item 9 Screen 3

8. Do you usually bring up phlegm like this as much as twice a day, 4 or more days out of the week?.....YES Y

NO N

PESPIRATORY SYMPTOMS/PHYSICAL ACTIVITY FORM (RPAA screen 3 of 17)

9. Do you usually bring up phlegm at all on getting up, or first thing in the morning?.....YES Y

NO N

10. Do you usually bring up phlegm at all during the rest of the day or at night?.....YES Y

NO N

If any of questions 7, 9, and 10 are answered "Yes", answer questions 11 and 12, if not, go to item 13

11. Do you bring up phlegm like this on most days for 3 consecutive months or more during the year?.....YES Y

NO N

12. For how many years have you had trouble with phlegm?..... ☐☐

C. WHEEZING

13. Does your chest ever sound wheezy or whistling when you have a cold?.....YES Y

NO N

RESPIRATORY SYMPTOMS/PHYSICAL ACTIVITY FORM (RPAA screen 4 of 17)

14. Does your chest ever sound wheezy or whistling apart from colds?.....YES Y
NO N

If either question 13 or 14 are answered "Yes", answer questions 15 and 16, if not, go to item 17

15. Does your chest sound wheezy or whistling most days or nights?.....YES Y
NO N

16. For how many years has this wheezy or whistling sound been present?..... ☐☐

17. Have you ever had an attack of wheezing that has made you feel short of breath?.....YES Y
NO N

Go to Item 21 Screen 5

18. How old were you when you had your first such attack?..... ☐☐

19. Have you had 2 or more such episodes?.....YES Y
NO N

20. Have you ever required medicine or treatment for the(se) attack(s)?.....YES Y
NO N

RESPIRATORY SYMPTOMS/PHYSICAL ACTIVITY FORM (RPAA screen 5 of 17)

D. BREATHLESSNESS

21. Are you disabled from walking by any condition other than heart or lung disease?.....YES Y

Go to Item 27 Screen 6

NO N

22. Are you troubled by shortness of breath when hurrying on the level or walking up a slight hill?.....YES Y
NO N

Go to Item 27 Screen 6

23. Do you have to walk slower than people of your age on the level because of breathlessness?.....YES Y
NO N

24. Do you ever have to stop for breath when walking at your own pace on the level?.....YES Y
NO N

RESPIRATORY SYMPTOMS/PHYSICAL ACTIVITY FORM (RPAA screen 6 of 17)

25. Do you ever have to stop for breath after walking about 100 yards (or after a few minutes) on the level?.....YES Y
NO N

26. Are you too breathless to leave the house or breathless on dressing or undressing?.....YES Y
NO N

E. BRONCHITIS

27. Have you ever had chronic bronchitis?.....YES Y
NO N

Go to Item 31

28. Do you still have it?.....YES Y
NO N

29. Was it confirmed by a doctor?.....YES Y
NO N

30. At what age did it start?.....

F. EMPHYSEMA

31. Have you ever had emphysema?.....YES Y
NO N

Go to Item 35 Screen 7

32. Do you still have it?.....YES Y
NO N

RESPIRATORY SYMPTOMS/PHYSICAL ACTIVITY FORM (RPAA screen 7 of 17)

33. Was it confirmed by a doctor?.....YES Y
NO N

34. At what age did it start?.....

G. ASTHMA

35. Have you ever had asthma?.....YES Y
NO N

Go to Section H

36. Was it confirmed by a doctor?.....YES Y
NO N

37. At what age did it start?.....

38. Do you still have it?.....YES Y

Go to Section H

NO N

39. At what age did it stop?.....

H. WORK ACTIVITY

"Now I'm going to ask you some questions about your physical activity. We are interested in your physical activity during the past year. I'll begin by asking about your activity level at work."

PESPIRATORY SYMPTOMS/PHYSICAL ACTIVITY FORM (RPAA screen 8 of 17)

40. At work do you sit:.....Never N
[rc 1]
SeLdom L
SoMetimes M
Often O
Always A
Does not work D

Go to Item 47
Screen 9

41. At work do you stand:.....Never N
[rc 1]
SeLdom L
SoMetimes M
Often O
Always A

42. At work do you walk:.....Never N
[rc 1]
SeLdom L
SoMetimes M
Often O
Always A

43. At work do you lift heavy loads:.....Never N
[rc 2]
SeLdom L
SoMetimes M
Often O
Very Often V

PESPIRATORY SYMPTOMS/PHYSICAL ACTIVITY FORM (RPAA screen 9 of 17)

44. After working are you physically tired:.....Never N
[rc 2]
SeLdom L
SoMetimes M
Often O
Very Often V

45. At work do you sweat:.....Never N
[rc 2]
SeLdom L
SoMetimes M
Often O
Very Often V

46. In comparison with others of your own age do you think your work is physically:.....Much lighter A
[rc 3]
Lighter B
As heavy C
Heavier D
Much heavier E

I. SPORTS

47. Do you exercise or play sports?.....YES Y
NO N

Go to Item 65
Screen 14

RESPIRATORY SYMPTOMS/PHYSICAL ACTIVITY FORM (RPAA screen 10 of 17)

48. Which sport or exercise do you do most frequently:..... [ ][ ][ ]

[Do not show card]

If the activity is coded enter code and go to item 49, if not coded enter 499 and specify the activity below.

a. [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

49. How many hours a week do you do this activity?... [rc 5]

Less than 1	A
At least 1 but not quite 2	B
At least 2 but not quite 3	C
At least 3 but not quite 4	D
4 or more	E

50. How many months a year do you do this activity?... [rc 6]

Less than 1	A
At least 1 but not quite 4	B
At least 4 but not quite 7	C
At least 7 but not quite 10	D
10 or more	E

51. Do you do other exercises or play other sports?.....YES Y

NO N

Go to Item 64 Screen 14

RESPIRATORY SYMPTOMS/PHYSICAL ACTIVITY FORM (RPAA screen 11 of 17)

52. What is your second most frequent sport or exercise:..... [ ][ ][ ]

[Do not show card]

If the activity is coded enter code and go to item 53, if not coded enter 499 and specify the activity below.

a. [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

53. How many hours a week do you do this activity?... [rc 5]

Less than 1	A
At least 1 but not quite 2	B
At least 2 but not quite 3	C
At least 3 but not quite 4	D
4 or more	E

54. How many months a year do you do this activity?... [rc 6]

Less than 1	A
At least 1 but not quite 4	B
At least 4 but not quite 7	C
At least 7 but not quite 10	D
10 or more	E

55. Do you do other exercises or play other sports?.....YES Y

NO N

Go to Item 64 Screen 14

RESPIRATORY SYMPTOMS/PHYSICAL ACTIVITY FORM (RPAA screen 12 of 17)

56. What is your third most frequent sport or exercise:..... [ ][ ][ ]

[Do not show card]

If the activity is coded enter code and go to item 57, if not coded enter 499 and specify the activity below.

a. [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

57. How many hours a week do you do this activity?... [rc 5]

Less than 1	A
At least 1 but not quite 2	B
At least 2 but not quite 3	C
At least 3 but not quite 4	D
4 or more	E

58. How many months a year do you do this activity?... [rc 6]

Less than 1	A
At least 1 but not quite 4	B
At least 4 but not quite 7	C
At least 7 but not quite 10	D
10 or more	E

59. Do you do other exercises or play other sports?.....YES Y

NO N

Go to Item 64 Screen 14

RESPIRATORY SYMPTOMS/PHYSICAL ACTIVITY FORM (RPAA screen 13 of 17)

60. What is your fourth most frequent sport or exercise:..... [ ][ ][ ]

[Do not show card]

If the activity is coded enter code and go to item 61, if not coded enter 499 and specify the activity below.

a. [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

61. How many hours a week do you do this activity?... [rc 5]

Less than 1	A
At least 1 but not quite 2	B
At least 2 but not quite 3	C
At least 3 but not quite 4	D
4 or more	E

62. How many months a year do you do this activity?... [rc 6]

Less than 1	A
At least 1 but not quite 4	B
At least 4 but not quite 7	C
At least 7 but not quite 10	D
10 or more	E

63. Do you do other exercises or play other sports?.....YES Y

NO N

RESPIRATORY SYMPTOMS/PHYSICAL ACTIVITY FORM (RPAA screen 14 of 17)

J. LEISURE TIME

64. During leisure time would you say you play sports or exercise:..... [rc 2]

Never	N
SeLdom	L
SoMetimes	M
Often	O
Very Often	V

65. In comparison with others of your own age do you think your physical activity during leisure time is:..... [rc 7]

Much less	A
Less	B
The same	C
More	D
Much more	E

RESPIRATORY SYMPTOMS/PHYSICAL ACTIVITY FORM (RPAA screen 15 of 17)

66. During leisure time do you sweat:..... [rc 2]

Never	N
SeLdom	L
SoMetimes	M
Often	O
Very Often	V

67. During leisure time do you watch television:..... [rc 2]

Never	N
SeLdom	L
SoMetimes	M
Often	O
Very Often	V

68. During leisure time do you walk:..... [rc 2]

Never	N
SeLdom	L
SoMetimes	M
Often	O
Very Often	V

RESPIRATORY SYMPTOMS/PHYSICAL ACTIVITY FORM (RPAA screen 16 of 17)

69. During leisure time do you bicycle..... [rc 2]

Never	N
SeLdom	L
SoMetimes	M
Often	O
Very Often	V

K. OTHER ACTIVITIES

70. How many minutes do you walk and/or bicycle per day to and from work or shopping?... [If seasonal, give average over the past year] [rc 8]

Less than 5	A
At least 5 but not quite 15	B
At least 15 but not quite 30	C
At least 30 but not quite 45	D
45 or more	E

RESPIRATORY SYMPTOMS/PHYSICAL ACTIVITY FORM (RPAA screen 17 of 17)

71. Have you done any heavy physical activity within the last 12 hours?.....YES Y

NO N

Go to Item 72

a. How long ago did you complete it?

☐☐ hours, ☐☐ minutes

72. How many flights of stairs do you climb up each day?...
[One flight equals 10 steps]

☐☐ flights per day

L. ADMINISTRATIVE INFORMATION

73. Date of data collection:..... ☐☐ - ☐☐ - ☐☐
month day year

74. Method of data collection:.....Computer C

Paper form P

75. Code number of person completing this form:..... ☐☐☐

RESPIRATORY SYMPTOMS/PHYSICAL ACTIVITY FORM INSTRUCTIONS

11-01-

"These questions pertain mainly to your chest."

A. COUGH

1. Do you usually have a cough?.....YES Y

   [Count a cough with first smoke or on first going out-of-doors Exclude clearing throat.] NO N

   Go to Item 3

2. Do you usually cough as much as 4 to 6 times a day, 4 or more days out of the week?.....YES Y

   NO N

3. Do you usually cough at all on getting up, or first thing in the morning?.....YES Y

   NO N

4. Do you usually cough at all during the rest of the day or at night?.....YES Y

   NO N

If any of questions 1, 3, and 4 are answered "Yes" answer questions 5 and 6, if not, go to item 7

I. GENERAL INSTRUCTIONS

The Respiratory Symptoms/Physical Activity Form should be completed during the interview portion of the participant clinic visit. The interviewer must be certified and shoul be familiar with and understand the document titled "General Instructions For Completing Paper Forms" prior t completing this form. ID Number, Contact Year, and Name should be completed as described in that document. Items on the form enclosed in brackets are instructions to the interviewer, and should not be stated verbally during the interview. Items in double quotes are to be read aloud. Skip rules are enclosed in boxes. When after a brief explanation doubt remains as to whether the answer should be "Yes" or "No", the answer should be recorded as "No".

The Respiratory Symptoms portion of the questionnaire has been adapted from the Epidemiology Standardizatin Project and the detailed instructions below are taken directly fr that source. Questions must be put to the subject exactly as they are printed; small changes may make unexpectedly large differences in responses. Unequivocal answers must recorded as such, whether they seem resonable or not. Probing questions should rarely be needed. When they have to be asked, they should depart as little as possible frc the wording of the initial question, and must not be such as to suggest any particular answer to the respondent.

II. DETAILED INSTRUCTIONS FOR RESPIRATORY QUESTIONS

Read instruction to respondent.

A. COUGH

If respondent answers No to 1, skip 2, but 3 and 4 must asked of all respondents. Do not ask questions 5 and 6, unless there is a postive response to 1 of the previous questions. For question 6, record actual number of years.

5. Do you usually cough like this on most days for 3 consecutive months or more during the year?.....YES Y

NO N

6. For how many years have you had this cough?..... ☐☐

6. Record the answer to this question rounding down to the nearest whole number. If the respondent answers "2½ years," code it as 02. For periods of less than 1 year, code as a zero. For "unknown," draw two horizontal lines through both boxes. If a range is given such as "5 to 8 years," use the the midpoint of the range (6.5) and round as indicated above (recording as 06).

B. PHLEGM

B. PHLEGM

7. Do you usually bring up phlegm from your chest?.....YES Y

[Count phlegm with the first smoke or on first going out-of-doors. Exclude phlegm from the nose. Count swallowed phlegm.] NO N

Go to Item 9 Screen 3

If the respondent answers No to 7, skip 8, but ask 9 and 10 of all respondents. Emphasis should be placed upon phlegm as coming up from the chest and postnasal discharge is discounted. This may be determined by: "Do you raise it up from your lungs, or do you merely clear it from your throat?" Some subjests admit to bringing up phlegm without admitting to cough. This claim should be accepted without changing the replies to "cough." Phlegm coughed up from the chest counts as positive. Include, if volunteered, phlegm with first smoke or "on first going out-of-doors." Do not ask questions 11 and 12 unless there is a positive response to 1 of the previous questions. For question 12, record actual number of years.

8. Do you usually bring up phlegm like this as much as twice a day, 4 or more days out of the week?.....YES Y

NO N

9. Do you usually bring up phlegm at all on getting up, or first thing in the morning?.....YES Y

NO N

10. Do you usually bring up phlegm at all during the rest of the day or at night?.....YES Y

NO N

If any of questions 7, 9, and 10 are answered "Yes", answer questions 11 and 12, if not, go to item 13

11. Do you bring up phlegm like this on most days for 3 consecutive months or more during the year?.....YES Y

NO N

12. For how many years have you had trouble with phlegm?..... ☐☐

12. Record the answer to this question rounding down to the nearest whole number. If the respondent answers "2½ years," code it as 02. For periods of less than 1 year, code as a zero. For "unknown," draw two horizontal lines through both boxes. If a range is given such as "5 to 8 years," use the midpoint of the range (6.5) and round as indicated above (recording as 06).

C. WHEEZING

13. Does your chest ever sound wheezy or whistling when you have a cold?.....YES Y
NO N

14. Does your chest ever sound wheezy or whistling apart from colds?.....YES Y
NO N

If either question 13 or 14 are answered "Yes", answer questions 15 and 16, if not, go to item 17

15. Does your chest sound wheezy or whistling most days or nights?.....YES Y
NO N

16. For how many years has this wheezy or whistling sound been present?..... [ ][ ]

17. Have you ever had an attack of wheezing that has made you feel short of breath?.....YES Y
NO N

Go to Item 21 Screen 5

18. How old were you when you had your first such attack?..... [ ][ ]

19. Have you had 2 or more such episodes?.....YES Y
NO N

20. Have you ever required medicine or treatment for the(se) attack(s)?.....YES Y
NO N

D. BREATHLESSNESS

21. Are you disabled from walking by any condition other than heart or lung disease?.....YES Y

Go to Item 27 Screen 6

NO N

22. Are you troubled by shortness of breath when hurrying on the level or walking up a slight hill?.....YES Y
NO N

Go to Item 27 Screen 6

C. WHEEZING

These questions are intended to identify subjects who have occasional and/or frequent wheezing. Those questions pertaining to asthma are asked in questions 17 through 21, and 35 through 39 but these questions may check that diagnosis. Subjects may confuse wheezing with snoring or bubble sounds in the chest; a demonstration "wheeze" will help if further clarification is requested. Can ask, "Does your husband (or wife) regularly complain of your wheezing (not snoring) at night?" Ask questions 13 and 14 of everyone; do not ask 15 or 16 if answers to 13 and 14 are No.

16. Record the answer to this question rounding down to the nearest whole number. If the respondent answers "2½ years," code it as 02. For periods of less than 1 year, code as a zero. For "unknown," draw two horizontal lines through both boxes. If a range is given such as "5 to 8 years, use the midpoint of the range (6.5) and round as indicated above (recording as 06).

18. Record the answer to this question rounding down to the nearest whole number. If the respondent answers "2½ years," code it as 02. For periods of less than 1 year, code as a zero. For "unknown," draw two horizontal lines through both boxes. If a range is given such as "5 to 8 years," use the midpoint of the range (6.5) and round as indicated above (recording as 06).

D. BREATHLESSNESS

If a subject volunteers that he is disabled from walking by any condition other than heart or lung disease, or obviously is confined to a wheelchair or uses crutches continuously, then questions 22 through 26 are not to be asked. If asked, the questions refer to the average condition during the preceeding winters. No attempt is mad to separate out cardiac breathlessness. If question 22 is No, skip remaining questions 23 through 26.

23. Do you have to walk slower than people of your age on the level because of breathlessness?.....YES Y

NO N

24. Do you ever have to stop for breath when walking at your own pace on the level?.....YES Y

NO N

25. Do you ever have to stop for breath after walking about 100 yards (or after a few minutes) on the level?.....YES Y

NO N

26. Are you too breathless to leave the house or breathless on dressing or undressing?..... YES Y

NO N

E. BRONCHITIS

27. Have you ever had chronic bronchitis?.....YES Y

NO N

Go to Item 31

28. Do you still have it?.....YES Y

NO N

29. Was it confirmed by a doctor?.....YES Y

NO N

30. At what age did it start?..... [ ][ ]

F. EMPHYSEMA

31. Have you ever had emphysema?.....YES Y

NO N

Go to Item 35
Screen 7

32. Do you still have it?.....YES Y

NO N

33. Was it confirmed by a doctor?.....YES Y

NO N

34. At what age did it start?..... [ ][ ]

E. BRONCHITIS

27. This diagnosis may be confused with pneumonia or bronchial asthma. The prominent feature is rapid onset of cough and phlegm that completely changes in character for those who have cough and phlegm always and returns to its former state or comes and goes over relatively short periods of time. Do not ask 28 through 30 if 27 is No.

30. Record the answer to this question rounding down to the nearest whole number. If the respondent answers "2½ years," code it as 02. For periods of less than 1 year, code as a zero. For "unknown," draw two horizontal lines through both boxes. If a range is given such as "5 to 8 years," use the midpoint of the range (6.5) and round as indicated above (recording as 06).

F. EMPHYSEMA

31. Do not ask 32 through 34 if 31 is No.

34. Record the answer to this question rounding down to the nearest whole number. If the respondent answers "2½ years," code it as 02. For periods of less than 1 year, code as a zero. For "unknown," draw two horizontal lines through both boxes. If a range is given such as "5 to 8 years," use the midpoint of the range (6.5) and round as indicated above (recording as 06).

G. ASTHMA

35. Have you ever had asthma?.....YES Y

NO N

Go to Section H

36. Was it confirmed by a doctor?.....YES Y

NO N

37. At what age did it start?..... ..... [ ][ ]

38. Do you still have it?.....YES Y

Go to Section H

NO N

39. At what age did it stop?..... [ ][ ]

H. WORK ACTIVITY

"Now I'm going to ask you some questions about your physical activity. We are interested in your physical activity during the past year. I'll begin by asking about your activity level at work."

40. At work do you sit:.....Never N
[rc 1]

SeLdom L

SoMetimes M

Go to Item 47 Screen 9

Often O

Always A

Does not work D

41. At work do you stand:.....Never N
[rc 1]

SeLdom L

SoMetimes M

Often O

Always A

G. ASTHMA

35. Do not ask 36 through 39 if 35 is No.

37. Record the answer to this question rounding down to the nearest whole number. If the respondent answers "2½ years," code it as 02. For periods of less than 1 year, code as a zero. For "unknown," draw two horizontal lines through both boxes. If a range is given such as "5 to 8 years," use the midpoint of the range (6.5) and round as indicated above (recording as 06).

38. Do not ask 39 if 38 is Yes.

39. Record the answer to this question rounding down to the nearest whole number. If the respondent answers "2½ years," code it as 02. For periods of less than 1 year, code as a zero. For "unknown," draw two horizontal lines through both boxes. If a range is given such as "5 to 8 years," use the midpoint of the range (6.5) and round as indicated above (recording as 06).

III. DETAILED INSTRUCTIONS FOR PHYSICAL ACTIVITY QUESTIONS

H. WORK ACTIVITY

Show response cards [RC] as indicated.

40. The Response Card does not include response D: "Does not work." Use this code only if the participant responds spontaneously that he/she does not work. In this case, ski to question 47.

These questions pertain to work activity. One answer per question.

42. At work do you walk:.....Never N
[rc 1]
SeLdom L
SoMetimes M
Often O
Always A

43. At work do you lift heavy loads:.....Never N
[rc 2]
SeLdom L
SoMetimes M
Often O
Very Often V

44. After working are you physically tired:.....Never N
[rc 2]
SeLdom L
SoMetimes M
Often O
Very Often V

45. At work do you sweat:.....Never N
[rc 2]
SeLdom L
SoMetimes M
Often O
Very Often V

45. This question asks about sweating as a result of activity, not background sweating due to climate or temperature. If the participants say they sweat a lot because it is hot outside, try to get them to focus on sweat due to activity beyond ambient conditions.

46. In comparison with others of your own age do you think your work is physically:.....Much lighter A
[rc 3]
Lighter B
As heavy C
Heavier D
Much heavier E

I. SPORTS

I. SPORTS

47. Do you exercise or play sports?.....YES Y

NO N

Go to Item 65
Screen 14

Note these questions' logic. If the participant reports not playing sports or exercising, the follow-up questions are not asked. If he/she does so report, then he/she is asked to report the major activities (up to four, in order of frequency) and to indicate the hours per week and months per year.

48. Which sport or exercise do you do most frequently:..... ☐☐☐

[Do not show card]

If the activity is coded enter code and go to item 49, if not coded enter 499 and specify the activity below.

a. ☐☐☐☐☐☐☐☐☐☐☐☐

☐☐☐☐☐☐☐☐☐☐☐☐

49. How many hours a week do you do this activity?... [rc 5]

Less than 1	A
At least 1 but not quite 2	B
At least 2 but not quite 3	C
At least 3 but not quite 4	D
4 or more	E

50. How many months a year do you do this activity?... [rc 6]

Less than 1	A
At least 1 but not quite 4	B
At least 4 but not quite 7	C
At least 7 but not quite 10	D
10 or more	E

51. Do you do other exercises or play other sports?.....YES Y

NO N

Go to Item 64 Screen 14

52. What is your second most frequent sport or exercise:..... ☐☐☐

[Do not show card]

If the activity is coded enter code and go to item 53, if not coded enter 499 and specify the activity below.

a. ☐☐☐☐☐☐☐☐☐☐☐☐

☐☐☐☐☐☐☐☐☐☐☐☐

A code sheet is provided, listing most physical activities and a corresponding three digit code. This sheet is not to be shown to the participant, because we do not want to prompt recall of activities. The three digit codes of the reported activities are to be entered in the three boxes or questions 48, 52, 56, and 60, as needed. If an activity cannot fit into one of the categories on the card, code the box 499 and specify the activity in the space provided. Some codes, such as swimming, require additional probing to determine speed.

In general, the hours per week should exclude rest time. If the reported hours seem excessive, repeat it to the participant to be certain. If the activity is seasonal, it should be averaged over the months the activity is engaged in.

The follow-up question "How many months a year do you do this activity?" will be confusing if the participant just began performing the activity. In that case, the interviewer should project for a one year period the participant's pattern of activity for the months since taking it up. For example, if the person took up an activity four months ago and has done it for three months out of four, that would project to a nine month per year pattern (assuming the activity could be done year round). Do your best to place it into a year time frame, based on current habit.

53. How many hours a week do you do this activity?... [rc 5]

Less than 1	A
At least 1 but not quite 2	B
At least 2 but not quite 3	C
At least 3 but not quite 4	D
4 or more	E

54. How many months a year do you do this activity?... [rc 6]

Less than 1	A
At least 1 but not quite 4	B
At least 4 but not quite 7	C
At least 7 but not quite 10	D
10 or more	E

55. Do you do other exercises or play other sports?.....YES Y

NO N

Go to Item 64 Screen 14

56. What is your third most frequent sport or exercise:.....

[Do not show card]

If the activity is coded enter code and go to item 57, if not coded enter 499 and specify the activity below.

a.

57. How many hours a week do you do this activity?... [rc 5]

Less than 1	A
At least 1 but not quite 2	B
At least 2 but not quite 3	C
At least 3 but not quite 4	D
4 or more	E

58. How many months a year do you do this activity?... [rc 6]

Less than 1	A
At least 1 but not quite 4	B
At least 4 but not quite 7	C
At least 7 but not quite 10	D
10 or more	E

59. Do you do other exercises or play other sports?.....YES Y

NO N

Go to Item 64 Screen 14

60. What is your fourth most frequent sport or exercise:.....

[Do not show card]

If the activity is coded enter code and go to item 61, if not coded enter 499 and specify the activity below.

a.

61. How many hours a week do you do this activity?... [rc 5]

Less than 1	A
At least 1 but not quite 2	B
At least 2 but not quite 3	C
At least 3 but not quite 4	D
4 or more	E

62. How many months a year do you do this activity?... [rc 6]

Less than 1	A
At least 1 but not quite 4	B
At least 4 but not quite 7	C
At least 7 but not quite 10	D
10 or more	E

63. Do you do other exercises or play other sports?.....YES Y

NO N

63. Indicate if the participant does more than four sports or exercises.

J. LEISURE TIME

J. LEISURE TIME

These pertain to leisure time activity. Leisure time is defined as time away from work. If the respondent is confused by "leisure time," you may provide this definition. One answer per question.

64. During leisure time would you say you play sports or exercise:.....Never N [rc 2]

SeLdom	L
SoMetimes	M
Often	O
Very Often	V

65. In comparison with others of your own age do you think your physical activity during leisure time is:.....Much less A
[rc 7]
Less B
The same C
More D
Much more E

66. During leisure time do you sweat:..... Never N
[rc 2]
SeLdom L
SoMetimes M
Often O
Very Often V

66. This question asks about sweating at leisure as a result of activity, not climate or temperature. If the participants say they sweat a lot because it is hot outside, try to get them to focus on sweat due to activity and beyond ambient conditions.

67. During leisure time do you watch television:..... Never N
[rc 2]
SeLdom L
SoMetimes M
Often O
Very Often V

68. During leisure time do you walk:.....Never N
[rc 2]
SeLdom L
SoMetimes M
Often O
Very Often V

69. During leisure time do you bicycle.....Never N
[rc 2]
SeLdom L
SoMetimes M
Often O
Very Often V

K. OTHER ACTIVITIES

K. OTHER ACTIVITIES

70. How many minutes do you walk and/or bicycle per day to and from work or shopping?...

[If seasonal, give average over the past year]
[rc 8]
Less than 5 A
At least 5 but not quite 15 B
At least 15 but not quite 30 C
At least 30 but not quite 45 D
45 or more E

70. This question should be completed even if walking or bicycling was listed in questions 48, 52, 56, 60, 68 or 69. Include time walking to and from car, but don't include time at work or shopping.

71. Have you done any heavy physical activity within the last 12 hours?.....YES Y

NO N

Go to Item 72

a. How long ago did you complete it?

☐☐ hours, ☐☐ minutes

72. How many flights of stairs do you climb up each day?...
[One flight equals 10 steps]

☐☐ flights per day

72. Includes stair climbing at home, at work, or during leisure time. If participant climbs larger or smaller flights of stairs than 10 steps, translate into 10 step flights, rounding down to the nearest whole number.

L. ADMINISTRATIVE INFORMATION

73. Date of data collection:..... ☐☐-☐☐-☐☐
month day year

73. Enter the date on which the subject was seen in the clinic. Code in numbers using leading zeroes where necessary to fill all boxes. For example, May 3, 1986 would be entered as:

05-03-86
month day year

74. Method of data collection:.....Computer C

Paper form P

74. If the form was completed partially on paper and partially on the computer, code as "Paper form."

75. Code number of person completing this form?..... ☐☐☐

75. The person at the clinic who has completed this form must enter his/her code number in the boxes provided

PHYSICAL ACTIVITY
RESPONSE CARDS

RESPONSE CARD NUMBER	TITLE	RESPONSES
[RC 1]		NEVER SELDOM SOMETIMES OFTEN ALWAYS
[RC 2]		NEVER SELDOM SOMETIMES OFTEN VERY OFTEN
[RC 3]		MUCH LIGHTER LIGHTER AS HEAVY HEAVIER MUCH HEAVIER
[RC 4]	SPORTS LIST	ALPHABETIZED LIST OF SPORT CODES, IF NOT CODED CODE AS 499 AND SPECIFY IN THE SPACE PROVIDED
[RC 5]	HOURS	LESS THAN 1 AT LEAST 1 BUT NOT QUITE 2 AT LEAST 2 BUT NOT QUITE 3 AT LEAST 3 BUT NOT QUITE 4 4 OR MORE
[RC 6]	MONTHS	LESS THAN 1 AT LEAST 1 BUT NOT QUITE 4 AT LEAST 4 BUT NOT QUITE 7 AT LEAST 7 BUT NOT QUITE 10 10 OR MORE
[RC 7]		MUCH LESS LESS THE SAME MORE MUCH MORE
[RC 8]	MINUTES	LESS THAN 5 AT LEAST 5 BUT NOT QUITE 15 AT LEAST 15 BUT NOT QUITE 30 AT LEAST 30 BUT NOT QUITE 45 45 OR MORE

ATHEROSCLEROSIS RISK IN COMMUNITIES STUDY

CODING LIST FOR THE RESPIRATORY/PHYSICAL ACTIVITY FORM SPORTS

ACTIVITY	CODE
Archery	1
Aqua Aerobics/Swimnastics/Water Exercise	2
Backpacking	4
Badminton	7
Baseball	10
Basketball, Game	13
Basketball, Non-game	16
Biathlon	19
Bicycle Racing	22
Bicycling < 10 mph	25
Bicycling ≥ 10 mph	28
Billiards	31
Bobsledding	37
Body Building	40
Bowling	43
Boxing	46
Broomball	49
Calisthenics	52
Canoeing < 2.6 mph	55
Canoeing in Competition	58
Carpentry/Woodworking	60
Car Racing	61
Crew	67
Cricket	70
Croquet	73
Crossbowing	76
Curling	79
Dancing, Aerobics (Low to moderate)	82
Dancing, Aerobic (high intensity)	85
Dancing, Ballet	88
Dancing - Jazz, Modern	91
Dancing - Ballroom and/or Square	94
Darts	97
Diving	100
Equestrian Events	109
Fencing	112
Field Hockey	115
Figure Skating	118
Fishing from Bank or Boat	121
Fishing in Stream with Wading Boots	124
Floor Exercise	125
Football, Game	127
Football, Non-game	130
Frisbee - Competition/Games	133
Frisbee - Recreational	136
Gardening/Yard Work	139
Golf - Using Cart	142
Golf - Walking and Carrying Clubs	145

CODING LIST FOR THE RESPIRATORY/PHYSICAL ACTIVITY FORM SPORTS, continued

ACTIVITY	CODE
Gut Buster/Stomach Exercise	146
Gymnastics (Beam, High Bar, Horse, Parallel and Uneven bars, Rings)	148
Gymnastics (Floor Exercise, Vault)	151
Hackey Sack	154
Handball	157
Hang Gliding	160
Hiking	163
Hiking in the Mountains	166
Hiking on Flat Trail	169
Hockey	172
Horseback Riding	175
Horseshoes/Quoits	178
Hunting	181
Hurling	184
Ice Sailing	187
Ice Skating	190
Jacket Wrestling	193
Jai-Alai	196
Jogging < 6 mph	199
Jogging $\geq$ 6 mph	202
Judo	205
Juggling	208
Jujitsu	211
Jumping Rope	214
Karate	217
Kayaking	220
Kick Boxing	223
Lacrosse	226
Lawn Bowling	229
Luge	232
Mini-Trampoline	235
Motocross	238
Mountain Climbing	241
Mowing Lawn with Riding Mower or Walking Behind Power Mover	244
Mowing Lawn Pushing Hand Mower	247
Nautilus	249
Orienteering	250
Paddleball	253
Polo	259
Power Lifting	262
Racewalking	265
Racquetball	268
Roller Skating	271
Rowing	274
Rugby	277
Running $\geq$ 6 mph	280
Running, Cross-County	283

CODING LIST FOR THE RESPIRATORY/PHYSICAL ACTIVITY FORM SPORTS, continued

ACTIVITY	CODE
Sailing - Calm Waters	286
Sailing - Rough Waters	289
Scuba Diving	292
Sculling < 95 meters/min.	295
Sculling ≥ 95 meters/min.	298
Shoveling	301
Shuffleboard	304
Skateboarding	310
Ski Jumping	313
Skiing, Cross-Country	316
Skiing, Downhill	319
Sky Diving	322
Sledding or Tobogganing	325
Snorkeling	328
Snow Blowing/Shoveling	331
Snowmobling/All Terrain Vehicle	333
Snow Shoeing	334
Soccer	337
Softball	340
Speed Skating	343
Squash	346
Stair Climbing	349
Surfing	352
Swim, Recreational	355
Swimming, Backstroke ≤ 35 yds/min.	358
Swimming, Backstroke > 35 yds/min.	361
Swimming, Breaststroke < 40 yds/min.	364
Swimming, Breaststroke > 40 yds/min.	367
Swimming, Butterfly	370
Swimming, Crawl	373
Swimming, Elementary Backstroke	376
Swimming, Sidestroke ≥ 40 yds/min.	379
Synchronized Swimming	382
Table Tennis	385
Tae Kwon Do	388
Tai Chi	391
Team Handball	394
Tennis	397
Trampoline	400
Trapshooting	403
Unicycling	406
Volleyball	409
Walking Briskly	412
Walking During Work Break	415
Walking for Pleasure	418
Walking To and From Work	421
Water Polo	424
Water Skiing	427
Weight Lifting	430
Whitewater Rafting	433

CODING LIST FOR THE RESPIRATORY/PHYSICAL ACTIVITY FORM SPORTS, continued

ACTIVITY	CODE
Windsurfing	436
Woodcutting	437
Wrestling	439
Wrist Wrestling	442
Yachting	448
Yard Work (See Gardening)	
Yoga	451
Coding Error - DO NOT USE	488
Health Club, Not Otherwise Specified	498
Unspecified	499

O.M.B. 0925-0281
exp. 7-31-89

ARIC REPRODUCTIVE HISTORY FORM

ID NUMBER: [ ][ ][ ][ ][ ][ ][ ] CONTACT YEAR: [0][1] FORM CODE: [R][H][X] VERSION: A 11/1/86

LAST NAME: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ] INITIALS: [ ][ ]

INSTRUCTIONS:

This form should be completed for female participants only. It should be completed during the interview portion of the participant's visit. ID Number 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 zeroes where necessary to fill all boxes. If a number is entered incorrectly, 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.

REPRODUCTIVE HISTORY FORM (screen 1 of 8)

A. MENSTRUAL HISTORY AND PREGNANCIES

"Next we would like to ask a few questions about your reproductive and menstrual history."

1. Approximately how old were you when your menstrual periods started? .... [ ][ ]

If Never Menstruated, Enter "0" and Go to Item 11, Screen 3

2. How many times have you been pregnant? ... [ ][ ]

If "0", Go to Item 4

3. How many live-born children have you had? [ ][ ]

4. Have you had any menstrual periods during the past 2 years? ..... Yes Y

No N

Go to Item 7, Screen 2

5. In what month and year was your last menstrual period? .. [ ][ ] - [ ][ ]

Month Year

REPRODUCTIVE HISTORY FORM (screen 2 of 8)

6. In the past 2 years, how many periods did you miss? ..... ☐☐

If "0", Go to Item 10

7. Have you reached menopause? ..... Yes Y

No N

Unknown U

Go to Item 11, Screen 3

8. At approximately what age did menopause begin? ..... ☐☐

9. Was your menopause natural or the result of surgery or radiation? .... Natural N

Surgery S

Radiation R

Unknown U

10. Are you having hot flashes? ..... Yes Y

No N

Unknown U

REPRODUCTIVE HISTORY FORM (screen 3 of 8)

B. BIRTH CONTROL PILLS

11. Have you ever taken birth control pills? ..... Yes Y

No N

Go to Item 16, Screen 4

12. At what age did you start taking them for the first time? ..... ☐☐

13. Are you currently taking them? ..... Yes Y

No N

Go to Item 15

14. At what age did you stop taking them? .... ☐☐

15. For how many years altogether have you used birth control pills? ..... ☐☐

REPRODUCTIVE HISTORY FORM (screen 4 of 8)

C. HORMONE USE

16. Have you ever taken female hormone pills, shots, or implants, not including birth control pills? ..... Yes Y

Go to Item 45, Screen 8 — No N; Unknown U

"Please give me the name of all female hormones you are using or have used, starting with the most recent one."

17. Name 1: _____

18. Code 1: ..... [ ][ ][ ][ ][ ]

19. At what age did you start taking this hormone for the first time? ..... [ ][ ]

20. Are you currently taking this hormone? ..... Yes Y

Go to Item 22 — No N

21. At what age did you stop taking this hormone? ..... [ ][ ]

22. For how many years altogether have you used this hormone? ..... [ ][ ]

23. How many days do/did you take this hormone in a four week period? ..... [ ][ ]

REPRODUCTIVE HISTORY FORM (screen 5 of 8)

24. Name 2: _____

25. Code 2: ..... [ ][ ][ ][ ][ ]

26. At what age did you start taking this hormone for the first time? ..... [ ][ ]

27. Are you currently taking this hormone? ..... Yes Y

Go to Item 29 — No N

28. At what age did you stop taking this hormone? ..... [ ][ ]

29. For how many years altogether have you used this hormone? ..... [ ][ ]

30. How many days do/did you take this hormone in a four week period? ..... [ ][ ]

REPRODUCTIVE HISTORY FORM (screen 6 of 8)

31. Name 3: _____

32. Code 3: ..... | | | | | |

33. At what age did you start taking this hormone for the first time? ..... | | |

34. Are you currently taking this hormone? ..... Yes Y

Go to Item 36 No N

35. At what age did you stop taking this hormone? ..... | | |

36. For how many years altogether have you used this hormone? ..... | | |

37. How many days do/did you take this hormone in a four week period? ..... | | |

REPRODUCTIVE HISTORY FORM (screen 7 of 8)

38. Name 4: _____

39. Code 4: ..... | | | | | |

40. At what age did you start taking this hormone for the first time? ..... | | |

41. Are you currently taking this hormone? ..... Yes Y

Go to Item 43 No N

42. At what age did you stop taking this hormone? ..... | | |

43. For how many years altogether have you used this hormone? ..... | | |

44. How many days do/did you take this hormone in a four week period? ..... | | |

REPRODUCTIVE HISTORY FORM (screen 8 of 8)

D. GYNECOLOGIC SURGERY

45. Have you had surgery to have your uterus or ovaries removed? (That is, a partial or total hysterectomy.) ..... Yes Y

Go to Item 50 — No N; Unknown U

46. Was your uterus (womb) removed? ..... Yes Y

Go to Item 48 — No N; Unknown U

47. How old were you when this operation was performed? ..... [ ][ ]

48. Have you had either one or both ovaries removed? ..... Yes, one O; Yes, both B

Go to Item 50 — No N; Unknown U

49. How old were you when this operation was performed? ..... [ ][ ]

E. ADMINISTRATIVE INFORMATION

50. Date of data collection: ... [ ][ ] - [ ][ ] - [ ][ ]
Month Day Year

51. Method of Data Collection: ..... Computer C; Paper Form P

52. Code number of person completing this form: ... [ ][ ][ ]

VERSION A 11/1/86

REPRODUCTIVE HISTORY FORM INSTRUCTIONS

A. MENSTRUAL HISTORY AND PREGNANCIES

"Next we would like to ask a few questions about your reproductive and menstrual history."

1. Approximately how old were you when your menstrual periods started? .... ☐☐

If Never Menstruated, Enter "0" and Go to Item 11, Screen 3

2. How many times have you been pregnant? ... ☐☐

If "0", Go to Item 4

3. How many live-born children have you had? ☐☐

4. Have you had any menstrual periods during the past 2 years? ..... Yes Y

No N

Go to Item 7, Screen 2

I. GENERAL INSTRUCTIONS

The Reproductive History Form should be completed during the interview portion of the participant's clinic visit. It is to be administered to female participants only. The interviewer must be certified and should be familiar with and understand the document titled "General Instructions For Completing Paper Forms" prior to completing this form. ID Number, Contact Year, and Name should be completed as described in that document.

The questionnaire is divided into 4 sections. Section A deals with menstrual history and pregnancy. Section B provides information on past and present use of birth control pills (BCP's), and Section C on past and present use of hormone preparations (the survey allows for the coding of past and present frequency information for four different hormones). Section D deals with history of gynecological surgery.

The exact wording and order of the questions should be followed to ensure standardization. Questions should not be skipped unless indicated by the skip pattern instructions. Because there are many skip patterns in this survey, the interviewer should be very familiar with the flow of the survey to insure smooth administration with a conversational tone.

NOTE: The participant may view this material as very sensitive. The interviewer should be aware of the sensitive nature of the information and make the participant feel comfortable. If required, the interviewer should explain that these are characteristics that can explain why some women develop heart disease. Beyond this, however, no specific information should be mentioned to the participant.

II. DETAILED INSTRUCTIONS FOR VARIOUS QUESTIONS

A. Menstrual History and Pregnancies

1. The exact age in years should be recorded. If the participant reports the time in school grades, probe for years. A "best estimate" is acceptable if the interviewer feels confident that a thoughtful estimate is provided. If the participant is unsure of at what age her first menstrual period occurred, probe by asking about possible other associated life events which she may recall more clearly. If she still does not know, draw 2 horizontal lines through the boxes.

If the participant says that she has never menstruated, enter "0" and skip to item 11.

2. Include pregnancies resulting in miscarriage and abortion. If the participant was uncertain of a pregnancy do not include it in the total. If not known, draw 2 horizontal lines through the boxes.

3. If not known, draw 2 horizontal lines through the boxes.

4. Even if the participant has had only one menstrual period in the past 2 years, or reports any bleeding in the past 2 years, answer "Yes" to item 4. Consider regular bleeding induced by medicine as a menstrual period. If the participant reports that she has not had any menstrual periods during the past 2 years, skip to item 7 to determine whether the participant has reached menopause.

5. In what month and year was your last menstrual period? .. ☐☐ - ☐☐
Month Year

5. If the participant cannot remember when she had her last menstrual period, draw 2 horizontal lines through the boxes.

6. In the past 2 years, how many periods did you miss? ..... ☐☐

If "0", Go to Item 10

6. This question determines the number of periods missed over the last 2 years. If the participant has not missed any periods over the last 2 years, skip to item 10. If not known, draw 2 horizontal lines through the boxes.

7. Have you reached menopause? ..... Yes Y
No N
Unknown U

Go to Item 11, Screen 3

7. If the term "menopause" is not immediately understood, ask: "Have your periods stopped for at least 6 months?" If the participant hesitates or is unsure, record "unknown" as her response and skip to question 11. If she reports with certainty that she has not reached menopause, answer "no" to question 7 and skip to question 11.

8. At approximately what age did menopause begin? ..... ☐☐

8. The age at which menopause began should be defined as the age at which "periods stopped permanently." If not known, draw 2 horizontal lines through the boxes.

9. Was your menopause natural or the result of surgery or radiation? .... Natural N
Surgery S
Radiation R
Unknown U

9. If the participant reports that she had already reached menopause before she had gynecological surgery, record the response as "natural".

10. Are you having hot flashes? ..... Yes Y
No N
Unknown U

10. If the participant is unsure of having hot flashes, suggest that a hot flash is "an intense sensation of warmth or feeling flushed all over, lasting anywhere from a few seconds to a few minutes."

B. BIRTH CONTROL PILLS

B. Birth Control Pills

11. Have you ever taken birth control pills? ..... Yes Y
No N

Go to Item 16, Screen 4

11. Only include birth control pills used for family planning purposes (or both family planning and non-family planning purposes). Birth control pills used exclusively for non-family planning purposes should be noted in Section C (Hormone Use). If the participant only reports ever taking <u>one</u> complete birth control pill cycle (21 or 28 day) in her lifetime, record "Yes". If the participant never completed even 1 (21 or 28 day) birth control pill cycle, record "No". (Consider a complete "mini-pill" regimen the same as a birth control pill cycle.)

12. At what age did you start taking them for the first time? ..... ☐☐

12. If the participant has started taking birth control pills several times, record the age of the first time. If not known, draw 2 horizontal lines through the boxes.

13. Are you currently taking them? ..... Yes Y

Go to Item 15

No N

13. "Current" refers to the time of the interview.

14. At what age did you stop taking them? .... ☐☐

14. Record the age when birth control pills were stopped for the <u>last</u> time. If not known, draw 2 horizontal lines through the boxes.

<u>Note</u>: A participant using 21-day cycle birth control pills might answer "no" to Question 13 if she is currently menstruating and not "currently taking" a daily pill for that week. Probe for this situation if the participant hesitates or acts surprised when you ask Question 14.

15. For how many years altogether have you used birth control pills? ..... ☐☐

15. Enter the total number of years of usage. If the participant has used the birth control pill more than once, enter the total number of years used, not counting the intervening periods of non-use. This requires all the time intervals of usage to be summed and then the total rounded off to the nearest year. Round partial year amounts of 1 to 6 months down; round partial year amounts of more than 6 full months up. (Example: If 2 years, 6 1/2 months is the total reported, record this as "3 years".) If the total "years" of usage is less than 6 full months, enter "0". (Example: If 5 1/2 months, record "0"; if 6 1/2 months, record "01"). If not known, draw 2 horizontal lines through the boxes.

C. HORMONE USE

C. Hormone Use

16. Have you ever taken female hormone pills, shots, or implants, not including birth control pills? ..... Yes Y

No N

Unknown U

Go to Item 45, Screen 8

16. If necessary, emphasize that this does not include birth control pills for family planning use. However, birth control pills prescribed for other therapeutic indications should be included in this section (e.g., for control of symptoms of a painful pelvic condition called "endometriosis"; for control of too frequent or too irregular menstrual periods).11. If the participant only reports ever taking one complete birth control pill cycle (21 or 28 day) in her lifetime, record "Yes". If the participant never completed even 1 (21 or 28 day) birth control pill cycle, record "No". (Consider a complete "mini-pill" regimen the same as a birth control pill cycle).

"Please give me the name of all female hormones you are using or have used, starting with the most recent one."

17. Name 1: _____

17,24,31,38. Record the name of the hormone. Print clearly. If the name is not known, draw two horizontal lines here and through the boxes for medication code, but attempt to complete the remaining questions.

18. Code 1: ..... ☐☐☐☐☐

18,25,32,39. Record the 5-digit medication code number of the hormone just recorded. If not known, this item may be temporarily skipped and completed later.

19. At what age did you start taking this hormone for the first time? ..... ☐☐

19,26,33,40. If the participant started taking the specified hormone more than once, enter the age of the first time. If not known, draw 2 horizontal lines through the boxes.

20. Are you currently taking this hormone? ..... Yes Y

Go to Item 22

No N

20,27,34,41. "Current" refers to the time of the interview.

21. At what age did you stop taking this hormone? ..... ☐☐

21,28,35,42. Enter the age of the last time she stopped taking the specified hormone. If not known, draw 2 horizontal lines through the boxes.

22. For how many years altogether have you used this hormone? ..... ☐☐

22,29,36,43. Add together all the years between starting and stopping use of the specified hormone. If the participant has used the hormone more than once, enter the total number of years used, not counting the intervening periods of non-use. Follow the rules given for item 15.

23. How many days do/did you take this hormone in a four week period? ..... ☐☐

23,30,37,44. Enter the usual or most representative figure if it has varied over time. If not known, draw 2 horizontal lines through the boxes.

Note: Space is allowed for four different hormones, starting with the most recent one. If more than four were used, only record the four which were most recent.

24. Name 2: _____

25. Code 2: ..... [ ][ ][ ][ ][ ]

26. At what age did you start taking this hormone for the first time? ..... [ ][ ]

27. Are you currently taking this hormone? ..... Yes Y

Go to Item 29 No N

28. At what age did you stop taking this hormone? ..... [ ][ ]

29. For how many years altogether have you used this hormone? ..... [ ][ ]

30. How many days do/did you take this hormone in a four week period? ..... [ ][ ]

24. Repeat for second most recent hormone. If none, skip to item 45. (Use "Next Field" or "Next Screen" key when skipping on computer.)

31. Name 3: _____

32. Code 3: ..... [ ][ ][ ][ ][ ]

33. At what age did you start taking this hormone for the first time? ..... [ ][ ]

34. Are you currently taking this hormone? ..... Yes Y

Go to Item 36 No N

35. At what age did you stop taking this hormone? ..... [ ][ ]

36. For how many years altogether have you used this hormone? ..... [ ][ ]

37. How many days do/did you take this hormone in a four week period? ..... [ ][ ]

31. Repeat for third most recent hormone. If none, skip to item 45. (Use "Next Field" or "Next Screen" key when skipping on computer.)

38. Name 4: _____

39. Code 4: ..... ☐☐☐☐☐

40. At what age did you start taking this hormone for the first time? ..... ☐☐

41. Are you currently taking this hormone? ..... Yes Y

Go to Item 43

No N

42. At what age did you stop taking this hormone? ..... ☐☐

43. For how many years altogether have you used this hormone? ..... ☐☐

44. How many days do/did you take this hormone in a four week period? ..... ☐☐

38. Repeat for fourth most recent hormone. If none, skip to item 45. (Use "Next Field" or "Next Screen" key when skipping on computer.)

D. GYNECOLOGIC SURGERY

D. Gynecologic Surgery

45. Have you had surgery to have your uterus or ovaries removed? (That is, a partial or total hysterectomy.) ..... Yes Y

Go to Item 50

No N

Unknown U

45. If the participant is unsure, probe by suggesting that the uterus is also called the womb, and that in some places this is called a "female operation." It may be necessary in some cases to clarify that surgery to "tack-up the bladder" is a different operation that does not involve the uterus nor ovaries.

46. Was your uterus (womb) removed? ..... Yes Y

Go to Item 48

No N

Unknown U

46. If necessary, suggest that the uterus is also called the womb.

47. How old were you when this operation was performed? ..... ☐☐

47. Enter the age at which the uterus was removed. If not known, draw 2 horizontal lines through the boxes.

48. Have you had either one or both ovaries removed? ..... Yes, one O

Yes, both B

No N

Go to Item 50

Unknown U

48. The interviewer should probe to determine whether only one or both ovaries were removed. Also note that with a vaginal hysterectomy (when the uterus is removed through the vagina and no abdominal incision is made), the ovaries are not removed.

49. How old were you when this operation was performed? ..... ☐☐

49. If more than one operation was performed, record the age of the most recent one. If not known, draw 2 horizontal lines through the boxes.

E. ADMINISTRATIVE INFORMATION

E. Administrative Information

50. Date of data collection: ... ☐☐ - ☐☐ - ☐☐

Month Day Year

50. Record the date on which the interview took place.

51. Method of Data Collection: ..... Computer C

Paper Form P

51. Record "C" if the form was completed on the computerized data entry system, or "P" if the paper form was used.

52. Code number of person completing this form: ... ☐☐☐

52. The person at the clinic who has performed the interview and completed the form must enter his/her code number in the boxes provided.

O.M.B. 0925-0281
exp. 7-31-89

A-184

ARIC DIETARY INTAKE FORM

ID NUMBER: | | | | | | | | CONTACT YEAR: | 0 | 1 | FORM CODE: | D | T | I | VERSION: A 11/1/86

LAST NAME: | | | | | | | | | | | | | INITIALS: | | |

INSTRUCTIONS:
This form should be completed during the interview portion of the participant's visit. ID Number 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 zeroes where necessary to fill all boxes. If a number is entered incorrectly, 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 or write in 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.

DIETARY INTAKE FORM (screen 1 of 18)

"In this part of the clinic visit we want to obtain information on your usual eating habits. We will go over specific foods by groups. I'll name a food and a portion size and you tell me how often, on average, you ate that during the past year.

If your portion was <u>much</u> different from the amount I say, please tell me if it was at least twice as much, or half as much. We have a few sizes of cups and glasses here for reference. Here are the choices for "how often" (show RC 1). The choices are number of times a day or week or month. Please respond with the appropriate letter. For example, "once a day" would be "D". If you ate or drank something less than twelve times a year, that would be the same as "less than once a month," which is "I".

It is important that your reply be brief in order to save time, but we want you to be as accurate as possible. If we miss food items that you usually eat often, we will list those at the end. Feel free to ask questions or have me repeat instructions if I am not being clear."

DIETARY INTAKE FORM (screen 2 of 18)

Response Categories:			
	>6 per day (A)	1 per day (D)	1 per week (G)
	4-6 per day (B)	5-6 per week (E)	1-3 per month (H)
	2-3 per day (C)	2-4 per week (F)	Almost Never (I)

A. [RC 1] DAIRY FOODS

"In the past year, how often on average did you consume..."

1. Skim or low fat milk; 8 oz. glass ..... ☐
2. Whole milk; 8 oz. glass ..... ☐
3. Yogurt; 1 c. ..... ☐
4. Ice cream; 1/2 c. ..... ☐
5. Cottage cheese or ricotta cheese; 1/2 c. ..... ☐
6. Other cheeses, plain or as part of a dish; 1 slice or serving..... ☐
7. Margarine or a margarine/butter blend; pats added to food or bread ..... ☐
8. Butter; pats added to food or bread ..... ☐

DIETARY INTAKE FORM (screen 3 of 18)

Response Categories:			
	>6 per day (A)	1 per day (D)	1 per week (G)
	4-6 per day (B)	5-6 per week (E)	1-3 per month (H)
	2-3 per day (C)	2-4 per week (F)	Almost Never (I)

B. [RC 1] FRUITS

"In the past year, how often on average did you consume..."

9. Fresh apples or pears; 1 .....
10. Oranges; 1 .....
11. Orange or grapefruit juice; small glass .....
12. Peaches, apricots or plums; 1 fresh or 1/2 c. canned or dried .....
13. Bananas; 1 .....
14. Other fruits; 1 fresh or 1/2 c. canned, including fruit cocktail .....

C. [RC 1] VEGETABLES -- Portion is 1/2 c.

"In the past year, how often on average did you consume..."

15. String beans or green beans; 1/2 c. .....
16. Broccoli; 1/2 c. .....

DIETARY INTAKE FORM (screen 4 of 18)

Response Categories:			
	>6 per day (A)	1 per day (D)	1 per week (G)
	4-6 per day (B)	5-6 per week (E)	1-3 per month (H)
	2-3 per day (C)	2-4 per week (F)	Almost Never (I)

17. Cabbage, cauliflower, brussels sprouts; 1/2 c.
18. Carrots; 1 whole or 1/2 c. cooked .....
19. Corn; 1 ear or 1/2 c. .....
20. Spinach, collards or other greens, but do not include lettuce; 1/2 c. .....
21. Peas or lima beans; 1/2 c. fresh, frozen or canned .....
22. Dark yellow, winter, squash such as acorn, butternut; 1/2 c. .....
23. Sweet potatoes; 1/2 c. .....
24. Beans or lentils, dried cooked, or canned, such as pinto, blackeye, baked beans; 1/2 c. .....
25. Tomatoes; 1, or tomato juice; 4 oz. .....

DIETARY INTAKE FORM (screen 5 of 18)

Response Categories:			
	>6 per day (A)	1 per day (D)	1 per week (G)
	4-6 per day (B)	5-6 per week (E)	1-3 per month (H)
	2-3 per day (C)	2-4 per week (F)	Almost Never (I)

D. [RC 1] MEATS

"In the past year, how often on average did you consume..."

26. Chicken or turkey, without skin .....
27. Chicken or turkey, with skin .....
28. Hamburgers; 1 .....
29. Hot dogs; 1 .....
30. Processed meats: sausage, salami, bologna, etc.; piece or slice .....
31. Bacon; 2 slices .....
32. Beef, pork or lamb as a sandwich or mixed dish, stew, casserole, lasagne, or in spaghetti sauce, etc. .....
33. Beef, pork or lamb as a main dish, steak, roast, ham, etc.....
34. Canned tuna fish; 3-4 oz. .....

DIETARY INTAKE FORM (screen 6 of 18)

Response Categories:			
	>6 per day (A)	1 per day (D)	1 per week (G)
	4-6 per day (B)	5-6 per week (E)	1-3 per month (H)
	2-3 per day (C)	2-4 per week (F)	Almost Never (I)

35. Dark meat fish, such as salmon, mackerel, swordfish, sardines, bluefish; 3-5 oz. .....
36. Other fish, such as cod, perch, catfish, etc.; 3-5 oz. .....
37. Shrimp, lobster, scallops as a main dish .....
38. Eggs; 1 .....

E. [RC 1] SWEETS, BAKED GOODS, CEREALS

"In the past year, how often on average did you consume..."

39. Chocolate bars or pieces, such as Hershey's, Plain M & M's, Snickers, Reeses; 1 oz. .....
40. Candy without chocolate; 1 oz.....
41. Pie, homemade from scratch; 1 slice .....

DIETARY INTAKE FORM (screen 7 of 18)

Response Categories:			
	>6 per day (A)	1 per day (D)	1 per week (G)
	4-6 per day (B)	5-6 per week (E)	1-3 per month (H)
	2-3 per day (C)	2-4 per week (F)	Almost Never (I)

42. Pie, ready-made or from a mix; 1 slice .....
43. Donut; 1 .....
44. Biscuits or cornbread; 1 .....
45. Danish pastry, sweet roll, coffee cake, croissant; 1 .....
46. Cake or brownie; 1 piece .....
47. Cookies; 1 .....
48. Cold breakfast cereal; 1/2 c. .....
49. Cooked cereals such as oatmeal, grits, cream of wheat; 1/2 c.....
50. White bread; 1 slice .....
51. Dark or whole grain bread; 1 slice .....

F. [RC 1] MISCELLANEOUS

"In the past year, how often on average did you consume..."

52. Peanut butter; 1 tbsp .....

DIETARY INTAKE FORM (screen 8 of 18)

Response Categories:			
	>6 per day (A)	1 per day (D)	1 per week (G)
	4-6 per day (B)	5-6 per week (E)	1-3 per month (H)
	2-3 per day (C)	2-4 per week (F)	Almost Never (I)

53. Potato chips or corn chips; small bag or 1 oz.
54. French fried potatoes; 1 serving, 4 oz. .....
55. Nuts; 1 oz. .....
56. Potatoes, mashed; 1 c. or baked; 1 .....
57. Rice; 1/2 c. .....
58. Spaghetti, noodles or other pasta; 1/2 c. ....
59. Home-fried food, such as any meats, poultry, fish, shrimp, eggs, vegetables, etc.; 1 serving .....
60. Food fried away from home, such as any fish, chicken, chicken nuggets, etc. .....

DIETARY INTAKE FORM (screen 9 of 18)

Response Categories:			
	>6 per day (A)	1 per day (D)	1 per week (G)
	4-6 per day (B)	5-6 per week (E)	1-3 per month (H)
	2-3 per day (C)	2-4 per week (F)	Almost Never (I)

G. [RC 1] BEVERAGES

"In the past year, how often on average did you consume..."

61. Coffee, not decaffeinated; 1 c. ..... ☐

62. Tea, iced or hot, not including decaf or herbal tea; 1 cup ..... ☐

63. Low calorie soft drinks, such as any diet Coke, diet Pepsi, diet 7-Up; 1 glass ..... ☐

64. Regular soft drinks, such as Coke, Pepsi, 7-Up, ginger ale; 1 glass ..... ☐

65. Fruit-flavored punch or non-carbonated beverages, such as lemonade, Kool-Aid or Hawaiian Punch; not diet; 1 glass ..... ☐

DIETARY INTAKE FORM (screen 10 of 18)

H. OTHER DIETARY ITEMS

66. [RC 2] How often do you eat liver; 3-4 oz. serving? .....

1/week	A
2-3/month	B
1/month or less	C
Never	D

67. Are there any other foods that you usually eat at least twice per week such as tortillas, prunes, or avocado? Do not include dry spices nor something that has been listed previously. .....

Yes	Y
No	N

→ Go to Item 74, Screen 11

68. Food #1 eaten at least twice per week (enter code and specify food and usual portion size below):.. ☐☐☐

a. _____

69. [RC 3] Frequency for food #1: .....

> 6/day	A
4-6/day	B
2-3/day	C
1/day	D
5-6/wk	E
2-4/wk	F

DIETARY INTAKE FORM (screen 11 of 18)

70. Food #2 eaten at least twice per week (enter code and specify food and usual portion size below):.. [ ][ ][ ]

a. _____

71. [RC 3] Frequency for food #2: ..... > 6/day A
4-6/day B
2-3/day C
1/day D
5-6/wk E
2-4/wk F

72. Food #3 eaten at least twice per week (enter code and specify food and usual portion size below):.. [ ][ ][ ]

a. _____

73. [RC 3] Frequency for food #3: ..... > 6/day A
4-6/day B
2-3/day C
1/day D
5-6/wk E
2-4/wk F

74. [RC 4] What do you do with the visible fat on your meat? .....
Eat most of the fat A
Eat some of the fat B
Eat as little as possible C
Don't eat meat D

DIETARY INTAKE FORM (screen 12 of 18)

75. [RC 5] What kind of fat do you usually use for frying and sauteing foods at home, excluding "Pam"-type spray? .....

Go to Item 77
- Real Butter A
- Margarine B
- Vegetable Oil C
- Vegetable Shortening D
- Lard E
- Bacon Grease F
- Not Applicable G
- Unknown H

76. Enter code and specify brand and form below: ..... [ ][ ][ ]

a. _____

77. [RC 5] What kind of fat do you usually use for baking? .....

Go to Item 79, Screen 13
- Real Butter A
- Margarine B
- Vegetable Oil C
- Vegetable Shortening D
- Lard E
- Bacon Grease F
- Not Applicable G
- Unknown H

78. Enter code and specify brand and form below: ..... [ ][ ][ ]

a. _____

DIETARY INTAKE FORM (screen 13 of 18)

79. [RC 6] What brand and form of margarine do you usually use at the table?

a. Form: ..... None A

Go to Item 80

Stick B

Tub C

Diet (low calorie) D

Other E

b. Code number: ..... ☐☐☐

c. Brand: _____

80. What kind of cold breakfast cereal do you most often use? (Enter code and specify brand name below): ..... ☐☐☐

a. Brand: _____

81. Are you currently on a special diet? ..... Yes Y

No N

Go to Item 84, Screen 14

82. For how many years have you been on it? .. ☐☐

83. [RC 7] What type of diet is it? ...

Weight Loss A

Low Salt B

Low Cholesterol C

Weight Gain D

Diabetic E

Other F

DIETARY INTAKE FORM (screen 14 of 18)

84. How many teaspoons of sugar do you add to your food daily? Include sugar added to coffee, tea, cereal, etc. ..... ☐☐

85. [RC 8] In cooking vegetables, how often do you add fat such as salt pork, butter, or margarine? .....

2-3 times per day A

1 time per day B

5-6 times per week C

2-4 times per week D

1 time per week E

1-3 times per month F

Never G

Unknown H

86. [RC 8] How often is salt or salt-containing seasoning such as garlic salt, onion salt, soy sauce, or Accent added to your food in cooking? .....

2-3 times per day A

1 time per day B

5-6 times per week C

2-4 times per week D

1 time per week E

1-3 times per month F

Never G

Unknown H

87. How many shakes of salt do you add to your food at the table every day? .... ☐☐

DIETARY INTAKE FORM (screen 15 of 18)

88. [RC 8] How often do you add catsup, hot sauce, soy or steak sauces to your food? ....

2-3 times per day	A
1 time per day	B
5-6 times per week	C
2-4 times per week	D
1 time per week	E
1-3 times per month	F
Never	G
Unknown	H

89. [RC 8] How often do you eat special low salt foods such as low salt chips, nuts, cheese, or salad dressing? .....

2-3 times per day	A
1 time per day	B
5-6 times per week	C
2-4 times per week	D
1 time per week	E
1-3 times per month	F
Never	G
Unknown	H

DIETARY INTAKE FORM (screen 16 of 18)

I. ALCOHOL

"I am going to ask you about wine, beer, and drinks made with hard liquor because these are the three major types of alcoholic beverages."

90. Do you presently drink alcoholic beverages? ..... Yes Y

No N

Go to Item 96, Screen 17

91. Have you ever consumed alcoholic beverages? ..... Yes Y

No N

Go to Item 101, Screen 18

92. Approximately how many years ago did you stop drinking? ..... ☐☐

93. For how many years did you drink alcoholic beverages? ..... ☐☐

94. In the past, which types of alcoholic beverages did you ordinarily drink? {Circle Y or N for each type below}

	Yes	No
a. Wine	Y	N
b. Beer	Y	N
c. Drinks made with hard liquor	Y	N
d. Other	Y	N

e. Specify: ☐☐☐☐☐☐☐☐☐☐

DIETARY INTAKE FORM (screen 17 of 18)

95. What was the usual number of drinks you had per week before you stopped drinking alcoholic beverages? ..... [ ][ ]
{One drink means 1 beer or 1 glass of wine or 1 shot of liquor or 1 mixed drink. Record 0 if less than one drink per week.}

After completing item 95, go to item 101

96. How many glasses of wine do you usually have per week? ..... [ ][ ]
{4 oz. glasses; round down}

97. How many bottles or cans of beer do you usually have per week? ..... [ ][ ]
{12 oz. bottles or cans; round down}

98. How many drinks of hard liquor do you usually have per week? ..... [ ][ ]
{1 1/2 oz. shots; round down}

99. During the past 24 hours, how many drinks have you had? ..... [ ][ ]

If "0", go to item 101

100. Were these: {Circle Y or N for each}

	Yes	No
a. Wine?	Y	N
b. Beer?	Y	N
c. Liquor?	Y	N

DIETARY INTAKE FORM (screen 18 of 18)

J. WEIGHT AT AGE 25

101. What was your weight at age 25? (pounds) ..... [ ][ ][ ]

K. ADMINISTRATIVE INFORMATION

102. Interviewer's opinion of information: ....

Reliable	A
Questionable	B
Participant uncooperative	C
Participant unable to estimate frequencies	D

103. Date of data collection: ... [ ][ ] - [ ][ ] - [ ][ ]
Month Day Year

104. Method of data collection: ..... Computer C
Paper Form P

105. Code number of person completing this form: ... [ ][ ][ ]

VERSION A 11/1/86

DIETARY INTAKE FORM INSTRUCTIONS

I. GENERAL INSTRUCTIONS

The Dietary Intake Form should be completed during the interview portion of the participant's clinic visit. The interviewer must be certified and should be familiar with and understand the document titled "General Instructions For Completing Paper Forms" prior to completing this form. ID Number, Contact Year, and Name should be completed as described in that document.

The physical setting should be quiet and private to put the participant at ease. The standard food unit models, help screens, instructions, and participant response cards are readily accessible. The participant's form is checked for completeness of I.D.

Note: The clinic staff receptionist should alert the interviewer in advance if participant is illiterate or has any problem in reading. In those instances, response cards must be read by the interviewer.

Greet the participant cordially. Explain that the purpose of the interview is to obtain information about usual dietary intake, that there will be questions on specific foods and portion sizes, and that you need to find out how often, on average, the specified amount was consumed during the past year. Explain that any difference from the stated portion size must be reported only if it is at least twice as much or half as much. Frequency of consumption will be based on number of times either per day, week or month. State that any foods not mentioned which he/she eats frequently may be added at the end. Assure the participant that he/she should feel free to have instructions repeated or to ask questions.

The interviewer must show an interest in the interview, using a pleasant non-judgmental tone and posture. In introducing the questionnaire the interviewer may use his/her own words but must cover the relevant points. The suggested statement follows:

"Hello (participant's name). My name is _____. In this part of the clinic visit we want to obtain information on your usual eating habits. We will go over specific foods by groups. I'll name a food and a portion size and you tell me how often, on average, you ate that during the past year.

If your portion was much different from the amount I say, please tell me if it was at least twice as much, or half as much. We have a few sizes of cups and glasses here for reference.

Here are the choices for "how often" (show RC 1). The choices are number of times a day or week or month. Please respond with the appropriate letter. For example, "once a day" would be "D". If you ate or drank something less than twelve times a year, that would be the same as "less than once a month," which is "I".

It is important that your reply be brief in order to save time, but we want you to be as accurate as possible. If we miss food items that you usually eat often, we will list those at the end. Feel free to ask questions or have me repeat instructions if I am not being clear.

First, the dairy group: In the past year, how often on average did you consume...?"

Make sure that the appropriate response card, as indicated on the form, is given to the participant. Remove response cards for questions that do not call for them.

All interviewers must be consistent in reading the Food and Amounts list to the participant. Read the questions clearly, using the exact wording on the form. It is imperative that there be no exclusions or inclusions in reading the food list. Do not add any interpretations.

For Sections A through G, these instructions list items that may be included for each category. Refer to them only if the participant asks if he/she should include certain food items. For example, the participant may ask if skim or low fat milk includes cocoa mix. By refering to these instructions, the interviewer can see that it does.

Periodically the interviewer may have to reiterate the comment "on average, the number of times in the past year", or may remind the participant of the stated portion size.

Problem items should be recorded in the note log. Resolution of these items will be handled by a nutritionist.

Enter frequency of intake in the appropriate column utilizing the help screen for portion/frequency conversions (this table appears at the end of these instructions). For example, the portion size for ice cream is 1/2 cup. If the participant reports a portion of 1 cup, 2-4 times per week, the interviewer calls up the portion/frequency help screen and finds the 2X Row in the Multiple of the Amount column. The interviewer reads across to the 2-4 Week column to obtain the adjusted frequency. The adjusted frequency is entered as 5-6 per week, or "E". If the amount is 3X or more, calculate the adjusted frequency or record the information in a note log and calculate later.

If the participant reports a seasonal intake of a food item which would total to more than 12 times per year, the average frequency must be calculated for the year (or the help screen for seasonal intake can be used). For example, if peaches are eaten only in season, but two peaches are eaten every week for three months, the frequency would be calculated as follows: 2 peaches x 4 weeks x 3 months = 24 divided by 12 (months in year) = 2 per month. The seasonal intake help screen is reprinted at the end of these instructions.

II. DETAILED INSTRUCTIONS FOR VARIOUS QUESTIONS

Response Categories:	>6 per day (A)	1 per day (D)	1 per week (G)
	4-6 per day (B)	5-6 per week (E)	1-3 per month (H)
	2-3 per day (C)	2-4 per week (F)	Almost Never (I)

A. [RC 1] DAIRY FOODS		Item includes:
1. Skim or low fat milk; 8 oz. glass	☐	1/2%, 1%, 2%, milk; reconstituted non-fat dry milk; cocoa from mix or vending; buttermilk--lowfat or unknown; lowfat chocolate milks
2. Whole milk; 8 oz. glass	☐	whole; "homogenized"; jersey milk; whole milk cocoa; whole buttermilk; unknown milk
3. Yogurt; 1 c.	☐	whole milk yogurts, regular or frozen, 2% or low fat yogurts, regular or frozen
4. Ice cream; 1/2 c.	☐	all brands, not ice milk (list at end if more than 2/week)
5. Cottage cheese or ricotta cheese; 1/2 c	☐	any cottage or ricotta cheese including any in recipes; farmer's cheese
6. Other cheeses, plain or as part of a dish; 1 slice or serving.....	☐	processed, cheddar and all hard natural cheeses
7. Margarine or a margarine/butter blend; pats added to food or bread	☐	at table
8. Butter; pats added to food or bread	☐	at table

Response Categories:			
	>6 per day (A)	1 per day (D)	1 per week (G)
	4-6 per day (B)	5-6 per week (E)	1-3 per month (H)
	2-3 per day (C)	2-4 per week (F)	Almost Never (I)

B. [RC 1] FRUITS		Item Includes:
9. Fresh apples or pears; 1	☐	
10. Oranges; 1	☐	
11. Orange or grapefruit juice; small glass	☐	4 to 6 ounce glass
12. Peaches, apricots or plums; 1 fresh or 1/2 c. canned or dried	☐	nectarines
13. Bananas; 1	☐	
14. Other fruits; 1 fresh or 1/2 c. canned, including fruit cocktail	☐	cantaloupe; grapefruit; strawberries; papaya; raspberries; raisins; grapes; pineapple; kiwi

Response Categories:			
	>6 per day (A)	1 per day (D)	1 per week (G)
	4-6 per day (B)	5-6 per week (E)	1-3 per month (H)
	2-3 per day (C)	2-4 per week (F)	Almost Never (I)

C. [RC 1] VEGETABLES -- Portion is 1/2 c.

(do not include small amounts in mixed dishes)

	Item Includes:
15. String beans or green beans; 1/2 c. ..... ☐	frozen or fresh; wax beans; fava beans
16. Broccoli; 1/2 c. ..... ☐	raw or cooked
17. Cabbage, cauliflower, brussels sprouts; 1/2 c. ☐	raw or cooked; coleslaw; sauerkraut
18. Carrots; 1 whole or 1/2 c. cooked ..... ☐	raw or cooked
19. Corn; 1 ear or 1/2 c. ..... ☐	fresh, frozen or canned; niblets, cream style, cob
20. Spinach, collards or other greens, but do not include lettuce; 1/2 c. ..... ☐	raw or cooked; beet greens, chard, kale, mustard greens, turnip greens; romaine
21. Peas or lima beans; 1/2 c. fresh, frozen or canned ..... ☐	mixed vegetables (peas, carrots, corn and limas), frozen or canned butter beans; not dried limas
22. Dark yellow, winter, squash such as acorn, butternut; 1/2 c. ..... ☐	hubbard, danish, buttercup, delicious, crookneck
23. Sweet potatoes; 1/2 c. ..... ☐	pumpkin, yams, fresh or canned
24. Beans or lentils, dried cooked, or canned, such as pinto, blackeye, baked beans; 1/2 c. ..... ☐	red; brown; navy; northern; kidney; blackeye; garbanzo; split peas; refried beans; dried limas
25. Tomatoes; 1, or tomato juice; 4 oz. ..... ☐	fresh or canned tomatoes; V-8 juice

VEGETABLES

Response Categories:	>6 per day (A)	1 per day (D)	1 per week (G)
	4-6 per day (B)	5-6 per week (E)	1-3 per month (H)
	2-3 per day (C)	2-4 per week (F)	Almost Never (I)

D. [RC 1] MEATS		Item Includes:
26. Chicken or turkey, without skin	☐	cornish hen; pheasant
27. Chicken or turkey, with skin	☐	cornish hen; turkey roll; pheasant
28. Hamburgers; 1	☐	any ground beef in patty form
29. Hot dogs; 1	☐	not chicken-type
30. Processed meats: sausage, salami, bologna, etc.; piece or slice	☐	cold cuts; luncheon meats, packaged or canned; tongue; (liver spread goes with liver)
31. Bacon; 2 slices	☐	not Canadian style: Canadian bacon is coded in next category
32. Beef, pork or lamb as a sandwich or mixed dish, stew, casserole, lasagne, or in spaghetti sauce, etc.	☐	hot dish; meat pies; pizza; meatloaf; meatball; barbeque; chitterlings; Canadian bacon; souse meat; pigs feet
33. Beef, pork or lamb as a main dish, steak, roast, ham, etc.....	☐	chops, corned beef
34. Canned tuna fish; 3-4 oz.	☐	all kinds, about 1/2-2/3 can
35. Dark meat fish, such as salmon, mackerel, swordfish, sardines, bluefish; 3-5 oz.	☐	canned salmon; lake trout; shad; herring; fresh tuna; capelin; dogfish; eel; halibut; sablefish; Atlantic sturgeon; Arctic char; lake whitefish
36. Other fish, such as cod, perch, catfish, etc.; 3-5 oz.	☐	orange roughy; grouper; walleye; crappie; whiting; unknown
37. Shrimp, lobster, scallops as a main dish	☐	clams; oysters; crab
38. Eggs; 1	☐	boiled; poached; fried; scrambled; omelettes; egg salad; quiche; not egg substitutes such as Egg Beaters

Response Categories:			
	>6 per day (A)	1 per day (D)	1 per week (G)
	4-6 per day (B)	5-6 per week (E)	1-3 per month (H)
	2-3 per day (C)	2-4 per week (F)	Almost Never (I)

E. [RC 1] SWEETS, BAKED GOODS, CEREALS		Item Includes:
39. Chocolate bars or pieces, such as Hershey's, Plain M & M's, Snickers, Reeses; 1 oz.	☐	Average bar = about 1 oz. Chocolate cream = 1/2 oz. chocolate fudge; chocolate chips; peanut M&M's go with nuts, group F
40. Candy without chocolate; 1 oz.....	☐	about 3-4 = 1 oz., hard candies; gum drops; 1 pkg. life savers; not "dietetic"
41. Pie, homemade from scratch; 1 slice	☐	any kind or tarts, crust from scratch
42. Pie, ready-made or from a mix; 1 slice	☐	any kind or tarts, bakery, mix or frozen dough or restaurant; cheese cake; cream puff; pound cake
43. Donut; 1	☐	all kinds
44. Biscuits or cornbread; 1	☐	
45. Danish pastry, sweet roll, coffee cake, croissant; 1	☐	
46. Cake or brownie; 1 piece	☐	cupcake; all cakes and bars
47. Cookies; 1	☐	
48. Cold breakfast cereal; 1/2 c.	☐	all ready-to-eat; wheat germ
49. Cooked cereals such as oatmeal, grits, cream of wheat; 1/2 c.....	☐	all cooked cereals
50. White bread; 1 slice	☐	French; Italian; raisin; 1/2 bagel; 1/2 white English muffin; average dinner roll; 1/2 frankfurter roll; 1/2 hamburger bun; pita bread; matzoh 4" x 6"
51. Dark or whole grain bread; 1 slice	☐	whole wheat; mixed grain; rye or pumpernickel; 2 graham cracker squares (2 1/2") 3 rye wafers (2" X 3")

Response Categories:	>6 per day (A)	1 per day (D)	1 per week (G)
	4-6 per day (B)	5-6 per week (E)	1-3 per month (H)
	2-3 per day (C)	2-4 per week (F)	Almost Never (I)

F. [RC 1] MISCELLANEOUS		Item Includes:
52. Peanut butter; 1 tbsp	☐	any kind
53. Potato chips or corn chips; small bag or 1 oz.	☐	nachos; 1 oz = about 1 c
54. French fried potatoes; 1 serving, 4 oz.	☐	4 oz = about 1 c
55. Nuts; 1 oz.	☐	all nuts, peanuts; mixed; M&M peanut; 1 oz. = about 3 tbsp
56. Potatoes, mashed; 1 c. or baked; 1	☐	boiled
57. Rice; 1/2 c.	☐	white rice; brown rice; wild rice; Rice-a-Roni
58. Spaghetti, noodles or other pasta; 1/2 c.	☐	macaroni; fettucini; noodles in lasagne
59. Home-fried food, such as any meats, poultry, fish, shrimp, eggs, vegetables, etc.; 1 serving	☐	any food fried at home except french fries; include sauteed foods
60. Food fried away from home, such as any fish, chicken, chicken nuggets, etc.	☐	any deep fried foods; fish sticks; fish patties; McNuggets; do not include french fries

Response Categories:			
	>6 per day (A)	1 per day (D)	1 per week (G)
	4-6 per day (B)	5-6 per week (E)	1-3 per month (H)
	2-3 per day (C)	2-4 per week (F)	Almost Never (I)

G. [RC 1] BEVERAGES		Item Includes:
61. Coffee, <u>not</u> decaffeinated; 1 c.	☐	brewed or instant
62. Tea, iced or hot, not including decaf or herbal tea; 1 cup	☐	
63. Low calorie soft drinks, such as any diet Coke, diet Pepsi, diet 7-Up; 1 glass	☐	all low calorie or diet carbonated beverages or sodas
64. Regular soft drinks, such as Coke, Pepsi, 7-Up, ginger ale; 1 glass	☐	all non-diet carbonated beverages or sodas
65. Fruit-flavored punch or non-carbonated beverages, such as lemonade, Kool-Aid or Hawaiian Punch; not diet; 1 glass	☐	Tang, Hi-C

H. OTHER DIETARY ITEMS

66. [RC 2] How often do you eat liver; 3-4 oz. serving? ..... 1/week A
2-3/month B
1/month or less C
Never D

67. Are there any other foods that you usually eat at least twice per week such as tortillas, prunes, or avocado? Do not include dry spices nor something that has been listed previously. ..... Yes Y
No N

Go to Item 74, Screen 11

68. Food #1 eaten at least twice per week (enter code and specify food and usual portion size below):.. [ ][ ][ ]

a. _____

69. [RC 3] Frequency for food #1: ..... > 6/day A
4-6/day B
2-3/day C
1/day D
5-6/wk E
2-4/wk F

70. Food #2 eaten at least twice per week (enter code and specify food and usual portion size below):.. [ ][ ][ ]

a. _____

71. [RC 3] Frequency for food #2: ..... > 6/day A
4-6/day B
2-3/day C
1/day D
5-6/wk E
2-4/wk F

H. Other Dietary Items

66. Remove Response Card 1; show participant RC 2. After this item, remove RC 2.

68. Look up food in "FOODS" list. Record 3-digit code number, if given. If it is not given, draw two horizontal lines through the boxes.

a. Enter food name. If the food does not appear in the "FOODS" list, also record usual portion size.

69. For the above food, enter frequency using Response Card 3. If the food appears in the list, base frequency on the portion size given in parentheses in that list. If the food does not appear in the "FOODS" list, base frequency on the portion size entered in (a).

70-71. Repeat above procedure for food #2. If none, skip to item 74. (Use "Next Field" key on computer.)

72. Food #3 eaten at least twice per week (enter code and specify food and usual portion size below):.. [ ][ ][ ]

a. _____

72-73. Repeat above procedure for food #3. If none, skip to item 74. (Use "Next Field" key on computer.)

73. [RC 3] Frequency for food #3: ..... > 6/day A
4-6/day B
2-3/day C
1/day D
5-6/wk E
2-4/wk F

74. [RC 4] What do you do with the visible fat on your meat? .....
Eat most of the fat A
Eat some of the fat B
Eat as little as possible C
Don't eat meat D

74. The question refers to visible fat on steaks, roasts, etc. Use Response Card 4, and remove it after this question.

75. [RC 5] What kind of fat do you usually use for frying and sauteing foods at home, excluding "Pam"-type spray? .....

Real Butter A
Margarine B
Vegetable Oil C
Vegetable Shortening D
Go to Item 77
Lard E
Bacon Grease F
Not Applicable G
Unknown H

75. Ask for the most often used, showing Response Card 5. If A,E,F,G, or H, skip to item 77.

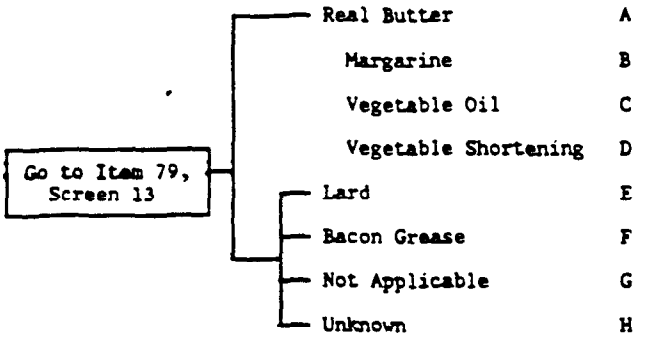
76. Enter code and specify brand and form below: ..... [ ][ ][ ]

a. _____

76. If "Margarine" was answered above, record the 3-digit code found in the "MARGARINE" listing. If "Vegetable Oil" or "Vegetable Shortening", record the code found in the "COOKING OILS" listing. If no code is given, draw two horizontal lines through the boxes.

a. Record the brand name of the oil, shortening, or margarine. If margarine, also record the form (tub, stick, diet, squeeze, etc.).

77. [RC 5] What kind of fat do you usually use for baking? .....



78. Enter code and specify brand and form below: ..... ☐☐☐

a. _____

79. [RC 6] What brand and form of margarine do you usually use at the table?

a. Form: ..... None A
Stick B
Tub C
Diet (low calorie) D
Other E

Go to Item 80

b. Code number: ..... ☐☐☐

c. Brand: _____

80. What kind of cold breakfast cereal do you most often use? (Enter code and specify brand name below): ..... ☐☐☐

a. Brand: _____

77-78. Complete as in items 75 and 76 above.

79. Note that the question refers to margarine used at the table. Obtain both brand name and form. Use Response Card 6, removing it after this item.

b. Record 3-digit code number found in "MARGARINE" list. If none given, draw two horizontal lines through the boxes.

c. Record the brand name of the margarine.

80. Look up the brand name in the "CEREALS" list, and enter the 3-digit code found there. If none is given, draw two horizontal lines through the boxes.

a. Record the brand name of the cereal.

81. Are you currently on a special diet? .. . Yes Y

: No N

Go to Item 84, Screen 14

82. For how many years have you been on it? .. ☐☐

82. The question refers to the current diet only.

83. [RC 7] What type of diet is it? ...

Weight Loss	A
Low Salt	B
Low Cholesterol	C
Weight Gain	D
Diabetic	E
Other	F

83. Use Response Card 7, removing it after this item.

84. How many teaspoons of sugar do you add to your food daily? Include sugar added to coffee, tea, cereal, etc. ..... ☐☐

84. Note 1 tablespoon = 3 teaspoons.

85. [RC 8] In cooking vegetables, how often do you add fat such as salt pork, butter, or margarine? .....

2-3 times per day	A
1 time per day	B
5-6 times per week	C
2-4 times per week	D
1 time per week	E
1-3 times per month	F
Never	G
Unknown	H

85. Show the participant Response Card 8 for items 85, 86, 88, and 89.

86. [RC 8] How often is salt or salt-containing seasoning such as garlic salt, onion salt, soy sauce, or Accent added to your food in cooking? .....

2-3 times per day	A
1 time per day	B
5-6 times per week	C
2-4 times per week	D
1 time per week	E
1-3 times per month	F
Never	G
Unknown	H

86. Include hot sauces.

87. How many shakes of salt do you add to your food at the table every day? .... ☐☐

88. [RC 8] How often do you add catsup, hot sauce, soy or steak sauces to your food? ....

2-3 times per day	A
1 time per day	B
5-6 times per week	C
2-4 times per week	D
1 time per week	E
1-3 times per month	F
Never	G
Unknown	H

88. At table.

89. [RC 8] How often do you eat special low salt foods such as low salt chips, nuts, cheese, or salad dressing? .....

2-3 times per day	A
1 time per day	B
5-6 times per week	C
2-4 times per week	D
1 time per week	E
1-3 times per month	F
Never	G
Unknown	H

I. ALCOHOL

"I am going to ask you about wine, beer, and drinks made with hard liquor because these are the three major types of alcoholic beverages."

90. Do you presently drink alcoholic beverages? ..... Yes Y

Go to Item 96, Screen 17

No N

91. Have you ever consumed alcoholic beverages? ..... Yes Y

No N

Go to Item 101, Screen 18

92. Approximately how many years ago did you stop drinking? ..... ☐☐

93. For how many years did you drink alcoholic beverages? ..... ☐☐

I. Alcohol

Frequency of alcohol consumption is determined as usual weekly intake. The serving sizes are different for beer, wine, and hard liquor. The definition of serving size, while consistent for measuring both present and past intake, is made more precise for present intake. This is done because recent intake is recalled better than past intake, and is probably more important for the ARIC study questions. For past intake serving sizes are defined as "one beer", "one glass of wine", and "one shot of liquor or one mixed drink". For present intake serving sizes are "12 oz. bottles or cans of beer", "4 oz. glasses of wine", and "1 and 1/2 oz. shots of hard liquor". For the final questions, which relate to the most recent 24 hours, the more precise definition of serving size is used.

90. If the participant asks, or if the answer is not explicit, "presently" is defined as within the last 6 months.

91. If the response is "No", skip to item 101. If the response is "Yes", continue with Question 92 to determine past alcohol consumption.

92. Record the response in years, rounding 1/2 down. For example, "1-1/2 years" would be recorded as 1 year. "About a half a year ago would be recorded as "0". If the participant stopped more than once, record the years since the most recent stopping. For example, if the participant says: "The last time I quit was two years ago. The first time I quit was twenty years ago," the response would be recorded as "2".
If not known, draw 2 horizontal lines through the boxes.

93. For those who have quit more than one time, record the total number of drinking years combined. Include in the total years that were "light" drinking years. If not known, draw 2 horizontal lines through the boxes.

94. In the past, which types of alcoholic beverages did you ordinarily drink? (Circle Y or N for each type below)

	Yes	No
a. Wine	Y	N
b. Beer	Y	N
c. Drinks made with hard liquor	Y	N
d. Other	Y	N

e. Specify: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

94. The interviewer reads each type (wine, beer and drinks made with hard liquor) and allows the respondent to answer with "Yes" or "No" to each. The respondent can answer "Yes" to more than one. "Wine" includes wine coolers, cordials, and "sweet wines". "Liquor" includes liqueurs.

95. What was the usual number of drinks you had per week before you stopped drinking alcoholic beverages? ..... [ ][ ]
{One drink means 1 beer or 1 glass of wine or 1 shot of liquor or 1 mixed drink. Record 0 if less than one drink per week.}

95. The definition of "drinks" in terms of serving size should be clear to the participant. Indicate that "per week" should include weekends. If the respondent used to drink more than one type of beverage, record the appropriate total (e.g., record "5" if the participant drank three beers and two glasses of wine per week). If not known, draw 2 horizontal lines through the boxes.

After completing item 95, go to item 101

96. How many glasses of wine do you usually have per week? ..... [ ][ ]
{4 oz. glasses; round down}

96-98. These questions are asked only if the participant answered "Yes" to Question 90. The serving sizes of wine, beer and hard liquor must be clear to the participant. For example, after asking: "How many glasses of wine do you usually have per week?", indicate that you are referring to 4 oz. glasses, and that "per week" includes the weekends. If the participant answers in terms of drinks per month, divide by four to derive the weekly intake. If the number of drinks is "half a drink" or less, record "0". If the number of drinks is more than 99 record as "99". "Wine" includes wine coolers, cordials, and "sweet wines". "Liquor" includes liqueurs. If not known, draw 2 horizontal lines through the boxes.

97. How many bottles or cans of beer do you usually have per week? ..... [ ][ ]
{12 oz. bottles or cans; round down}

98. How many drinks of hard liquor do you usually have per week? ..... [ ][ ]
{1 1/2 oz. shots; round down}

99. During the past 24 hours, how many drinks have you had? ..... [ ][ ]

99. The definition of "drinks" should be clear to the participant. If the participant asks, or the interviewer thinks that the serving sizes are no longer clear to him/her, read the serving size definitions given in items 96-98. If not known, draw 2 horizontal lines through the boxes.

If "0", go to item 101

100. Were these: {Circle Y or N for each}

	Yes	No
a. Wine?	Y	N
b. Beer?	Y	N
c. Liquor?	Y	N

100. Ask the participant slowly and in sequence if he/she had wine, beer or liquor, and allow the participant to answer "Yes" or "No" for each type. "Wine" includes wine coolers, cordials, and "sweet wines". "Liquor" includes liqueurs.

J. WEIGHT AT AGE 25

101. What was your weight at age 25? (pounds) ..... ☐☐☐

J. Weight At Age 25

101. Help the participant estimate his/her weight at 25 by recalling associated life events. If not known, draw 2 horizontal lines through the boxes.

K. ADMINISTRATIVE INFORMATION

102. Interviewer's opinion of information: ....

Reliable	A
Questionable	B
Participant uncooperative	C
Participant unable to estimate frequencies	D

K. Administrative Information

102. Evaluate the quality of the interview, emphasizing the dietary portion.

103. Date of data collection: ... ☐☐ - ☐☐ - ☐☐
Month Day Year

103. Record the date on which the interview took place.

104. Method of data collection: ..... Computer C
Paper Form P

104. Record "C" if the form was completed on the computerized data entry system, or "P" if the paper form was used.

105. Code number of person completing this form: ... ☐☐☐

105. The person at the clinic who has performed the interview and completed the form must enter his/her code number in the boxes provided.

CONVERSION OF NONSTANDARD PORTION SIZES TO FREQUENCIES

	FREQUENCY								
MULTIPLE OF AMOUNT	A > 6 per day	B 4-6 per day	C 2-3 per day	D 1 per day	E 5-6 per wk	F 2-4 per wk	G 1 per wk	H 1-3 per mo	I Almost never
2X	A	A	B	C	D	E	F	H	I
0.5X	B	C	D	F	F	G	H	I	I

FREQUENCY CONVERSION FOR SEASONAL INTAKE

SEASON LENGTH	FREQUENCY				
	1 time /week	2 times /week	3 times /week	4-5 times /week	1 time /day
2 mo.	I	H	H	H	G
3 mo.	H	H	H	G	G
4 mo.	H	H	G	G	F

O.M.B. 0925-0281
exp. 7-31-89

A-211

ARIC

ATHEROSCLEROSIS RISK IN COMMUNITIES STUDY

TIA / STROKE FORM

ID NUMBER: | | | | | | | | CONTACT YEAR: | 0 | 1 | FORM CODE: | T | I | A | VERSION: B 6/19/87

LAST NAME: | | | | | | | | | | | | | INITIALS: | | | DRAFT

INSTRUCTIONS:
This form should be completed during the interview portion of the participant's visit. ID Number 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 zeroes where necessary to fill all boxes. If a number is entered incorrectly, 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.

TIA/STROKE FORM (TIAA screen 1 of 30)

A. MEDICAL HISTORY

1. Have you ever been told by a physician that you had a stroke, slight stroke, transient ischemic attack or TIA? ..... Yes Y
No N

Go to Item 3, Screen 1

2. When did the (first) stroke or TIA occur?

| | | Month | | | Year

B. SUDDEN LOSS OR CHANGE OF SPEECH

3. Have you ever had any sudden loss or changes in speech? ..... Yes Y
No N
Don't Know D

Go to Item 10, Screen 6

TIA/STROKE FORM (TIAA screen 2 of 30)

4. How many episodes of loss or changes in speech have you had? .....

1	A
2	B
3	C
4	D
5	E
6-20	F
More than 20, or frequent, intermittent events, too numerous to count.	G

5. When was the (most recent) episode? ...

In the past day	A
2-7 days ago	B
8-30 days ago	C
1-6 months ago	D
7-12 months ago	E
More than a year ago	F

TIA/STROKE FORM (TIAA screen 3 of 30)

6. How long did it (the longest episode) last? .....

Less than 30 seconds	A
At least 30 seconds, but less than 1 minute	B
At least 1 minute, but less than 3 minutes	C
At least 3 minutes, but less than 1 hour	D
At least 1 hour, but less than 6 hours	E
At least 6 hours, but less than 12 hours	F
At least 12 hours, but less than 24 hours	G
At least 24 hours	H

7. Did the (worst) episode come on suddenly? ..... Yes Y

No N

a. How long did it take for the symptoms to get as bad as they were going to get? .....

0-2 seconds (instantly)	A
At least 3 seconds, but less than 1 minute	B
At least 1 minute, but less than 1 hour	C
At least 1 hour, but less than 2 hours	D
At least 2 hours, but less than 24 hours	E
At least 24 hours	F

TIA/STROKE FORM (TIAA screen 4 of 30)

8. Do any of the following describe your change in speech? ..... {READ ALL CHOICES}

	Yes	No	Don't Know
a. Slurred speech like you were drunk	Y	N	D
b. Could talk but the wrong words came out	Y	N	D
c. Knew what you wanted to say, but the words would not come out	Y	N	D

9. While you were having your (worst) episode of change in speech, did any of the following occur? ..... {INCLUDE ALL THAT APPLY}

a. Numbness or tingling ..... Yes Y

No N

Go to Item 9.c Screen 5

b. Did you have difficulty on: ..... {READ ALL CHOICES}

The right side only R

The left side only L

Both sides B

TIA/STROKE FORM (TIAA screen 5 of 30)

c. Paralysis or weakness ..... Yes Y

No N

Go to Item 9.e Screen 5

d. Did you have difficulty on: ..... {READ ALL CHOICES}

The right side only R

The left side only L

Both sides B

e. Lightheadedness or dizzy spells ..... Yes Y

No N

f. Blackouts or fainting ..... Yes Y

No N

g. Seizures or convulsions ..... Yes Y

No N

h. Headache ..... Yes Y

No N

TIA/STROKE FORM (TIAA screen 6 of 30)

i. Visual Disturbances ..... Yes Y

No N

Go to Item 10, Screen 6

j. Did you have: .....
{READ ALL CHOICES UNTIL A POSITIVE RESPONSE IS GIVEN}

Double vision	A
Vision loss in right eye only	B
Vision loss in left eye only	C
Total loss of vision in both eyes	D
Trouble in both eyes seeing to the right	E
Trouble in both eyes seeing to the left	F
Other If "Other," specify ...	G

C. SUDDEN LOSS OF VISION

10. Have you ever had any sudden loss of vision, complete or partial?..... Yes Y

No N

Don't Know D

Go to Item 17, Screen 10

TIA/STROKE FORM (TIAA screen 7 of 30)

11. How many episodes of loss of vision have you had? .....

1	A
2	B
3	C
4	D
5	E
6-20	F
More than 20, or frequent, intermittent events, too numerous to count.	G

12. When was the (most recent) episode? ...

In the past day	A
2-7 days ago	B
8-30 days ago	C
1-6 months ago	D
7-12 months ago	E
More than a year ago	F

TIA/STROKE FORM (TIAA screen 8 of 30)

13. How long did it (the longest episode) last? ....

- Less than 30 seconds — A
- At least 30 seconds, but less than 1 minute — B
- At least 1 minute, but less than 3 minutes — C
- At least 3 minutes, but less than 1 hour — D
- At least 1 hour, but less than 6 hours — E
- At least 6 hours, but less than 12 hours — F
- At least 12 hours, but less than 24 hours — G
- At least 24 hours — H

14. Did the (worst) episode come on suddenly? ..... Yes — Y / No — N

a. How long did it take for the symptoms to get as bad as they were going to get? .....

- 0-2 seconds (instantly) — A
- At least 3 seconds, but less than 1 minute — B
- At least 1 minute, but less than 1 hour — C
- At least 1 hour, but less than 2 hours — D
- At least 2 hours, but less than 24 hours — E
- At least 24 hours — F

TIA/STROKE FORM (TIAA screen 9 of 30)

15. During the (worst) episode, which of the following parts of your vision were affected? .....
{READ ALL CHOICES}

- Only the right eye — R
- Only the left eye — L
- Both eyes — B

→ Go to Item 16, Screen 9

a. Did you have: .....
{READ ALL CHOICES UNTIL A POSITIVE RESPONSE IS GIVEN}

- Total loss of vision — B
- Trouble seeing to the right — R
- Trouble seeing to the left — L
- Other vision difficulties — O

16. While you were having your (worst episode of) loss of vision, did any of the following occur?
{INCLUDE ALL THAT APPLY}

a. Speech disturbance ..... Yes — Y / No — N

b. Numbness or tingling ..... Yes — Y / No — N

→ Go to Item 16.d, Screen 10

c. Did you have difficulty on: .....
{READ ALL CHOICES}

- The right side only — R
- The left side only — L
- Both sides — B

TIA/STROKE FORM (TIAA screen 10 of 30)

d. Paralysis or weakness ..... Yes Y
No N

Go to Item 16.f, Screen 10

e. Did you have difficulty on: .....
{READ ALL CHOICES}

The right side only R
The left side only L
Both sides B

f. Lightheadedness or dizzy spells ..... Yes Y
No N

g. Blackouts or fainting ..... Yes Y
No N

h. Seizures or convulsions ..... Yes Y
No N

i. Headache ..... Yes Y
No N

D. DOUBLE VISION

17. Have you ever had a sudden spell of double vision? ..... Yes Y
No N
Don't Know D

Go to Item 23, Screen 15

a. If you closed one eye, did the double vision go away? ..... Yes Y
No N
Don't Know D

Go to Item 23, Screen 15

TIA/STROKE FORM (TIAA screen 11 of 30)

18. How many episodes of double vision have you had? .....

1 A
2 B
3 C
4 D
5 E
6-20 F
More than 20, or frequent, intermittent events, too numerous to count. G

19. When was the (most recent) episode? ...

In the past day A
2-7 days ago B
8-30 days ago C
1-6 months ago D
7-12 months ago E
More than a year ago F

TIA/STROKE FORM (TIAA screen 12 of 30)

20. How long did it (the longest episode) last? ....

Less than 30 seconds	A
At least 30 seconds, but less than 1 minute	B
At least 1 minute, but less than 3 minutes	C
At least 3 minutes, but less than 1 hour	D
At least 1 hour, but less than 6 hours	E
At least 6 hours, but less than 12 hours	F
At least 12 hours, but less than 24 hours	G
At least 24 hours	H

21. Did the (worst) episode come on suddenly? ..... Yes Y / No N

a. How long did it take for the symptoms to get as bad as they were going to get? .....

0-2 seconds (instantly)	A
At least 3 seconds, but less than 1 minute	B
At least 1 minute, but less than 1 hour	C
At least 1 hour, but less than 2 hours	D
At least 2 hours, but less than 24 hours	E
At least 24 hours	F

TIA/STROKE FORM (TIAA screen 13 of 30)

22. While you were having your (worst episode of) double vision, did any of the following occur? {INCLUDE ALL THAT APPLY}

a. Speech disturbances ..... Yes Y / No N

b. Numbness or tingling ..... Yes Y / No N

Go to Item 22.d, Screen 14

c. Did you have difficulty on: ..... {READ ALL CHOICES}

The right side only	R
The left side only	L
Both sides	B

TIA/STROKE FORM (TIAA screen 14 of 30)

d. Paralysis or weakness ..... Yes Y
No N

Go to Item 22.f, Screen 14

e. Did you have difficulty on: .....
{READ ALL CHOICES}

The right side only R
The left side only L
Both sides B

f. Lightheadedness or dizzy spells ..... Yes Y
No N

g. Blackouts or fainting ..... Yes Y
No N

h. Seizures or convulsions ..... Yes Y
No N

i. Headache ..... Yes Y
No N

TIA/STROKE FORM (TIAA screen 15 of 30)

E. SUDDEN NUMBNESS OR TINGLING

23. Have you ever had sudden numbness, tingling, or loss of feeling on one side of your body? ... Yes Y
No N
Don't Know D

Go to Item 32, Screen 20

24. Did the feeling of numbness or tingling occur only when you kept your arms or legs in a certain position? ..... Yes Y
No N
Don't Know D

Go to Item 32, Screen 20

25. How many episodes of numbness, tingling, or loss of sensation have you had?

1 A
2 B
3 C
4 D
5 E
6-20 F
More than 20, or frequent, intermittent events, too numerous to count. G

TIA/STROKE FORM (TIAA screen 16 of 30)

26. When was the (most recent) episode? ...

In the past day	A
2-7 days ago	B
8-30 days ago	C
1-6 months ago	D
7-12 months ago	E
More than a year ago	F

27. How long did it (the longest episode) last? ....

Less than 30 seconds	A
At least 30 seconds, but less than 1 minute	B
At least 1 minute, but less than 3 minutes	C
At least 3 minutes, but less than 1 hour	D
At least 1 hour, but less than 6 hours	E
At least 6 hours, but less than 12 hours	F
At least 12 hours, but less than 24 hours	G
At least 24 hours	H

TIA/STROKE FORM (TIAA screen 17 of 30)

28. Did the (worst) episode come on suddenly? ..... Yes Y

No N

a. How long did it take for the symptoms to get as bad as they were going to get? .....

0-2 seconds (instantly)	A
At least 3 seconds, but less than 1 minute	B
At least 1 minute, but less than 1 hour	C
At least 1 hour, but less than 2 hours	D
At least 2 hours, but less than 24 hours	E
At least 24 hours	F

29. During the (worst) episode, which part or parts of your body were affected? {READ ALL CHOICES}

	Yes	No	Don't Know
a. Left arm or hand	Y	N	D
b. Left leg or foot	Y	N	D
c. Left side of face	Y	N	D
d. Right arm or hand	Y	N	D
e. Right foot or leg	Y	N	D
f. Right side of face	Y	N	D
g. Other	Y	N	D

TIA/STROKE FORM (TIAA screen 18 of 30)

30. During this episode, did the abnormal sensation start in one part of your body and spread to another, or did it stay in the same place? .....

- In one part and spread to another — S
- Stayed in one part — O
- Don't Know — D

31. While you were having your (worst) episode of numbness, tingling or loss of sensation, did any of the following occur? {INCLUDE ALL THAT APPLY}

a. Speech disturbance ..... Yes — Y / No — N

TIA/STROKE FORM (TIAA screen 19 of 30)

b. Paralysis or weakness ..... Yes — Y / No — N

→ Go to Item 31.d, Screen 19

c. Did you have difficulty on: ..... {READ ALL CHOICES}

- The right side only — R
- The left side only — L
- Both sides — B

d. Lightheadedness or dizzy spells ..... Yes — Y / No — N

e. Blackouts or fainting ..... Yes — Y / No — N

f. Seizures or convulsions ..... Yes — Y / No — N

g. Headache ..... Yes — Y / No — N

h. Pain in the numb or tingling arm, leg or face ..... Yes — Y / No — N

TIA/STROKE FORM (TIAA screen 20 of 30)

i. Visual disturbances ..... Yes Y

No N

Go to Item 32, Screen 20

j. Did you have: .....
{READ ALL CHOICES UNTIL A POSITIVE RESPONSE IS GIVEN

Double vision	A
Vision loss in right eye only	B
Vision loss in left eye only	C
Total loss of vision in both eyes	D
Trouble in both eyes seeing to the right	E
Trouble in both eyes seeing to the left	F
Other If "Other," specify ...	G

F. SUDDEN PARALYSIS OR WEAKNESS

32. Have you ever had any sudden episodes of paralysis or weakness on one side of your body? ..... Yes Y

No N

Don't Know D

Go to Item 40, Screen 25

TIA/STROKE FORM (TIAA screen 21 of 30)

33. How many episodes of paralysis or weakness have you had? .....

1	A
2	B
3	C
4	D
5	E
6-20	F
More than 20, or frequent, intermittent events, too numerous to count.	G

34. When was the (most recent) episode? ...

In the past day	A
2-7 days ago	B
8-30 days ago	C
1-6 months ago	D
7-12 months ago	E
More than a year ago	F

TIA/STROKE FORM (TIAA screen 22 of 30)

35. How long did it (the longest episode) last? ....

Less than 30 seconds	A
At least 30 seconds, but less than 1 minute	B
At least 1 minute, but less than 3 minutes	C
At least 3 minutes, but less than 1 hour	D
At least 1 hour, but less than 6 hours	E
At least 6 hours, but less than 12 hours	F
At least 12 hours, but less than 24 hours	G
At least 24 hours	H

36. Did the (worst) episode come on suddenly? ..... Yes Y

No N

a. How long did it take for the symptoms to get as bad as they were going to get? .....

0-2 seconds (instantly)	A
At least 3 seconds, but less than 1 minute	B
At least 1 minute, but less than 1 hour	C
At least 1 hour, but less than 2 hours	D
At least 2 hours, but less than 24 hours	E
At least 24 hours	F

TIA/STROKE FORM (TIAA screen 23 of 30)

37. During this episode, what part or parts of your body were affected? {READ ALL CHOICES}

	Yes	No	Don't Know
a. Left arm or hand	Y	N	D
b. Left leg or foot	Y	N	D
c. Left side of face	Y	N	D
d. Right arm or hand	Y	N	D
e. Right foot or leg	Y	N	D
f. Right side of face	Y	N	D
g. Other	Y	N	D

38. During this episode, did the paralysis or weakness start in one part of your body and spread to another, or did it stay in the same place? .....

Started in one part and spread to another	S
Stayed in one part	O
Don't know	D

39. While you were having your worst episode of paralysis or weakness did any of the following occur? {INCLUDE ALL THAT APPLY}

a. Speech disturbances ..... Yes Y

No N

TIA/STROKE FORM (TIAA screen 24 of 30)

b. Numbness or tingling ..... Yes Y
No N

Go to Item 39.d, Screen 24

c. Did you have difficulty on: .....
{READ ALL CHOICES}

The right side only R
The left side only L
Both sides B

d. Lightheadedness or dizzy spells ..... Yes Y
No N

e. Blackouts or fainting ..... Yes Y
No N

f. Seizures or convulsions ..... Yes Y
No N

g. Headache ..... Yes Y
No N

h. Pain in the weak arm, leg or face ..... Yes Y
No N

TIA/STROKE FORM (TIAA screen 25 of 30)

i. Visual Disturbances ..... Yes Y
No N

Go to Item 40, Screen 25

j. Did you have: .....
{READ ALL CHOICES UNTIL A POSITIVE RESPONSE IS GIVEN}

Double vision A
Vision loss in right eye only B
Vision loss in left eye only C
Total loss of vision in both eyes D
Trouble in both eyes seeing to the right E
Trouble in both eyes seeing to the left F
Other G
If "Other," specify ...

G. SUDDEN SPELLS OF DIZZINESS OR LOSS OF BALANCE

40. Have you ever had any sudden spells of dizziness, loss of balance, or sensation of spinning? ..... Yes Y
No N
Don't Know D

Go to Item 47, Screen 30

41. Did the dizziness, loss of balance or spinning sensation occur only when changing the position of your head or body? ..... Yes Y
No N
Don't Know D

Go to Item 47, Screen 30

TIA/STROKE FORM (TIAA screen 26 of 30)

42. While you were having your (worst) episode of dizziness, loss of balance or spinning sensation, did any of the following occur? {INCLUDE ALL THAT APPLY}

a. Speech disturbances ..... Yes Y
No N

b. Paralysis or weakness ..... Yes Y
No N

Go to Item 42.d, Screen 27

c. Did you have difficulty on: ..... {READ ALL CHOICES}

The right side only R
The left side only L
Both sides B

TIA/STROKE FORM (TIAA screen 27 of 30)

d. Numbness or tingling ..... Yes Y
No N

Go to Item 42.f, Screen 27

e. Did you have difficulty on: ..... {READ ALL CHOICES}

The right side only R
The left side only L
Both sides B

f. Blackouts or fainting ..... Yes Y
No N

g. Seizures or convulsions ..... Yes Y
No N

h. Headache ..... Yes Y
No N

TIA/STROKE FORM (TIAA screen 28 of 30)

i. Visual disturbances ..... Yes Y

No N

Go to Item 43, Screen 28

IF ALL OF ITEMS 42.a THROUGH 42.i ARE NO, GO TO ITEM 47 ON SCREEN 30

j. Did you have: .....
{READ ALL CHOICES UNTIL A POSITIVE RESPONSE IS GIVEN}

Double vision	A
Vision loss in right eye only	B
Vision loss in left eye only	C
Total loss of vision in both eyes	D
Trouble in both eyes seeing to the right	E
Trouble in both eyes seeing to the left	F
Other If "Other," specify ...	G

43. How many episodes of dizziness, loss of balance or spinning sensation have you had? .....

1	A
2	B
3	C
4	D
5	E
6-20	F
More than 20, or frequent, intermittent events, too numerous to count.	G

TIA/STROKE FORM (TIAA screen 29 of 30)

44. When was the (most recent) episode? ...

In the past day	A
2-7 days ago	B
8-30 days ago	C
1-6 months ago	D
7-12 months ago	E
More than a year ago	F

45. How long did it (the longest episode) last? ....

Less than 30 seconds	A
At least 30 seconds, but less than 1 minute	B
At least 1 minute, but less than 3 minutes	C
At least 3 minutes, but less than 1 hour	D
At least 1 hour, but less than 6 hours	E
At least 6 hours, but less than 12 hours	F
At least 12 hours, but less than 24 hours	G
At least 24 hours	H

TIA/STROKE FORM (TIAA screen 30 of 30)

46. Did the (worst) episode come on suddenly? ..... Yes Y

No N

a. How long did it take for the symptoms to get as bad as they were going to get? .....

0-2 seconds (instantly) A

At least 3 seconds, but less than 1 minute B

At least 1 minute, but less than 1 hour C

At least 1 hour, but less than 2 hours D

At least 2 hours, but less than 24 hours E

At least 24 hours F

H. ADMINISTRATIVE INFORMATION

47. Date of data collection: ... [ ][ ] - [ ][ ] - [ ][ ]
Month Day Year

48. Method of data collection: ..... Computer C

Paper form P

49. Code number of person completing this form: ... [ ][ ][ ]

TIA/STROKE FORM INSTRUCTIONS: QUESTION BY QUESTION
(Matches the 6-19-87 version of the form)

I. GENERAL INSTRUCTIONS

The Stroke/TIA form should be completed during the participant's baseline visit and clinic follow-up visit. The interviewer must be certified according to ARIC protocol. The recorder should be familiar with and understand the document titled "General Instructions for Completing Paper Forms" and the DES Training Manual prior to completing this form. ID Number, Visit Code, and Patient Name should be completed as described in those documents. Data for this form may be collected by first filling out the paper version of the form and later transcribing the data to the computerized form, or by collecting the data directly onto the computerized form (when available). If the paper version of the form is used, fill in the boxes (right justify and zero fill numeric entries, and using block letters, right justify alphabetic entries) and circle the letter in the right column corresponding to the response. If the data are being recorded directly into the computer, enter the letter corresponding to the response in the blank provided on the computerized form. In the instructions for the individual questions, "Record" is used as a generic descriptor for filling in the boxes, circling the correct response or entering the correct letter in the blank.

II. GENERAL DEFINITIONS

This set of questions is designed to help determine whether the participant has ever had a physician-diagnosed or undiagnosed stroke or TIA. A stroke generally includes one or more of the following symptoms which begin <u>suddenly</u>: (1) loss or change of speech, (2) loss of vision, (3) double vision, (4) numbness or tingling on one side of the body, (5) paralysis or weakness on one side of the body, or (6) spells of dizziness or loss of balance. These symptoms may improve after a period of time, or may be persistent. The likelihood of a particular symptom being caused by a stroke depends on the rapidity of onset, the duration of symptoms and the associated symptoms. Certain <u>patterns</u> of these factors are supportive of a diagnosis of stroke/TIA, while other patterns are supportive of a diagnosis other than stroke/TIA.

TIA, or transient ischemic attack, is considered to be a slight stroke or light stroke where the same patterns occur as in stroke; the only difference being that the symptoms last less than 24 hours. TIA's are <u>episodic</u>: that is, they occur as discrete episodes with a clear onset or beginning and resolution or ending. A participant may have a single episode or several episodes of either the same symptom complex or different symptoms.

The Stroke/TIA form is divided into seven sections: (1) medical history, (2) sudden loss or change of speech, (3) sudden loss of vision, (4) double vision, (5) sudden numbness or tingling, (6) sudden paralysis or weakness, and (7) sudden spells of dizziness or loss of balance.

The first section is to determine whether the participant has a history of physician-diagnosed stroke or TIA. Sections 2-6 ask a battery of similar questions about each category of symptoms. The first question always asks if the participant has ever experienced the sudden onset of the particular symptom. If the response is NO or DON'T KNOW, you do not read the rest of the questions in that section and skip to the first question in the next section. If the answer is YES, you continue reading the rest of the questions in that section unless another "skip" question is encountered. The second question in each set of questions establishes if more than one episode occurred. If the participant has had more than one episode, subsequent questions in that set should be asked by reading the qualifying phrases in parentheses regarding the most recent, longest and worst events. Several questions ask about the rapidity of onset and some specific characteristics about the worst episode of the event. The definition of worst is left to the discretion of the participant. The last question in each section asks about associated symptoms.

The last section, Section 7, asks similar questions as those in Sections 2-6 but they are presented in a different order to identify those participants who have experienced symptoms of sudden dizziness or loss of balance from a non-neurologic cause.

III. Detailed Instructions for Each Item

A.1. Here we are specifically looking for a physician diagnosis of stroke or TIA. Light stroke, minor stroke or small stroke would all be considered appropriate synonyms resulting in a YES response if participant was told by a physician. Record Y for YES or N for NO. If the participant is unsure, record as N. If response is N, skip to Section B, question 3.

A.2. Record 01-12 for month; 01-99 for year. If either the month or year is unknown, record an equal sign for the unknown month and/or year, i.e.,

=	=	/	8	2	or	1	0	/	=	=	or
m	m		y	y		m	m		y	y	

=	=	/	=	=	or	=	=	/	=	=	
m	m		y	y		m	m		y	y	

B.3. This question is concerned with the sudden onset of loss of voice. This should help to differentiate a neurologic etiology from that of laryngitis, sore throat, cold, or being drunk. Record Y, N, or D. If NO or DON'T KNOW, skip to Section C, question 10. If YES, go to question B.4.

B.4. Record the letter by the response given. If the participant has had "many episodes," determine whether or not they feel there have been more or less than 20 and record the appropriate category.

B.5. Record the letter by the response given. This question focuses on the length of time since the most recent event, if more than one has occurred.

B.6. This question is concerned with the duration of the longest (or only) episode of the symptom. It is used to differentiate between a stroke, TIA, or non-neurologic event. Record the letter corresponding to the response category which contains the duration given by the subject. Specific categories should not be read to the participant. However, prompts such as "a few seconds" or "several hours" may be given to help identify the appropriate category.

B.7. Let the participant decide which was the worst episode if more than one occurred. If the participant requests a definition of "worst", the participant may be prompted to define "worst" in terms of the severity or intensity of an episode, or an episode accompanied by other symptoms. Record Y or N. The next question (B.7.a) attempts to identify the time until the symptoms reached their peak intensity. This would be the time from when the symptom was first perceived by the participant until the time that the symptom maximized or reached its worst. If the response to B.7 is YES, record the letter of the response category which contains the length of time given by the subject. Specific categories should not be read to the participant. However, prompts such as "a few seconds" or "several hours" may be given to identify the appropriate category.

B.8. Read the question and each response category to the participant. Record Y, N, or D for each of the categories (a-c). Categories are not mutually exclusive and more than one can be positive.

B.9. Read the question to the participant. Record Y or N for each of the categories. Categories are not mutually exclusive and more than one can be positive. It is essential that each category be answered YES only if the symptom occurred at the same time as the loss of speech. Note the skip rules for categories a, c and i. The questions immediately following these categories (b, d and j) are not to be asked unless the response to the previous question is YES. The purpose of these follow-up questions is to localize the symptoms. The responses to questions b, d, and j are mutually exclusive. For Questions 9.b. and 9.d., read all resopnse categories to the participant before asking for the response. When asking question 9.j, read down the list of responses

until the participant gives a positive response. When a positive response is given, record the letter corresponding to the response and skip to question 10. If the subject does not respond positively to responses A through F, record "G" and ask the subject to describe the visual symptom. Record the symptom in the blank provided.

C.10. The intent of this question is to determine if the onset of loss of vision was sudden. If NO or DON'T KNOW, go to the next section (D).

C.11. Record the letter by the response given. If the participant has had "many episodes," determine whether or not they feel there have been more or less than 20 and record the appropriate category.

C.12. Record the letter by the response given. This question focuses on the length of time since the most recent event, if more than one has occurred.

C.13. This question is concerned with the duration of the longest (or only) episode of the symptom. It is used to differentiate between a stroke, TIA, or non-neurologic event. Record the letter corresponding to the response category which contains the duration given by the subject. Specific categories should not be read to the participant. However, prompts such as "a few seconds" or "several hours" may be given to help identify the appropriate category.

C.14. Let the participant decide which was the worst episode if more than one occurred. If the participant requests a definition of "worst", the participant may be prompted to define "worst" in terms of the severity or intensity of an episode, or an episode accompanied by other symptoms. Record Y or N. The next question (C.14.a) attempts to identify the time until the symptoms reached their peak intensity. This would be the time from when the symptom was first perceived by the participant until the time that the symptom maximized or reached its worst. If the response to C.14 is YES, record the letter of the response category which contains the length of time given by the subject. Specific categories should not be read to the participant. However, prompts such as "a few seconds" or "several hours" may be given to identify the appropriate category.

C.15. The categories for the first question are mutually exclusive. The keyword in the response categories is only. Read all three responses to the participant before asking for the best response. Record R for affected vision only in the right eye, L for affected vision only in the left eye and B for vision problems in both eyes. If only the right or left eye were

involved, go to question C.16. If both eyes were involved, continue with 15.a.

For question 15.a., read the question, repeating if necessary, "if both eyes were involved", and the response categories. The response categories are mutually exclusive. Read down the list until the participant gives a positive response. Record B if the subject had total loss of vision, R if the subject had difficulty seeing to the right, L if there was difficulty seeing to the left, and O if some other type vision loss was experienced. When a positive response is given, record the letter corresponding to the response and skip to the next question.

D.16. Read the question and the response categories to the participant. Record Y or N for each of the categories. Categories are not mutually exclusive and more than one can be positive. It is essential that each category be answered YES only if the symptom occurred at the same time as the loss of vision. Note the skip rules for categories b and d. The questions immediately following these categories (c and e) are not to be asked unless the response to the previous question is YES. The purpose of these follow-up questions is to localize the symptoms. The responses to questions c and e are mutually exclusive. Read all response categories to the participant before asking for the best response.

D.17. Define double vision, if asked, as seeing two images. This may include objects appearing side by side, one on top of the other or diagonally overlapping each other. Blurred vision, triple vision or seeing "multiple" images (more than two) are not included. Record Y, N, or D. If NO or DON'T KNOW, go to the next section. If YES, continue with D.17.a.

For question 17.a., ask the subject if he/she closed one eye, did the double vision go away. Record Y, N, or D in the blank. If N, go to Section E. If didn't close one eye, code as DON'T KNOW.

D.18. Record the letter by the response given. If the participant has had "many episodes," determine whether or not they feel there have been more or less than 20 and record the appropriate category.

D.19. This question focuses on the length of time since the most recent event, if more than one has occurred. Record the letter by the response given.

D.20. This question is concerned with the duration of the longest (or only) episode of the symptom. It is used to differentiate between a stroke, TIA, or non-neurologic event. Record the letter corresponding to the response category which contains the

duration given by the subject. Specific categories should not be read to the participant. However, prompts such as "a few seconds" or "several hours" may be given to help identify the appropriate category.

D.21. Let the participant decide which was the worst episode if more than one occurred. If the participant requests a definition of "worst", the participant may be prompted to define "worst" in terms of the severity or intensity of an episode, or an episode accompanied by other symptoms. Record Y or N. The next question (D.21.a) attempts to identify the time until the symptoms reached their peak intensity. This would be the time from when the symptom was first perceived by the participant until the time that the symptom maximized or reached its worst. If the response to D.21 is YES, record the letter of the response category which contains the length of time given by the subject. Specific categories should not be read to the participant. However, prompts such as "a few seconds" or "several hours" may be given to identify the appropriate category.

D.22. Read the question and the response categories to the participant. Record Y or N for each of the categories. Categories are not mutually exclusive and more than one can be positive. It is essential that each category be answered YES only if the symptom occurred at the same time as the double vision. Note the skip rules for categories b and d. The questions immediately following these categories (c and e) are not to be asked unless the answer to the previous question is YES. The purpose of the questions is to localize the symptoms. The responses to questions c and e are mutually exclusive. Read all response categories to the participant before asking for the best response.

E.23. Record Y, N, or D. If NO or DON'T KNOW, go to the next section (F).

E.24. Record Y, N or D. This question seeks to find participants who had extremities that "fell asleep". If the response is YES, skip to the next section (F).

E.25. Record the letter by the response given. If the participant has had "many episodes," determine whether or not they feel there have been more or less than 20 and record the appropriate category.

E.26. This question focuses on the length of time since the most recent event, if more than one has occurred. Record the letter by the response given. E.27. This question is concerned with the duration of the longest (or only) episode of the symptom. It is used to differentiate between a stroke, TIA, or non-neurologic

event. Record the letter corresponding to the response category which contains the duration given by the subject. Specific categories should not be read to the participant. However, prompts such as "a few seconds" or "several hours" may be given to help identify the appropriate category.

E.28. Let the participant decide which was the worst episode if more than one occurred. If the participant requests a definition of "worst", the participant may be prompted to define "worst" in terms of the severity or intensity of an episode, or an episode accompanied by other symptoms. Record Y or N. The next question (E.28.a) attempts to identify the time until the symptoms reached their peak intensity. This would be the time from when the symptom was first perceived by the participant until the time that the symptom maximized or reached its worst. If the response to E.28 is YES, record the letter of the response category which contains the length of time given by the subject. Specific categories should not be read to the participant. However, prompts such as "a few seconds" or "several hours" may be given to identify the appropriate category.

E.29. Ask the question as "the" or "the worst" episode based on the response to E.25. Read all choices and record the appropriate responses. Record Y, N, or D for each category. The categories are not mutually exclusive. A response of "other" would refer to body parts not listed, such as chest wall, abdomen or back.

E.30. This question is to determine whether the participant experienced migration of numbness or tingling. The categories are mutually exclusive. Record S if the symptoms spread from one part of the body to another, O if the symptoms started and stayed in one part of the body, or D if the participant doesn't know or remember.

E.31. Read the question and the response categories to the participant. Record Y or N for each of the categories. Categories are not mutually exclusive and more than one can be positive. It is essential that each category be answered YES only if the symptom occurred at the same time as the numbness. Note the skip rules for categories b and i. The questions immediately following these categories (c and j) are not to be asked unless the answer to the previous question is YES. The purpose of questions c and j is to localize the symptoms. The responses questions c and j are mutually exclusive. For Questions 31.b. and 31.d., read all response categories to the participant before asking for the response. When asking question 31.j, read down the list of responses until the participant gives a positive response. When a positive response is given, record the letter corresponding to the response and skip to question 32. If the subject does not respond positively to responses A through F, record "G" and ask the subject to describe the visual symptom. Record the symptom in the blank provided.

F.32. Record Y, N, or D. If NO or DON'T KNOW, go to the next section (G).

F.33. Record the letter by the response given. If the participant has had "many episodes," determine whether or not they feel there have been more or less than 20 and record the appropriate category.

F.34. This question focuses on the length of time since the most recent event, if more than one has occurred. Record the letter by the response given.

F.35. This question is concerned with the duration of the longest (or only) episode of the symptom. It is used to differentiate between a stroke, TIA, or non-neurologic event. Record the letter corresponding to the response category which contains the duration given by the subject. Specific categories should not be read to the participant. However, prompts such as "a few seconds" or "several hours" may be given to help identify the appropriate category.

F.36. Let the participant decide which was the worst episode if more than one occurred. If the participant requests a definition of "worst", the participant may be prompted to define "worst" in terms of the severity or intensity of an episode, or an episode accompanied by other symptoms. Record Y or N. The next question (F.36.a) attempts to identify the time until the symptoms reached their peak intensity. This would be the time from when the symptom was first perceived by the participant until the time that the symptom maximized or reached its worst. If the response to F.36 is YES, record the letter of the response category which contains the length of time given by the subject. Specific categories should not be read to the participant. However, prompts such as "a few seconds" or "several hours" may be given to identify the appropriate category.

F.37. Ask the question as "the" or "the worst" episode based on the response to F.33. Read all choices and record the appropriate responses. Record Y, N, or D for each category. The categories are not mutually exclusive. A response of "other" would refer to body parts not listed, such as chest wall, abdomen or back.

F.38. This question is to determine whether the participant experienced migration of paralysis or weakness. The categories are mutually exclusive. Record S if the symptoms spread from one part of the body to another, O if the symptoms started and stayed in one part of the body or D if the participant doesn't know or remember.

F.39. Read the question to the participant. Record Y or N for each of the categories. Categories are not mutually exclusive and more than one can be positive. It is essential that each category be answered YES only if the symptom occurred at the same time as the weakness or paralysis. Note the skip rules for categories b and i. The questions immediately following these categories (c and j) are not to be asked unless the answer to the previous question is YES. The purpose of questions c and j is to localize the symptoms. The responses to questions c and j are mutually exclusive. For Questin 39.b. and 39.d., read all response categories to the participant before asking for the response. When asking question 39.j, read down the list of responses until the participant gives a positive response. When a positive response is given, record the letter corresponding to the response and skip to question 40. If the subject does not respond positively to responses A through F, record "G" and ask the subject to describe the visual symptom. Record the symptom in the blank provided. G.40. Record Y, N, or D. If NO or DON'T KNOW, skip to Section H.

G.41. Record Y, N, or D. This question is to find participants who stood up too quickly or experienced other non-neurologically caused dizziness. If participant has experienced multiple episodes of dizziness, mark YES only if all episodes occur when participant changes body position. If only some are related to position change, mark NO. If the response is YES, skip to Section H.

G.42. Read the question and the response categories to the participant. Record Y or N for each of the categories. Categories are not mutually exclusive and more than one can be positive. It is essential that each category be answered YES only if the symptom occurred at the same time as the dizziness. If all responses are NO, skip to Section H. Note that this question on other symptoms occurs in a different order than in other sections, to allow skipping out of the section if no accompanying symptoms occur. Note the skip rules for categories b, d and i. The questions immediately following these categories (c, e and j) are not to be asked unless the answer to the previous question is YES. The purpose of questions c, e and j is to localize the symptoms. The responses to questions c, e and j are mutually exclusive. For Questions 42.b. and 42.d., read all response categories to the participant before asking for the response. When asking question 42.j, read down the list of responses until the participant gives a positive response. When a positive response is given, record the letter corresponding to the response and skip to question 43. If the subject does not respond positively to responses A through F, record "G" and ask the subject to describe the visual symptom. Record the symptom in the blank provided.

G.43. Record the letter by the response given. If the participant has had "many episodes," determine whether or not they feel there have been more or less than 20 and record the appropriate category.

G.44. This question focuses on the length of time since the most recent event, if more than one has occurred. Record the letter by the respone given.

G.45. This question is concerned with the duration of the longest (or only) episode of the symptom. It is used to differentiate between a stroke, TIA, or non-neurologic event. Record the letter corresponding to the response category which contains the duration given by the subject. Specific categories should not be read to the participant. However, prompts such as "a few seconds" or "several hours" may be given to help identify the appropriate category.

G.46. Let the participant decide which was the worst episode if more than one occurred. If the participant requests a definition of "worst", the participant may be prompted to define "worst" in terms of the severity or intensity of an episode, or an episode accompanied by other symptoms. Record Y or N. The next question (G.46.a) attempts to identify the time until the symptoms reached their peak intensity. This would be the time from when the symptom was first perceived by the participant until the time that the symptom maximized or reached its worst. If the response to G.46 is YES, record the letter of the response category which contains the length of time given by the subject. Specific categories should not be read to the participant. However, prompts such as "a few seconds" or "several hours" may be given to identify the appropriate category.

H.47. Enter the date on which the subject was interviewed. Record numbers using leading zeroes where necessary to fill each blank. For example, May 3, 1988, would be entered as :

0	5	/	0	3	/	8	8
m	m		d	d		y	y

H.48. If the form was completed partially on paper and partially on the computer, code as "Paper form".

H.49. The person at the clinic who has completed this form must enter his/her code number in the blanks provided.

O.M.B. 0925-0281
exp. 7-31-89

A-237

ARIC ANTHROPOMETRY FORM

ID NUMBER: | | | | | | | | CONTACT YEAR: | 0 | 1 | FORM CODE: | A | N | T | VERSION: A 11-01-

LAST NAME: | | | | | | | | | | | | | INITIALS: | | |

INSTRUCTIONS: This form should be completed during the participant's visit. ID Number 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 zeroes where necessary to fill all boxes. If a number is entered incorrectly, mark through the incorrect entry with an "X". Code the correct entry clearly above the incorrect entry.

ANTHROPOMETRY (ANTA screen 1 of 2)

A. HEIGHT AND WEIGHT

1. Standing height (to the nearest cm):..... | | | | cm

2. Unadjusted sitting height (to the nearest cm):..... | | | | cm

3. Stool height (to the nearest cm):..... | | | | cm

4. Weight (to the nearest lb):..... | | | | lb

B. SKINFOLDS (to the nearest mm)

5. Triceps Measurements (mm):...

	1	2
a.		mm
b.		mm

6. Subscapular Measurements (mm):...

	1	2
a.		mm
b.		mm

ANTHROPOMETRY (ANTA screen 2 of 2)

C. BODY SIZE

7. Girths (to the nearest cm)

a. Waist:..... | | | | cm

b. Hip:..... | | | | cm

c. Calf:..... | | | | cm

8. Wrist breadth (to the nearest mm):..... | | | mm

D. ADMINISTRATIVE INFORMATION

9. Date of data collection:..... | | | - | | | - | | |
month day year

10. Method of data collection:.....Computer
Paper form

11. Code number of person completing this form:..... | | | |

O.M.B. 0925-0281 exp. 7-31-89 A-238

ARIC PHYSICAL EXAMINATION FORM

ID NUMBER: | | | | | | | | CONTACT YEAR: | 0 | 1 | FORM CODE: | P | H | E | VERSION: A 11-01-86

LAST NAME: | | | | | | | | | | | | | INITIALS: | | |

INSTRUCTIONS:
This form should be completed during the participant's visit. 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 zeroes where necessary to fill all boxes. If a number is entered incorrectly, 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.

PHYSICAL EXAMINATION (PHFA screen 1 of 9)

A. WALKING/STANDING

1. Does the participant use a wheelchair, crutches or walker?.....YES Y

Go to Item 4

NO N

2. Does participant walk with a cane?.....YES Y

NO N

3. The participant's gait is?.....Normal N

Go to Item 4

Abnormal A

a. Dystaxic:.....YES Y

NO N

b. Hemiplegic or hemiparetic:.....NO N

Right R

Left L

4. Is there arm weakness?.....NO N

Right R

Left L

Both B

PHYSICAL EXAMINATION (PHEA screen 2 of 9)

5. Rhomberg?.....Positive P

Negative N

Cannot balance C

B. INVASIVE PROCEDURES

6. Have you ever had surgery on your heart, or the arteries of your neck or legs, excluding surgery for varicose veins?.....YES Y

NO N

Go to Item 8 Screen 3

7. [Probe for type of procedure]

a. Coronary bypass:.....YES Y

NO N

b. Other heart procedure:.....YES Y

NO N

Go to Item c

Specify: _____

_____

c. Carotid endarterectomy:.....YES Y

NO N

Go to Item e

d. Site:.....Right R

Left L

Both B

e. Other arterial revascularization:.....YES Y

NO N

Go to Item g

f. Specify:

g. Other:.....YES Y

NO N

PHYSICAL EXAMINATION (PHEA screen 3 of 9)

8. Have you ever had a balloon angioplasty on the arteries of your heart or legs?.....YES Y

NO N

Go to Item 10 Screen 4

9. [Probe for type of procedure]

a. Angioplasty of coronary artery(ies):.....YES Y

NO N

b. Angioplasty of lower extremity arteries:..YES Y

NO N

c. Cardiac catheterization:.....YES Y

NO N

d. Other arterial revascularization:.....YES Y

NO N

Go to Item f

e. Specify:

f. Other:.....YES Y

NO N

PHYSICAL EXAMINATION (PHEA screen 4 of 9)

C. NECK

10. Carotid Bruits?.....NO N

Right R

Left L

Both B

11. Other head or neck findings?.....YES Y

NO N

Go to Item 12

a. _____

_____

_____

D. CARDIO PULMONARY

12. Rhonchi?.....NO N

Right R

Left L

Both B

13. Rales?.....YES Y

NO N

Go to Item 16 Screen 5

14. Right lung rales:.....YES Y

NO N

Go to Item 15 Screen 5

a. Basilar:.....YES Y

NO N

b. Lower half:.....YES Y

NO N

c. Upper Half:.....YES Y

NO N

PHYSICAL EXAMINATION (PHEA screen 5 of 9)

15. Left lung rales:.....YES Y

NO N

Go to Item 16

a. Basilar:.....YES Y

NO N

b. Lower half:.....YES Y

NO N

c. Upper Half:.....YES Y

NO N

16. Other chest findings?.....YES Y

NO N

Go to Item 17

a. _____

_____

_____

17. Systolic murmur?.....YES Y

NO N

DON'T KNOW D

Go to Item 18 Screen 6

a. Grade:..... 1 2 3 4 5 6

b. Location:.....Apex A

Left lower sternal border S

2nd left interspace L

2nd right interspace R

Other O

PHYSICAL EXAMINATION (PHEA screen 6 of 9)

18. Diastolic murmur?.....YES Y

NO N

DON'T KNOW D

Go to Item 19

a. Grade:..... 1 2 3 4 5 6

b. Location:.....Apex A

Left lower sternal border S

2nd left interspace L

2nd right interspace R

Other O

19. Other heart findings?.....YES Y

NO N

Go to Item 20

a. _____

_____

_____

E. BREAST EXAMINATION

20. Examination?.....Performed P

Declined D

Not offered-male N

Feild center doesn't offer F

Go to Item 25 Screen 8

21. Palpable mass?.....YES Y

NO N

Go to Item 24 Screen 7

PHYSICAL EXAMINATION (PHEA screen 7 of 9)

22. Right breast mass:.....YES Y
NO N

Go to Item 23

a. Central:.....YES Y
NO N

b. Upper outer:.....YES Y
NO N

c. Upper inner:.....YES Y
NO N

d. Lower outer:.....YES Y
NO N

e. Lower inner:.....YES Y
NO N

23. Left breast mass:.....YES Y
NO N

Go to Item 24

a. Central:.....YES Y
NO N

b. Upper outer:.....YES Y
NO N

c. Upper inner:.....YES Y
NO N

d. Lower outer:.....YES Y
NO N

e. Lower inner:.....YES Y
NO N

24. Other breast findings?.....YES Y
NO N

Go to Item 25
Screen 8

a. _____
_____
_____

PHYSICAL EXAMINATION (PHEA screen 8 of 9)

F. LOWER EXTREMITIES

25. Ankle edema?.....YES Y

NO N

Go to Item 26

a. Right ankle edema:.....NO N

Mild L

Marked R

b. Left ankle edema:.....NO N

Mild L

Marked R

26. Posterior tibial pulse?.....Absent bilaterally A

Right only R

Left only L

Present bilaterally P

27. Other extremity findings?.....YES Y

NO N

Go to Item 28

a. _____

_____

_____

28. Babinski?.....NO N

Right R

Left L

Both B

PHYSICAL EXAMINATION (PHEA screen 9 of 9)

G. GENERAL

29. Other significant physical findings?.....YES Y

NO N

Go to Item 30

a. _____

_____

_____

H. ADMINISTRATIVE INFORMATION

30. Date of data collection:..... ☐☐ - ☐☐ - ☐☐

month day year

31. Method of data collection:.....Computer C

Paper form P

32. Code number of person performing this examination:..... ☐☐☐

ARIC
Medical Data Review

1. Name: ____ _____ _____ _____
2. ID Number: _____
3. Date of Birth (IDN11M,D,Y) ___/___/___
4. Date of Visit (FTR1M,D,Y) ___/___/___
5. Age in years: ___
6. Physican Name (FTR34-36) _____ ___ _____
7. Height (ANT1) __'__"
8. Weight (ANT4) ___
9. Average sitting BP (SBP21/SBP22) ___/___

.....

10. Particpant currently taking antihypertensives?(MSR8a) __
11. M.D. ever said you had High Blood Pressure?(HOM10.a) __
12. M.D. ever said you had Diabetes?(HOM10.e) __
13. M.D. ever said you had Cancer?(HOM10.f) __

.....

14. Pulmonary Function Test: Record from printout

    FEV1 _____ ml _____% of predicted
    FVC _____ ml _____% of predicted
    FEV1/FVC _____

15. Have you ever smoked cigarettes?(HOM28) __
16. Do you currently smoke cigarettes?(HOM30) __
17. Troubled by shortness of breath when hurrying?(RPA22) __
18. Do you walk slow due to breathlessness?(RPA23) __
19. Do you have to stop for breath when walking?(RPA24) __
20. Chronic Bronchitis confirmed by M.D.?(RPA29) __
21. Ever had emphysema confirmed by M.D.?(RPA33) __
22. Asthma confirmed by M.D.?(RPA36) __

.....

23. ECG: Read tracing.

a. Preliminary Interpretation

_____

_____

_____

b. Was a physician notified ? ___ No ___ Yes

If yes, Physician's name _____

.....

24. Physical examination findings:

a. Abnormal gait: Dystaxic?(PHE3.a) ___
Hemiplegic/hemiparetic?(PHE3.b) ___

b. Arm weakness:(PHE4) ___

c. Romberg:(PHE5) ___

d. Babinski:(PHE28) ___

.....

e. Carotid Bruits:(PHE10) ___

f. Other Neck Findings:(PHE11) ___
(If Yes, see Note Log PHE11)

.....

g. Rhonchi:(PHE12) ___

h. Rales:(PHE13) ___

i. Other Pulmonary Findings:(PHE16) ___
(If yes, see Note Log PHE16)

.....

j. Systolic Murmur:(PHE17) ___
Grade:(PHE17a) ___

k. Diastolic Murmur:(PHE18) ___
Grade:(PHE18.a) ___

l. Other Heart Findings:(PHE19) ___
(If Yes, see Note Log PHE19)

.....

m. Breast Mass:(PHE21) ___
(For referrals, return to PHE form for details.)

.....

n. Ankle Edema:(PHE25) __

o. Posterior tibial pulse:(PHE26) __

p. Other Significant Findings:(PHE29) __
(If yes, note Log PHE29)

25. History Consistent With:

a. Rose questionnaire angina:
What did he say Rose pain was?(MHX13) __

b. Previous diagnosis:
Did you see a doctor?(MHX12) __
What did he say Rose pain was?(MHX13) __

c. Unstable Angina:
Pain occurred twice as often?(MHX17) __
Pain become more severe?(MHX18) __
Pain lasted longer?(MHX19) __
Ever use nitroglycerin?(MHX20) __
Need more nitroglycerin?(MHX21) __
Get pain with less exertion?(MHX22) __
Get pain when sitting still?(MHX23) __
Get pain when sleeping?(MHX24) __

d. Previous MI:
What did he say Rose pain was?(MHX13) __
What did he say MI pain was?(MHX27) __
Hospitalized for a heart attack?(MHX28) __

e. Possible congestive heart failure:
Ever needed 2 pillows?(MHX43) __
Awakened by trouble breathing?(MHX44) __
Swelling go down overnight?(MHX46) __

f. Claudication:
Leg pain relieved in 10 minutes?(MHX41) __

g. Recognized TIA or stroke:(TIA1) __
First occurred:(TIA2mm,yy) __ __

h. Unrecognized TIA or Stroke:
Loss of speech?(TIA3) __
Loss of vision?(TIA10) __
Double vision?(TIA17) __
Numbness or tingling?(TIA23) __
Paralysis or weakness?(TIA32) __
Dizziness or loss of balance?(TIA40) __

26. Abnormal Exercise Test:(MHX32) __

27. Invasive Cardiovscular Procedure:
    a. Ever had heart or arterial surgery?(PHE6) __
       Coronary bypass?(PHE7a) __
       Other heart procedure?(PHE7b) __
       (If yes, see Note Log PHE7b)
       Carotid endartarectomy?(PHE7c) __
       Site?(PHE7d) __
       Other arterial revascularization?(PHE7e) __
       Specify(PHE7f) _____
       Other procedures?(PHE7g) __

    b. Ever had ballon angioplasty?(PHE8) __
       Angioplasty of coronary artery?(PHE9a) __
       Angioplasty of leg artery?(PHE9b) __
       Cardiac catheterization?(PHE9c) __
       Other arterial revascularization?(PHE9d) __
       Specify(PHE9e) _____
       Other angioplasty?(PHE9f) __

.....

28. Was a referral made ? __ No
__ Yes; Specify on Alert/Referral Form

29. Code of person completing Medical Data Review __ __ __

M.D. Review

30. M.D. reviewed Medical Data Review Report? __ No __ Yes

31. M.D.'s Interpretation of ECG:

_____

_____

_____

32. Any referrals/action taken modified by M.D. ? __ No __ Yes

33. Any referral/action initiated by M.D. ? __ No __ Yes
(If yes, specify on Alert/Referral Form.)

34. Date of review by M.D. __ __ / __ __ / __ __

35. Code number of M.D. reviewing this form __ __ __

O.M.B. 0925-0281
Expires 7-31-89 A-248

ARIC TIA / STROKE SUMMARY FORM

ID NUMBER: [ ][ ][ ][ ][ ][ ][ ] CONTACT YEAR: [ ][ ] FORM CODE: [T][S][R] VERSION: A 9/14/87

LAST NAME: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ] INITIALS: [ ][ ] DATE OF REVIEW: [ ][ ] Month [ ][ ] Day [ ][ ] Year

INSTRUCTIONS: This form is completed during the Medical Data Review after all clinical exams are completed. For every positive symptom checked in column (a), check either Yes, No or Unsure in columns (b) and/or (c). In addition, indicate in column (b) and/or (c) your opinion whether the event(s) corresponds to a TIA/Stroke.

TIA/STROKE SUMMARY FORM

Symptoms from TIA/Stroke Form	(a) POSITIVE SYMPTOM {Check Yes or No}	(b) MEDICAL DATA REVIEWER {Check Yes, No, or Unsure}	(c) ARIC PHYSICIAN {Check Yes, No or Unsure}
Questions from TIA/Stroke Form		IS THERE A NON-CVD CAUSE?	IS THERE A NON-CVD CAUSE?
	Yes / No	Yes / No / Unsure	Yes / No / Unsure
B. Sudden loss of speech. Question 3 is Yes.	[ ] [ ]	1. [ ] [ ] [ ]	9. [ ] [ ] [ ]
C. Sudden loss of vision. Question 10 is Yes.	[ ] [ ]	2. [ ] [ ] [ ]	10. [ ] [ ] [ ]
D. Sudden double vision. Question 17a is Yes or Don't Know.	[ ] [ ]	3. [ ] [ ] [ ]	11. [ ] [ ] [ ]
E. Sudden numbness, tingling or loss of feeling. Question 24 is No or Don't Know.	[ ] [ ]	4. [ ] [ ] [ ]	12. [ ] [ ] [ ]
F. Sudden paralysis or weakness. Question 32 is Yes.	[ ] [ ]	5. [ ] [ ] [ ]	13. [ ] [ ] [ ]
G. Sudden dizziness, loss of balance or sensation of spinning. Question 41 is No or Don't Know.	[ ] [ ]	6. [ ] [ ] [ ]	14. [ ] [ ] [ ]
WAS THIS A TIA/STROKE?		7. [ ] [ ] [ ]	15. [ ] [ ] [ ]
H. Code Number	[ ][ ][ ]	8. [ ][ ][ ] (Reviewer)	16. [ ][ ][ ] (Reviewer)

ARIC ID LABEL: _____ ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

LAST NAME

TIA/STROKE SYMPTOMS MEDICAL DATA REVIEW WORKSHEET:

SPEECH VISION DOUBLE VISION NUMBNESS WEAKNESS DIZZINESS (Circle one)

1. Please describe this event: _____

_____

_____

2. Did you see a physician for your problem? ☐ ☐ If NO, skip to question 2b.
Yes No

a. What was the diagnosis? ☐ ☐ ☐ ☐
TIA Stroke Unk Other: Specify_____

b. What is your explanation for this event? _____

_____

==========

SPEECH VISION DOUBLE VISION NUMBNESS WEAKNESS DIZZINESS (Circle one)

1. Please describe this event: _____

_____

_____

2. Did you see a physician for your problem? ☐ ☐ If NO, skip to question 2b.
Yes No

a. What was the diagnosis? ☐ ☐ ☐ ☐
TIA Stroke Unk Other: Specify_____

b. What is your explanation for this event? _____

_____

==========

SPEECH VISION DOUBLE VISION NUMBNESS WEAKNESS DIZZINESS (Circle one)

1. Please describe this event: _____

_____

_____

2. Did you see a physician for your problem? ☐ ☐ If NO, skip to question 2b.
Yes No

a. What was the diagnosis? ☐ ☐ ☐ ☐
TIA Stroke Unk Other: Specify_____

b. What is your explanation for this event? _____

_____

(turn over)

SPEECH VISION DOUBLE VISION NUMBNESS WEAKNESS DIZZINESS (Circle one)

1. Please describe this event: ______________________________

____

____

2. Did you see a physician for your problem? ☐ Yes ☐ No If NO, skip to question 2b.

   a. What was the diagnosis? ☐ TIA ☐ Stroke ☐ Unk ☐ Other: Specify______________

   b. What is your explanation for this event? ______________________________

____

SPEECH VISION DOUBLE VISION NUMBNESS WEAKNESS DIZZINESS (Circle one)

1. Please describe this event: ______________________________

____

____

2. Did you see a physician for your problem? ☐ Yes ☐ No If NO, skip to question 2b.

   a. What was the diagnosis? ☐ TIA ☐ Stroke ☐ Unk ☐ Other: Specify______________

   b. What is your explanation for this event? ______________________________

____

SPEECH VISION DOUBLE VISION NUMBNESS WEAKNESS DIZZINESS (Circle one)

1. Please describe this event: ______________________________

____

____

2. Did you see a physician for your problem? ☐ Yes ☐ No If NO, skip to question 2b.

   a. What was the diagnosis? ☐ TIA ☐ Stroke ☐ Unk ☐ Other: Specify______________

   b. What is your explanation for this event? ______________________________

____

Date of data collection: ☐☐ month ☐☐ day ☐☐ year

Code of person completing this worksheet: ☐☐☐

INSTRUCTIONS FOR COMPLETING THE MEDICAL DATA REVIEW OF TIA/STROKE SYMPTOMS (For TSR dated 9-14-87)

INTRODUCTION

The TIA/STROKE SUMMARY FORM is completed during the Medical Data Review for all participants. The form has two sections: the header and the review of symptoms. The header consists of the participant's ID number, contact year, name (last and initials) and the date of the TIA/Stroke interview.

The remainder of the form is divided into four columns. The first column lists the three elements which are recorded in columns (a), (b) and (c). These include (1) the symptoms from the TIA/STROKE questionnaire which could be attributable to a non-CVD cause, (2) the verification of a stroke/TIA and (3) the reviewer's administrative ID numbers.

The second column (a) is a check list to use as an aid in preparing the TIA/Stroke medical data review worksheet(s). The Yes/No responses correspond to the categories B-G in the first column. The three blank boxes corresponding to line H in the first column are to record the reviewer's ID number.

The third column (b) is completed by the individual conducting the Medical Data Review. Questions (1-6) document the Reviewer's clinical impression as to whether the positive symptom(s) checked in the second column (a) was attributable to a non-cerebrovascular (CVD) cause. Question (7) records whether the reviewer felt the positive symptom(s) constituted a stroke/TIA. Question (8) records the Medical Data Reviewer's ARIC identification code.

The fourth column (c) is completed by the ARIC physician, if different from the person who performed the Medical Data Review and completed the third column. Questions (9-14) document the physician's clinical impression as to whether the positive symptom(s) checked in the second column (a) was attributable to a non-CVD cause. Question (15) records whether the physician thought the positive event(s) was a TIA/Stroke. Question 16 records the physician's ARIC ID.

POSITIVE SYMPTOM CHECKLIST

After the participant has completed the TIA/stroke interview and before beginning the medical data review, the header section of the TIA/STROKE SUMMARY FORM is completed. A patient ID label can be substituted for hand coded information. Information not printed on the label must be entered by hand.

EXAMPLE OF HEADER OF TIA/STROKE SUMMARY FORM

ID NUMBER: T 1 2 3 4 5 6 CONTACT YEAR: 0 1 FORM CODE: I S R VERSION: A 9/14/87

LAST NAME: S M I T H INITIALS: J P DATE OF REVIEW: 0 6 (Month) 1 5 (Day) 4 7 (Year)

INSTRUCTIONS: This form is completed during the Medical Data Review after all clinical exams are completed. For every positive symptom checked in column (a), check either Yes, No or Unsure in columns (b) and/or (c). In addition, indicate in column (b) and/or (c) your opinion whether the event(s) corresponds to a TIA/Stroke.

The receptionist, interviewer, or designated staff completes the checklist in the second column (a). Symptom categories which are positive, (see the definitions for positive symptoms below) are recorded in the boxes under the YES column. Those which do not meet the definitions are recorded in the boxes under the NO column. A participant ID label is affixed to the top of the form and the date of the participant's visit is recorded in the space provided.

EXAMPLE OF FIRST AND SECOND COLUMNS OF TIA/STROKE SUMMARY FORM

	(a)
Symptoms from TIA/Stroke Form	POSITIVE SYMPTOM (Check Yes or No)
Questions from TIA/Stroke Form	
	Yes / No
B. Sudden loss of speech. Question 3 is Yes.	☑ / ☐
C. Sudden loss of vision. Question 10 is Yes.	☐ / ☑
D. Sudden double vision. Question 17a is Yes or Don't Know.	☐ / ☑
E. Sudden numbness, tingling or loss of feeling. Question 24 is No or Don't Know.	☑ / ☐
F. Sudden paralysis or weakness. Question 32 is Yes.	☐ / ☑
G. Sudden dizziness, loss of balance or sensation of spinning. Question 41 is No or Don't Know.	☐ / ☑
WAS THIS A TIA/STROKE?	
H. Code Number	A A A

MEDICAL DATA REVIEW

The Medical Data Reviewer reviews the positive symptom checklist on the TIA/STROKE SUMMARY FORM. If there are any positive symptoms, each positive symptom requires the completion of a positive symptom module on the TIA/STROKE SYMPTOMS MEDICAL DATA REVIEW **WORKSHEET** and the corresponding Yes/No/Unsure box in Column (b) of the **SUMMARY FORM**.

The TIA/STROKE SYMPTOMS MEDICAL DATA REVIEW **WORKSHEET** provides space to record the participant's impression as to why he/she reported a positive symptom. To complete the WORKSHEET, the Reviewer identifies the category which the participant reported as positive by circling the appropriate symptom at the top of the module. The written set of questions are read to the participant and the answers recorded. If the participant reported more than one positive symptom, a second, third, etc., module is completed.

EXAMPLE OF TIA/STROKE SYMPTOMS MEDICAL DATA REVIEW WORKSHEET

ARIC ID LABEL: T123456 SMITH
LAST NAME

TIA/STROKE SYMPTOMS MEDICAL DATA REVIEW WORKSHEET:

(SPEECH circled) VISION DOUBLE VISION NUMBNESS WEAKNESS DIZZINESS (Circle one)

1. Please describe this event: ______

2. Did you see a physician for your problem? [x] Yes [ ] No If NO, skip to question 2b.
   a. What was the diagnosis? [ ] TIA [x] Stroke [ ] Unk [ ] Other: Specify ______
   b. What is your explanation for this event? ______

SPEECH VISION DOUBLE VISION (NUMBNESS circled) WEAKNESS DIZZINESS (Circle one)

1. Please describe this event: ______

2. Did you see a physician for your problem? [x] Yes [ ] No If NO, skip to question 2b.
   a. What was the diagnosis? [ ] TIA [x] Stroke [ ] Unk [ ] Other: Specify ______
   b. What is your explanation for this event? ______

SPEECH VISION DOUBLE VISION NUMBNESS WEAKNESS DIZZINESS (Circle one)

1. Please describe this event: ______

2. Did you see a physician for your problem? [ ] Yes [ ] No If NO, skip to question 2b.
   a. What was the diagnosis? [ ] TIA [ ] Stroke [ ] Unk [ ] Other: Specify ______
   b. What is your explanation for this event? ______

(turn over)

After the WORKSHEET is completed, the Reviewer proceeds to complete the third column (b) of the TIA/STROKE SUMMARY FORM. For each positive symptom category checked as positive in the second column, the Reviewer checks Yes/No/Unsure in column (b) to indicate whether, in his/her opinion, the symptom could be attributable to a non-CVD cause. The Reviewer must also check Yes/No/Unsure in Question 7 to document his/her clinical impression of the occurrence of a TIA/stroke. The Reviewer completes the column by recording his/her ID code in Question 8.

EXAMPLE OF FIRST THREE COLUMNS OF TIA/STROKE SUMMARY FORM

	(a)	(b)
Symptoms from TIA/Stroke Form	POSITIVE SYMPTOM (Check Yes or No)	MEDICAL DATA REVIEWER (Check Yes, No, or Unsure)
Questions from TIA/Stroke Form		IS THERE A NON-CVD CAUSE?
	Yes / No	Yes / No / Unsure
B. Sudden loss of speech. Question 3 is Yes.	☑ / ☐	1. ☐ / ☑ / ☐
C. Sudden loss of vision. Question 10 is Yes.	☐ / ☑	2. ☐ / ☐ / ☐
D. Sudden double vision. Question 17a is Yes or Don't Know.	☐ / ☑	3. ☐ / ☐ / ☐
E. Sudden numbness, tingling or loss of feeling. Question 24 is No or Don't Know.	☑ / ☐	4. ☐ / ☑ / ☐
F. Sudden paralysis or weakness. Question 32 is Yes.	☐ / ☑	5. ☐ / ☐ / ☐
G. Sudden dizziness, loss of balance or sensation of spinning. Question 41 is No or Don't Know.	☐ / ☑	6. ☐ / ☐ / ☐
WAS THIS A TIA/STROKE?		7. ☑ / ☐ / ☐
H. Code Number	A A A	8. B B B (Reviewer)

PHYSICIAN REVIEW

The ARIC physician completes the fourth column of the TIA/STROKE SUMMARY FORM as part of the medical review. If there are no positive symptoms checked in column (a), Questions 9-15 are left blank and the Physician records his/her ID code in Question 16.

If there are positive symptoms checked in the second column, the physician reviews the MEDREVU printout and the TIA/STROKE SYMPTOMS MEDICAL DATA REVIEW WORKSHEET. The physician then completes the fourth column (c) of the TIA/STROKE SUMMARY FORM. For each positive symptom category checked as positive in the second column, the Reviewer checks Yes/No/Unsure for Questions 9-14 in column (c) to indicate whether, in his/her opinion, the symptom could be attributable to a non-CVD cause. The Physician also checks Yes/No/Unsure in Question 15 to document his/her clinical impression of the occurrence of a TIA/stroke. The physician completes column (c) by recording his/her ID code in Question 16. In cases where the Medical Data Review and the subsequent medical review are performed by the same ARIC physician, that physician must complete both column (b) and (c).

EXAMPLE OF FIRST FOUR COLUMNS OF TIA/STROKE SUMMARY FORM

	(a)	(b)	(c)
Symptoms from TIA/Stroke Form	POSITIVE SYMPTOM (Check Yes or No)	MEDICAL DATA REVIEWER (Check Yes, No, or Unsure)	ARIC PHYSICIAN (Check Yes, No or Unsure)
Questions from TIA/Stroke Form		IS THERE A NON-CVD CAUSE?	IS THERE A NON-CVD CAUSE?
	Yes / No	Yes / No / Unsure	Yes / No / Unsure
B. Sudden loss of speech. Question 3 is Yes.	☑ / ☐	1. ☐ / ☑ / ☐	9. ☐ / ☑ / ☐
C. Sudden loss of vision. Question 10 is Yes.	☐ / ☑	2. ☐ / ☐ / ☐	10. ☐ / ☐ / ☐
D. Sudden double vision. Question 17a is Yes or Don't Know.	☐ / ☑	3. ☐ / ☐ / ☐	11. ☐ / ☐ / ☐
E. Sudden numbness, tingling or loss of feeling. Question 24 is No or Don't Know.	☑ / ☐	4. ☐ / ☑ / ☐	12. ☐ / ☑ / ☐
F. Sudden paralysis or weakness. Question 32 is Yes.	☐ / ☑	5. ☐ / ☐ / ☐	13. ☐ / ☐ / ☐
G. Sudden dizziness, loss of balance or sensation of spinning. Question 41 is No or Don't Know.	☐ / ☑	6. ☐ / ☐ / ☐	14. ☐ / ☐ / ☐
WAS THIS A TIA/STROKE?		7. ☑ / ☐ / ☐	15. ☑ / ☐ / ☐
H. Code Number	A A A	8. B B B (Reviewer)	16. C C C (Reviewer)

O.M.B. 0925-0281
Exp 7/31/89

ARIC COHORT ANNUAL FOLLOW-UP

ID: _____ CONTACT YEAR: ___ FORM CODE: TRC VERSION: A 12/06/88

NAME: _____

CONTACT YEAR __ DATE RANGE

Earliest: __ / __ / __ Target: __ / __ / __ Latest: __ / __ / __

RECORD OF CALLS				
Day of Week/ Date (mm/dd/yy)	Time	Notes	Result Code*	Int ID-
S M T W R F S / /	A P			
S M T W R F S / /	A P			
S M T W R F S / /	A P			
S M T W R F S / /	A P			
S M T W R F S / /	A P			
S M T W R F S / /	A P			
S M T W R F S / /	A P			
S M T W R F S / /	A P			
S M T W R F S / /	A P			

*RESULT CODES (CIRCLE THE FINAL SCREENING RESULT CODE)
1-No Action Taken
2-Tracing (Not yet contacted any source)
3-Contacted, Interview Complete
4-Contacted, Interview Partially Complete or Rescheduled
5-Contacted, Interview Refused
6-Reported Alive, Will Continue to Attempt Contact this Year
7-Reported Alive, Contact Not Possible this Year
8-Reported Deceased
9-Unknown

O.M.B. 0925-0281 A-257
exp. 7-31-89

ARIC ANNUAL FOLLOW-UP QUESTIONNAIRE FORM

ID NUMBER: [ ][ ][ ][ ][ ][ ][ ] CONTACT YEAR: [ ][ ] FORM CODE: [A][F][U] VERSION: A 11/20/87

LAST NAME: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ] INITIALS: [ ][ ]

INSTRUCTIONS:
This form should be completed during the interview portion of the participant's annual follow-up. 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 zeroes where necessary to fill all boxes. If a number is entered incorrectly, 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.

ANNUAL FOLLOW-UP QUESTIONNAIRE (AFUA screen 1 of 8)

A. VITAL STATUS

1. Date of status determination: .....

[ ][ ] - [ ][ ] - [ ][ ]
Month Day Year

2. Final Status: .....
{Circle one below}

3. Information obtained from: .....
{Circle one corresponding choice below}

- Contacted and alive C
  - Phone A
  - Personal Interview B
  - → Go to Item 6, Screen 2
  - Letter C
  - → Go to Item 30, Screen 8
- Contacted & Refused F → Go to Item 32, Screen 8
- Reported alive R
  - Relative, spouse, acquaintance D
  - Employer information E
  - Other F
  - → Go to Item 30, Screen 8
- Reported Deceased D
  - Relative, spouse, acquaintance G
  - Surveillance H
  - Other (National Death Index) I
  - → Continue to Item 4
- Unknown U → Go to Item 32, Screen 8

ANNUAL FOLLOW-UP QUESTIONNAIRE (AFUA screen 2 of 8)

B. DEATH INFORMATION

4. Date of death: ... [ ][ ] - [ ][ ] - [ ][ ]
Month Day Year

5. Location of death (city/county, state):

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

After Item 5, skip to Item 30, Screen 8

C. GENERAL HEALTH

6. Now I will ask you some questions about your health since we last spoke with you; that is, from (mm/dd/yy of last contact) until today. During that time, compared to other people your age, would you say that your health has been excellent, good, fair or poor? ..... Excellent E

Good G

Fair F

Poor P

ANNUAL FOLLOW-UP QUESTIONNAIRE (AFUA screen 3 of 8)

D. CHEST PAIN ON EFFORT

7. Since our last contact on (mm/dd/yy of last contact), have you had any pain or discomfort in your chest? ..... Yes Y

No N

Go to Item 20, Screen 5

8. Do you get it when you walk uphill or hurry? ..... Yes Y

Go to Item 17, Screen 5 — No N

Never hurries or walks uphill H

9. Do you get it when you walk at an ordinary pace on the level? ..... Yes Y

No N

10. What do you do if you get it it while you are walking? ... Stop or slow down S

Carry on C

{Record "Stop or slow down" if subject carries on after taking nitroglycerin}

Go to Item 17, Screen 5

11. If you stand still, what happens to it? ..... Relieved R

Not relieved N

Go to Item 17, Screen 5

ANNUAL FOLLOW-UP QUESTIONNAIRE (AFUA screen 5 of 8)

E. POSSIBLE INFARCTION

17. Since our last contact have you had a severe pain across the front of your chest lasting for half an hour or more? ..... Yes Y

No N

Go to Item 20

18. Did you see a doctor because of this pain? ..... Yes Y

No N

Go to Item 20

19. What did he say it was? ..... Heart Attack H

Other Disorder O

F. INTERMITTENT CLAUDICATION

20. Since our last contact on (mm/dd/yy of last contact), have you had pain in either leg on walking? ..... Yes Y

No N

Go to Item 29, Screen 7

21. Does this pain ever begin when you are standing still or sitting? ..... Yes Y

No N

Go to Item 29, Screen 7

ANNUAL FOLLOW-UP QUESTIONNAIRE (AFUA screen 4 of 8)

12. How soon? ..... 10 minutes or less L

More than 10 minutes M

Go to Item 17, Screen 5

13. Will you tell me where it was?
{Record answer verbatim in space below.
Then, circle Y or N for all areas.}

_____

_____

	Yes	No
a. Sternum (upper or middle)	Y	N
b. Sternum (lower)	Y	N
c. Left anterior chest	Y	N
d. Left arm	Y	N
e. Other	Y	N
f. Specify:		

14. Do you feel it anywhere else? ..... Yes Y
{If "Yes", record above}
No N

15. Did you see a doctor because of this pain or discomfort? ..... Yes Y

No N

Go to Item 17, Screen 5

16. What did he say it was? ... Angina A

Heart Attack H

Other Heart Disease D

Other O

ANNUAL FOLLOW-UP QUESTIONNAIRE (AFUA screen 6 of 8)

22. In what part of your leg do you feel it? .....
{If calves not mentioned, ask: Anywhere else?}

Pain includes calf/calves C

Pain does not include calf/calves N

→ Go to Item 29, Screen 7

23. Do you get it if you walk uphill or hurry? ..... Yes Y

No N → Go to Item 29, Screen 7

Never hurries or walks uphill H

24. Do you get it if you walk at an ordinary pace on the level? ..... Yes Y

No N

25. Does the pain ever disappear while you are walking? ..... Yes Y → Go to Item 29, Screen 7

No N

26. What do you do if you get it when you are walking? ... Stop or slow down S

Carry on C → Go to Item 29, Screen 7

ANNUAL FOLLOW-UP QUESTIONNAIRE (AFUA screen 7 of 8)

27. What happens to it if you stand still? ..... Relieved R

Not relieved N

Go to Item 29

28. How soon? ..... 10 minutes or less L

More than 10 minutes M

G. STROKE/TIA

29. Since our last contact have you been told by a physician that you had a stroke, slight stroke, transient ischemic attack, or TIA? ..... Yes Y

No N

If "Yes", ensure that this event is included in the "HOSPITALIZATIONS" section.

ANNUAL FOLLOW-UP QUESTIONNAIRE (AFUA screen 8 of 8)

H. HOSPITALIZATIONS

30. Were you (Was _____)
hospitalized for a heart
attack since our last contact
on (mm/dd/yy of last contact)? ..... Yes Y

No N

Unknown U

If "Yes", complete "HOSPITALIZATIONS" section.

31. Have you stayed (Did _____ stay)
overnight as a patient in a
hospital for any other reason
since our last contact? ..... Yes Y

No N

If "Yes", add to "HOSPITALIZATIONS" section.

I. INTERVIEWER CODE NUMBER

32. Code number of person
completing this form: ... | | | |

NAME: _____ ID: _____ CONTACT YEAR: 02

HOSPITALIZATIONS (Obtain following questionnaire)

For each time you were (he/she was) a patient over night in a hospital, I would like to obtain the reason you were (he/she was) admitted, the name of the hospital, and the date. When was the first time you were (he/she was) hospitalized since our last contact with you (him/her) on (mm/dd/yy of last contact)?

[Fill in, probing as necessary. If reason and/or hospital are repeated, record "same as (a/b/c/d/e, etc.)". Probe for additional hospitalizations.]

	Hospitalization Reason	Name, City and St of Hospital	Mnth/Yr	Transmit to Surveillance
a.				☐
			___/___	
b.				☐
			___/___	
c.				☐
			___/___	
d.				☐
			___/___	
e.				☐
			___/___	
f.				☐
			___/___	
g.				☐
			___/___	
h.				☐
			___/___	
i.				☐
			___/___	
j.				☐
			___/___	

NAME: _____ ID: _____ CONTACT YEAR: 02

	Hospitalization Reason	Name, City and St of Hospital	Mnth/Yr	Transmit to Surveillance
k.	_____	_____		☐
	_____	_____	___/___	
l.	_____	_____		☐
	_____	_____	___/___	
m.	_____	_____		☐
	_____	_____	___/___	

"As explained in your original clinic visit, records of these hospitalizations will be checked for medical information that may apply to the ARIC Study."

HOSPITAL RECORD ABSTRACTION FORM (HRA)

Final form not available as of date of this printing.

HOSPITAL STROKE FORM (STR)

Final form not available as of date of this printing.

O.M.B. 0925-0281
exp. 7-31-89

A-269

ARIC COHORT EVENT ELIGIBILITY FORM

EVENT ID: [ ][ ][ ][ ][ ][ ][ ] FORM CODE: [C][E][L] VERSION: A 12/7/87

INSTRUCTIONS:
This form should be completed for all Cohort events. It is the counterpart of the Surveillance Event Eligibility Form for events occurring in cohort participants. For this form only, the header information should be completed AFTER completing the remainder of the form and ONLY for eligible events and deaths. Refer to this form's Q by Q instructions for information on entering numerical responses. 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.

COHORT EVENT ELIGIBILITY FORM (CELA page 1 of 4)

A. IDENTIFYING INFORMATION

1. Name (First, Middle, Last): _____

2. Participant ID: [ ][ ][ ][ ][ ][ ][ ]

3. Visit 1 date: ..... [ ][ ] - [ ][ ] - [ ][ ]
Month Day Year

4. Date of discharge or death: ... [ ][ ] - [ ][ ] - [ ][ ]
Month Day Year

If item 3 is <u>not</u> earlier than item 4, go to Item 19 on Page 4.

5. Source used to identify event: ..... Cohort Annual Follow-Up F
Surveillance Procedures S
Other O

6. Is this event a death? ..... Yes Y
No N

Go to Item 8, Page 2

COHORT EVENT ELIGIBILITY FORM (CHLA page 2 of 4)

7. Is this event an out-of-hospital death, or a death for which hospitalization information cannot be located? ..... Yes Y

Go to Item 13, Page 3

No N

C. INFORMATION FROM HOSPITAL DISCHARGE INDEX

8. Hospital Name:

9. Hospital Record Number:

10. Hospital discharge diagnosis codes:

a. . b. . c. . d. . e. . f. . g. . h. . i. . j. . k. . l. . m. . n. . o. . p. .

11. a. Is a 402, 410-414, 427, 428, or 518.4 code listed? ..... Yes Y

No N

b. Is a 430-438 code listed? ..... Yes Y

No N

c. Is a 35-39, 88.5, 250, 390-459, 745-747, 794.3, 798, or 799 code listed? ..... Yes Y

No N

If all of Items 11a, 11b, and 11c are "No," go to Item 12 on Page 3.

Otherwise, continue with Item 11d.

d. Are any of the following mentioned or suggested in the discharge summary? . Yes Y

No N

Acute Chest pain
Angina
MI
Unstable angina
CHD
Ischemic heart disease
Atherosclerotic heart disease
Cardiac arrest

Or during this admission:
CABG
Coronary angiography or angioplasty
Cardiac catheterization
CCU care
Elevated CK-MB
Nitroglycerin

e. Are any of the following mentioned or suggested in the discharge summary? . Yes Y

No N

Acute Stroke
TIA
Cerebrovascular disease
Cerebral hemorrhage
Cerebral infarction
Subarachnoid hemorrhage
Cerebral embolus
Paralysis
Aphasia
Diplopia

Or during this admission:
Cerebral angiography
Carotid endarterectomy
CT scan
Neuro ICU care

If any of Items 11a, 11b, 11d or 11e is "Yes," go to Item 15 on Page 4.

Otherwise, continue with Item 12.

COHORT EVENT ELIGIBILITY FORM (CELA page 3 of 4)

12. Is this event an <u>in-hospital</u> death? ..... Yes Y

No N

Go to Item 19, Page 4

B. INFORMATION FROM DEATH INDEX/CERTIFICATE

13. Death Certificate Number:

14. a. ICD code for <u>underlying</u> cause of death:

				.	

b. Is the code 250, 401, 402, 410-414, 427-429, 440, 518.4, 798, or 799? ..... Yes Y

No N

Go to Item 17, Page 4

COHORT EVENT ELIGIBILITY FORM (CEL: page 4 of 4)

D. ELIGIBILITY AND ID ASSIGNMENT

15. Record Y, indicating that event is eligible. ..... Yes Y

16. Event Identification Number (assign here): [| | | | | | |]

After completing Item 16, go to Item 20

17. Record N, indicating that event is not eligible. ..... No N

18. Event Identification Number (assign here for ineligible deaths):

[| | | | | | |]

After completing Item 18, go to Item 20

19. Record N, indicating that event is not eligible. ..... No N

E. ADMINISTRATIVE INFORMATION

20. Date of data collection: ..... [| |] - [| |] - [| |]
Month Day Year

21. Code number of person completing this form:..... [| | |]

Based solely on the information gathered in this form, indicate what additional forms are needed:

Form	Criteria based on this form
☐ AFU	Item 6 = Y
☐ DTH	Item 6 = Y
☐ [illegible]	Item 11a = Y or Item 11d = Y
☐ HRA	Item 12 = Y and Item 14b = Y
☐ STR	Item 11b = Y or Item 11e = Y
☐ IFI(s)	Item 7 = Y (out-of-hospital) and Item 15 = Y
☐ PHQ(s)	Item 7 = Y (out-of-hospital) and Item 15 = Y

O.M.B. 0925-0281
exp 7-31-89

A-273

ARIC DEATH CERTIFICATE FORM

EVENT ID: | | | | | | | | SEQUENCE NUMBER: | 0 | 1 | FORM CODE: | D | T | H | VERSION:A 9-30-87

LAST NAME: | | | | | | | | | | | | | INITIALS: | | |

INSTRUCTIONS:
The Death Certificate Form is completed for each eligible death as determined by the Surveillance Event Eligibility Form, and for all Cohort deaths. Event ID and Name must be entered above. Refer to this form's Q by Q instructions for information on entering numerical responses. 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.

DEATH CERTIFICATE FORM (DTHA page 1 of 6)

A. INFORMATION FROM DEATH INDEX/CERTIFICATE

1. Decedent:

a. First Name: ..... | | | | | | | | | | | | |

b. Middle Name: .... | | | | | | | | | | | | |

c. Last Name: ..... | | | | | | | | | | | | | | | | | | | | |

2. Death Certificate Number: .... | | | | | | | | | | | | | | | |

3. Social Security Number: ..... | | | | - | | | - | | | | |

4. Sex: ..... Male M
Female F

5. Race or ethnic group: ..... White/Caucasian W
Black/Negro B
Asian/Pacific Islander A
American Indian/Native Alaskan I
Unknown/Not Recorded U

DEATH CERTIFICATE FORM (DTHA page 2 of 6)

6. Hispanic: ..... Yes Y
No N
Unknown U

7. Marital status: ..... Married M
Single (never married) S
Separated P
Divorced D
Widowed W
Other O
Unknown/not recorded U

8. Date of birth: ..... [ ][ ] - [ ][ ] - [ ][ ]
Month Day Year

9. Date of death: ..... [ ][ ] - [ ][ ] - [ ][ ]
Month Day Year

10. Age at death: ..... [ ][ ]

11. Time of death (24 hr clock): ..... [ ][ ] : [ ][ ]

12. Where did the decedent die? ..... Hospital within catchment area A
Hospital out of catchment area or location unknown B
Nursing home N
Other O
a.(specify): _____
_____

If Other or Nursing home go to Item 15 on Page 3.

DEATH CERTIFICATE FORM (DTHA page 3 of 6)

13. If decedent died in hospital: ..... Dead on arrival A
Emergency room patient B
Outpatient C
Inpatient D
None of above E
Not recorded F

14. Name and location of hospital: .....

a. Name: _____

b. City: _____

c. State: _____

15. Was this a coroner's or medical examiner's case? ..... Yes Y
No N

Go to Item 17

16. Coroner or Medical Examiner: .....

a. Name: _____

b. Address: _____

_____

_____

17. Was an autopsy performed? ..... Yes Y
No N

18. ICD9 code for underlying cause of death:

					.	

DEATH CERTIFICATE FORM (DTHA page 4 of 6)

19. All other listed ICD9 codes:

a. ☐☐☐☐.☐
b. ☐☐☐☐.☐
c. ☐☐☐☐.☐
d. ☐☐☐☐.☐
e. ☐☐☐☐.☐
f. ☐☐☐☐.☐
g. ☐☐☐☐.☐
h. ☐☐☐☐.☐
i. ☐☐☐☐.☐
j. ☐☐☐☐.☐

20. Transcribe up to 3 causes of death as they were recorded on the death certificate: .....

a. Immediate cause:

_____

_____

b. Due to or as a consequence of (1):

_____

_____

c. Due to or as a consequence of (2):

_____

_____

21. Transcribe other significant conditions as they were recorded on the death certificate: .....

_____

_____

_____

_____

DEATH CERTIFICATE FORM (DTHA page 5 of 6)

22. Interval between onset and death for immediate cause of death: ..... 5 minutes or less A
1 hour or less B
1 day or less C
1 week or less D
1 month or less E
More than 1 month F
Unknown or not recorded U

23. Informant: .....

a. Name: _____

b. Address: _____

_____

_____

24. Relationship of informant to deceased: ..... Spouse S

Go to Item 26

Other O
Unknown U
a.(specify): _____

25. Spouse (If not informant listed above): .....

a. Name: _____

b. Address: _____

_____

_____

26. Certifying physician: .....

a. Name: _____

b. Address: _____

_____

_____

DEATH CERTIFICATE FORM (DTHA page 6 of 6)

B. ADMINISTRATIVE INFORMATION

27. Date abstract completed: ..... ☐☐ - ☐☐ - ☐☐
Month Day Year

28. Code number of abstractor completing this form: ..... ☐☐☐

Based solely on the information gathered in this form, indicate what additional forms are needed:

	Form	Criteria based on this form
☐	IFI	(Item 12=O or N) or (Item 12=A or B and Item 13=A,B, or C). Items 23 and/or 25 completed (contact relatives first when possible).
☐	IFI	(Item 12=O or N) or (Item 12=A or B and Item 13=A,B, or C). Items 23 and/or 25 completed (informant not already selected above).
☐	PHQ	(Item 12=O or N) or (Item 12=A or B and Item 13=A,B, or C). Item 26 completed.
☐	HRA	Item 12 = A and Item 13 = D, E, or F.
☐	COR	(Item 12=O or N) or (Item 12=A or B and Item 13=A,B, or C). Item 16 completed.
☐	AUT	Item 17 completed (eligible cohort deaths only)

O.M.B. 0925-0281
exp 7-31-89

ARIC INFORMANT INTERVIEW FORM

EVENT ID: [| | | | | | |] INFORMANT NUMBER: [| |] FORM CODE: [I | F | I] VERSION: A 10-16-87

LAST NAME: [| | | | | | | | | | | |] INITIALS: [| |]

INSTRUCTIONS:
The Informant Interview Form is completed for each informant for an out-of-hospital death as determined by the ARIC Event Investigation Summary. Event ID and Name must be entered above, as described in the document, "General Instructions For Completing Paper Forms". Informant Number should be determined from the Event Investigation Summary Form. For "multiple choice" and "yes/no" type questions, circle the letter corresponding to the most appropriate response. If a letter is circle incorrectly, mark through it with an "X" and circle the correct response.

INFORMANT INTERVIEW TRACING INFORMATION

DECEDENT

Name: _____

Address: _____

_____ _____ _____
City State Zip Code

Date of death: __/__/__
mm dd yy

INFORMANT

Name: _____

Address: _____

_____

_____ _____ _____
City State Zip Code

Telephone: (___) ___-____

Relationship to the deceased: _____

RECORD OF CALLS					
Day of Week	Date	Time	Notes	Code*	Int
S M T W R F S	MM/DD/YY	A P			
S M T W R F S	MM/DD/YY	A P			
S M T W R F S	MM/DD/YY	A P			
S M T W R F S	MM/DD/YY	A P			
S M T W R F S	MM/DD/YY	A P			
S M T W R F S	MM/DD/YY	A P			
S M T W R F S	MM/DD/YY	A P			
S M T W R F S	MM/DD/YY	A P			

*RESULT CODES (CIRCLE THE FINAL SCREENING RESULT CODE)

1 Complete
2 Partially complete
3 Unknowledgable
4 Refusal
5 Informant away or can't be found
6 Language barrier
7 No one home
9 Other (specify in Notes)

INFORMANT INTERVIEW FORM (IFIA Screen 1 of 16)

A. HISTORY

1. Before we get started, could you please tell me what was your relationship to the deceased?

{Respondent was deceased's}

Spouse	S
Parent	P
Daughter/Son	C
Other relative	R
Friend	F
Workmate	W
Other	O

"I'd like to ask you about (_____)'s medical history. If you have any questions as we go along, please ask me."

2. First, think back to about one month before (_____) died. At that time, was he/she sick or ill, with his/her activities limited, or was he/she normally active for the most part?

Sick/ill/limited activities	R
Normally Active	N
Unknown	U

INFORMANT INTERVIEW FORM (IFIA Screen 2 of 16)

3. Was (_____) being cared for at a nursing home, or at another place at the time of death?

Yes,nursing home	R
Yes,at home	H
Yes,other	O
No	N
Unknown	U

[If not "Yes,nursing home" skip to item 5]

4. Could you tell me the name and location of the nursing home?

a. Name _____

_____

b. City _____

c. State _____

5. Was (_____) hospitalized within the four weeks prior to death?

Yes	Y
No	N
Unknown	U

[If No or Unknown skip to item 9]

6. What was the reason for hospitalization?

{Circle (Y), (N), or (U) for each. Probe if not offered.}	Yes	No	Unknown
a. Heart attack or chest pain	Y	N	U
b. Heart surgery	Y	N	U
c. Other	Y	N	U

[If No or Unknown for "Heart attack" and "Heart surgery" skip to item 9]

INFORMANT INTERVIEW FORM (IFIA Screen 3 of 16)

7. What was the date of the hospital admission?

☐☐ - ☐☐ - ☐☐

\- Month Day Year

8. Could you tell me the name and location of the hospital?

a. Name _____

_____

b. City _____

c. State _____

9. Was (_____) seen by a physician anytime in the last four weeks prior to death?

Yes	Y
No	N
Unknown	U

[If No or Unknown skip to item 11]

10. Could you tell me the name and address of this physician?

a. Name _____

_____

b. City _____

c. State _____

11. Could you tell me the name and address of (_____)'s usual physician? (If same as Q10 record as "same".)

a. Name _____

_____

b. City _____

c. State _____

INFORMANT INTERVIEW FORM (IFIA Screen 4 of 16)

12. Before (_____) 's final illness, had he/she ever had pains in the chest from heart disease, for example angina pectoris?

Yes	Y
No	N
Unknown	U

[If No skip to item 14]

13. Did (_____) ever take nitroglycerin for this pain?

Yes	Y
No	N
Unknown	U

14. Did a doctor ever say that (_____) had a heart attack prior to his/her final illness?

Yes	Y
No	N
Unknown	U

[If No or Unknown skip to item 16]

15. Was (_____) hospitalized for a heart attack?

Yes	Y
No	N
Unknown	U

INFORMANT INTERVIEW FORM (IFIA Screen 5 of 16)

16. Did he/she ever have a coronary bypass operation, balloon angioplasty or some other operation or procedure to improve circulation of blood to the heart?

Yes	Y
No	N
Unknown	U

17. Did (_____) ever have any other heart disease or heart condition before his/her final illness?

Yes	Y
No	N
Unknown	U

If Yes, specify:_____

_____

_____

18. Did (_____) ever have a stroke?

Yes	Y
No	N
Unknown	U

[If No or Unknown skip to item 20]

19. Did he/she have a stroke within four weeks of his/her final illness?

Yes	Y
No	N
Unknown	U

INFORMANT INTERVIEW FORM (IFIA Screen 6 of 16)

B. CIRCUMSTANCES SURROUNDING DEATH

Attach Event ID Label Here

"The next few questions are concerned with the circumstances surrounding (_____)'s death."

20. Could you please tell me what you can of (_____)'s general health, health on the day he/she died, and of the death itself?

Yes (Y)
No (N)
Unknown (U)

Specify: _____

INFORMANT INTERVIEW FORM (IFIA Screen 7 of 16)

"The next set of questions may go over some of what you have already told me. Although it may seem repetitious, I must ask these questions for consistency of information."

21. Were you present when (_____) died?

Yes	Y
No	N

[If Yes skip to item 25]

22. Did anyone see or hear (____) when he/she died?

Yes	Y
No	N
Unknown	U

[If Yes skip to item 25]

23. Was anyone close enough to hear (_____) if he/she had called out?

Yes	Y
No	N
Unknown	U

[If Yes skip to item 25]

24. How long after (_____) was last known to be alive was he/she found dead?

{Enter the shortest interval known to be true}

5 minutes or less	A
1 hour or less	B
24 hours or less	C
more than 24 hours	D
Unknown	U

INFORMANT INTERVIEW FORM (IFIA Screen 8 of 16)

25. Where was (_____) when he/she died?

Home (or other private residence)	A
Work	B
In a public building	C
On a bus or public transportation	D
On the street	E
In an automobile	F
In a nursing home	G
In an emergency room	H
In an ambulance	I
In the hospital	J
Other	O
Unknown	U

C. SYMPTOMS

"The next few questons are concerned with any symptoms (_____) may have had shortly before he/she died."

26. Did (_____) experience pain or discomfort in his/her chest,left arm or shoulder or jaw either just before death or within 3 days (72 hours) of death?

Yes	Y
No	N
Unknown	U

[If No or Unknown skip to item 30]

INFORMANT INTERVIEW FORM (IFIA Screen 9 of 16)

" The next set of questions deal specifically with the last episode of (_____)'s pain or discomfort. The last episode is defined as starting at the time (_____) noticed discomfort that caused him/her to stop or change what he/she was doing."

27. Did (_____)'s last episode of pain or discomfort specifically involve the chest?

Yes	Y
No	N
Unknown	U

28. Did he/she take nitroglycerin because of this last episode of pain or discomfort?

Yes	Y
No	N
Unknown	U

INFORMANT INTERVIEW FORM (IFIA Screen 10 of 16)

29. How long was it from the beginning of (_____)'s last episode of pain or discomfort to the time he/she stopped breathing on his/her own?

{Circle the shortest interval known to be true}

5 minutes or less	A
10 minutes or less	B
1 hour or less	C
24 hours or less	D
more than 24 hours	E
Unknown	U

30. Within 3 days of death or just before (_____) died, did any of the following symptoms begin for the first time?

{Circle (Y), (N), or (U) for each}	Yes	No	Unknown
a. Shortness of breath	Y	N	U
b. Dizziness	Y	N	U
c. Palpitations (pounding in the chest)	Y	N	U
d. Marked or increased fatigue, tiredness, or weakness	Y	N	U
e. Headache	Y	N	U
f. Sweating	Y	N	U
g. Paralysis	Y	N	U
h. Loss of speech	Y	N	U
i. Attack of indigestion or nausea or vomiting	Y	N	U
j. Other	Y	N	U

If Other, specify_____

_____

_____

INFORMANT INTERVIEW FORM (IFIA Screen 11 of 16)

D. EMERGENCY MEDICAL CARE

" The next few questions are concerned with emergency medical care (_____) may have received prior to or at the time of death. You may have already given this information in an answer to an earlier question. Since it is important to obtain information specifically on emergency medical care, I hope you don't mind if these questions seem repetitive."

31. Was a physician, ambulance, or other emergency medical team called?

Yes	Y
No	N
Unknown	U

[If No or Unknown skip to item 35]

32. Was (the physician, ambulance, or EMS team) called because of symptoms (_____) was having or after he/she was already dead?

Symptoms	S
Already dead	D

INFORMANT INTERVIEW FORM (IFIA Screen 12 of 16)

33. How long was it from the time the last episode of symptoms started to the time that medical assistance was called for?

{Circle the shortest interval known to be true}

5 minutes or less	A
10 minutes or less	B
1 hour or less	C
6 hours or less	D
24 hours or less	E
more than 24 hours	F
Unknown	U

34. How long was it from the time that medical care was called to the time when it arrived?

{Circle the shortest interval known to be true}

5 minutes or less	A
10 minutes or less	B
1 hour or less	C
6 hours or less	D
24 hours or less	E
more than 24 hours	F
Unknown	U
Did not come	X

INFORMANT INTERVIEW FORM (IFIA Screen 13 of 16)

35. Were resuscitation measures, such as closed chest massage or CPR, attempted at the time?

Yes	Y
No	N
Unknown	U

[If No or Unknown skip to item 38]

36. Who started the resuscitation or CPR?

Bystander, non-health professional	A
M.D.	B
Ambulance attendant, paramedic, or other health professional	C
Fireman or policeman	D
Other	O
Unknown	U

37. Where was resuscitation or CPR started?

Home (or other private residence)	A
Work	B
Public place	C
Ambulance or other emergency vehicle	D
Emergency room	E
Hospital	F
Other	O
Unknown	U

[If Emergency room or Hospital skip to item 39]

INFORMANT INTERVIEW FORM (IFIA Screen 14 of 16)

38. Was (_____) taken to a hospital?

Yes	Y
No	N
Unknown	U

[If No or Unknown skip to item 40]

39. Could you tell me the name and location of this hospital?

a. Name _____

_____

b. City _____

c. State _____

E. ADDITIONAL INFORMATION

40. Is there someone else whom we could contact, who might know more about the circumstances surrounding (_____)'s death or his/her usual state of health?

Yes	Y
No	N
Unknown	U

[If No or Unknown read "final script", then go to 43]

41. Could you tell me the name, address, and telephone number of this person?

a. Name _____

_____

b. City _____

c. State _____

d. Phone _____

INFORMANT INTERVIEW FORM (IFIA Screen 15 of 16)

42. How was he/she related to the deceased?

Spouse	S
Parent	P
Daughter/Son	C
Other relative	R
Friend	F
Workmate	W
Other	O

[Read "final script, then go to Item 43]

F. RELIABILITY

{To be completed immediately after the interview}

43. Did the respondent frequently contradict himself/herself or give information that he/she would have no way of knowing?

Yes	Y
No	N

44. Did the respondent seem to be reluctant to answer questions and thus might not have given all the information the interviewer would wish to know?

Yes	Y
No	N

INFORMANT INTERVIEW FORM (IFIA Screen 16 of 16)

45. On the basis of these questions, give your rating of reliability of the interview.

Good	G
Fair	F
Poor	P

46. Would you like to add other details concerning the quality of the interview?

Yes	Y
No	N

If Yes, specify_____

_____

_____

47. Informant agreed to provide consent to gather further information.

Yes	Y
No	N
Not applicable	A

G. ADMINISTRATIVE INFORMATION

48. Date of data collection:

Month	Day	Year
[ ][ ]	[ ][ ]	[ ][ ]

49. Method of data collection:

Computer	C
Paper Form	P

50. Code number of the person completing this form

[ ][ ][ ]

Based solely on the information gathered in this form, indicate what additional forms are needed for this event:

	Form	Criteria based on this form
☐	IFI	Item 41 completed
☐	PHQ	Item 3 = R and item 4 completed
☐	PHQ	Item 10 completed (most recent)
☐	PHQ	Item 11 completed (additional)
☐	HRA	Item 8 completed (most recent)
☐	HRA	Item 8 completed (additional)

PHYSICIAN QUESTIONNNAIRE

O.M.B. 0925-0281
exp. 7-31-89

Decedent's Name: _____ ID _____ No. __

Age: ____ Date of Birth: ___/___/___ Date of Death: ___/___/___

Physician's Name: _____ Form PHQ A: 4-12-88

Please complete the following to the best of your ability and return in the enclosed envelope.

A. MEDICAL HISTORY

1. Are you familiar with the decedent's medical history?

Yes ☐ No ☐

If No, skip to Item 5 on Page 3

2. When did you last see the decedent? ..... ☐☐ - ☐☐
Month Year

3. Did the decedent have a history of any of the following?

	Yes	No	Uncertain
a. Angina pectoris or coronary insufficiency .	☐	☐	☐
b. Valvular disease or cardiomyopathy	☐	☐	☐
c. Coronary bypass surgery	☐	☐	☐
d. Coronary angioplasty	☐	☐	☐
e. Hypertension	☐	☐	☐

f. Myocardial infarction

Yes ☐ No ☐ Uncertain ☐

g. If Yes, date of most recent event: ☐☐ - ☐☐
Month Year

3. (cont'd) Did the decedent have a history of any of the following?

h. Other chronic ischemic heart disease

Yes ☐ No ☐ Uncertain ☐

i. Stroke (CVA)

Yes ☐ No ☐ Uncertain ☐

☐ j. If Yes, date of most recent event: ☐☐ - ☐☐
Month Year

k. Any non-cardiac condition that might have contributed to this death

Yes ☐ No ☐ Uncertain ☐

☐ l. If Yes, specify: _____

4. Was the decedent taking any of the following medications within four weeks prior to death?

	Yes	No	Uncertain
a. Nitrates	☐	☐	☐
b. Calcium channel blockers ...	☐	☐	☐
c. Digitalis	☐	☐	☐
d. Beta-blockers	☐	☐	☐

e. Other cardiovascular drugs

Yes ☐ No ☐ Uncertain ☐

☐ f. If Yes, specify: _____

_____

_____

B. DETAILS OF DEATH

5. Are you familiar with the events surrounding the decedent's death?

Yes ☐ No ☐

6. Did you witness the death?

Yes ☐ No ☐

If you answered **No** to <u>both 5 & 6</u>, skip to item 14 on page 4. Otherwise, continue with item 7.

7. a. Was there any pain in the chest, left arm or shoulder or jaw within 72 hours of death?

Yes ☐ No ☐ Uncertain ☐

If **No** or **Uncertain**, skip to item 8

b. Did the pain include the chest?

Yes ☐ No ☐ Uncertain ☐

c. Did you think this pain was of a cardiac origin?

Yes ☐ No ☐ Uncertain ☐

d. <u>If No</u>, specify what you think was the cause:

_____

8. Did the decedent take (or was he/she given) nitrates at the time of the acute episode?

Yes ☐ No ☐ Uncertain ☐

9. Was coronary reperfusion (intravenous or intracoronary streptokinase or TPA, angioplasty, etc.) attempted during the acute episode?

Yes ☐ No ☐ Uncertain ☐

10. Was CPR and/or cardioversion performed within 24 hours of death?

Yes ☐ No ☐ Uncertain ☐

11. Please give time between onset of acute symptoms to death. (We are defining death as the point where spontaneous breathing ceased and the patient never recovered.)

- ☐ More than 3 days
- ☐ 2 - 3 days
- ☐ 1 day
- ☐ At least 12 hours, but less than 24 hours
- ☐ At least 4 hours, but less than 12 hours
- ☐ At least 1 hour, but less than 4 hours
- ☐ Less than 1 hour
- ☐ Death instantaneous, no symptoms
- ☐ Unknown

12. Would you classify the decedent's cause of death as due to CHD?

Yes ☐ No ☐ Uncertain ☐

└13. If No, what do you believe to be the cause of death?

	Yes	No	Uncertain
a. Pulmonary embolism	☐	☐	☐
b. Acute pulmonary edema .	☐	☐	☐
c. Stroke	☐	☐	☐
d. Pneumonia	☐	☐	☐

e. Other

Yes ☐ No ☐ Uncertain ☐

└ f. Specify: _____

C. SIGNATURE

14. Form completed by: _____
Signature

15. Date: ☐☐ - ☐☐ - ☐☐
Month Day Year

Thank you very much for your help. Please return this questionnaire in the enclosed self-addressed envelope or mail it to: ARIC Central Receiving, Collaborative Studies Coordinating Center Suite 203 NCNB Plaza,137 E. Franklin Street,Chapel Hill NC 27514

OFFICE USE ONLY: 16. Self__ Interview __ E.R. records __

CORONER/MEDICAL EXAMINER FORM (COR)

Final form not available as of date of this printing.

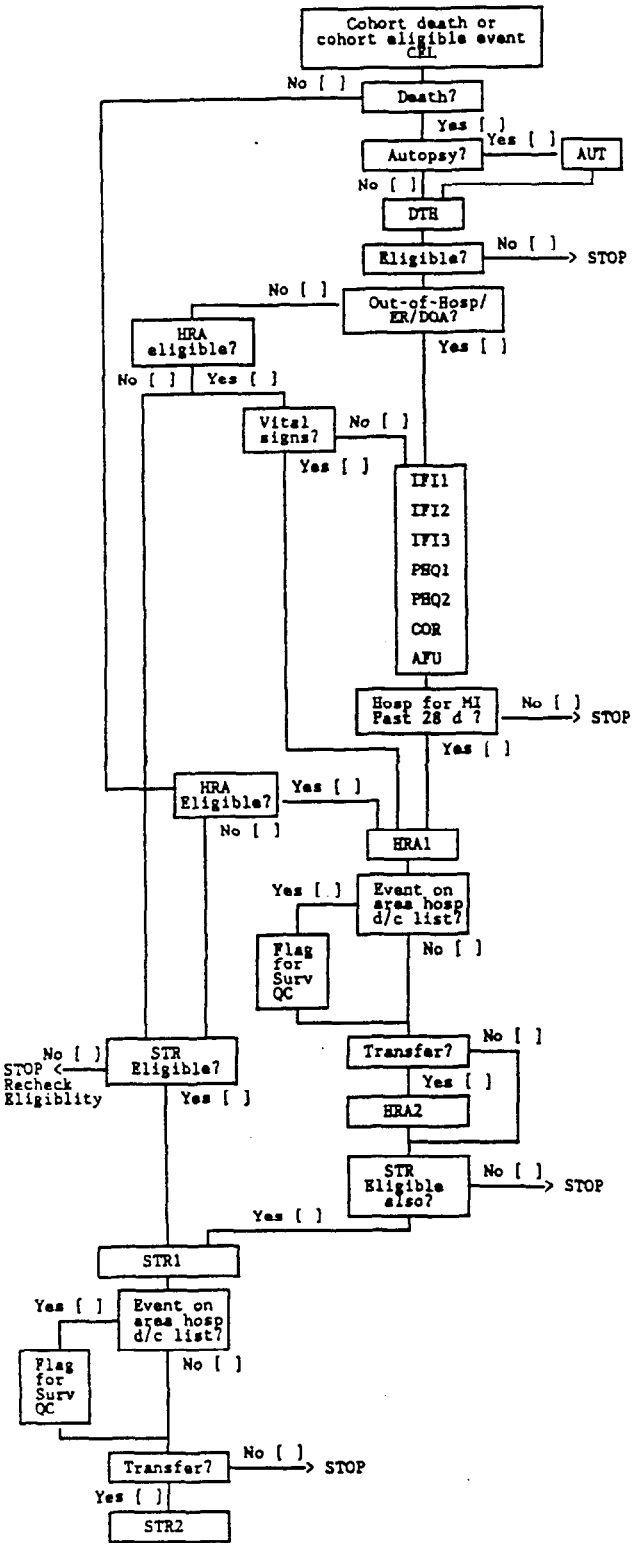
AUTOPSY FORM (AUT)

Final form not available as of date of this printing.

ARIC COHORT EVENT INVESTIGATION SUMMARY FORM (CEI)

Event ID [| | | | | | |] Date Begun ___/___/___

Name of Individual _____



Form	Need?	Complete/ Perm Miss		Date Initiated	Other Information
Eligibility	Y	C	P	___/___/___	_____
Autopsy	Y	C	P	___/___/___	_____
Death Certificate	Y	C	P	___/___/___	_____
Informant Interview-1	Y	C	P	___/___/___	_____
Informant Interview-2	Y	C	P	___/___/___	_____
Informant Interview-3	Y	C	P	___/___/___	_____
Physician Quest-1	Y	C	P	___/___/___	_____
Physician Quest-2	Y	C	P	___/___/___	_____
Coroner/Med Examiner	Y	C	P	___/___/___	_____
Annual Follow-Up	Y	C	P	___/___/___	_____
Hosp Record Abstract-1	Y	C	P	___/___/___	_____
Hosp Record Abstract-2	Y	C	P	___/___/___	_____
Hosp Stroke Abstract-1	Y	C	P	___/___/___	_____
Hosp Stroke Abstract-2	Y	C	P	___/___/___	_____

This worksheet is not considered an official study form.

IFI-1 (Informant Interview 1)

Name: _____

Address: _____

_____

_____

Phone: _____

Tracing Info: _____

_____

_____

PHQ-1 (Physician Questionnaire 1)

Name: _____

Address: _____

_____

_____

Phone: _____

Tracing Info: _____

_____

_____

IFI-2 (Informant Interview 2)

Name: _____

Address: _____

_____

_____

Phone: _____

Tracing Info: _____

_____

_____

PHQ-2 (Physician Questionnaire 2)

Name: _____

Address: _____

_____

_____

Phone: _____

Tracing Info: _____

_____

_____

IFI-3 (Informant Interview 3)

Name: _____

Address: _____

_____

_____

Phone: _____

Tracing Info: _____

_____

_____

Date Investigation Completed: ____/____/____

Code Number of Person Completing This Form: ___ ___ ___

Comments: _____

_____

_____

_____

_____

_____

ARIC General Instructions For Completing Paper Forms

A. BACKGROUND

The Atherosclerosis Risk In Communities (ARIC) Study utilizes computer-assisted direct data entry as its primary mode of data collection. Nevertheless, the existence of paper forms is necessary for situations in which direct data entry is not possible. In such instances, data is collected on paper forms and then entered on the computer at some later time. The purpose of this document is to provide instructions for completing these paper forms. It should be read carefully prior to working with any forms. Specific sets of instructions associated with each form should then be read for those forms which are of interest.

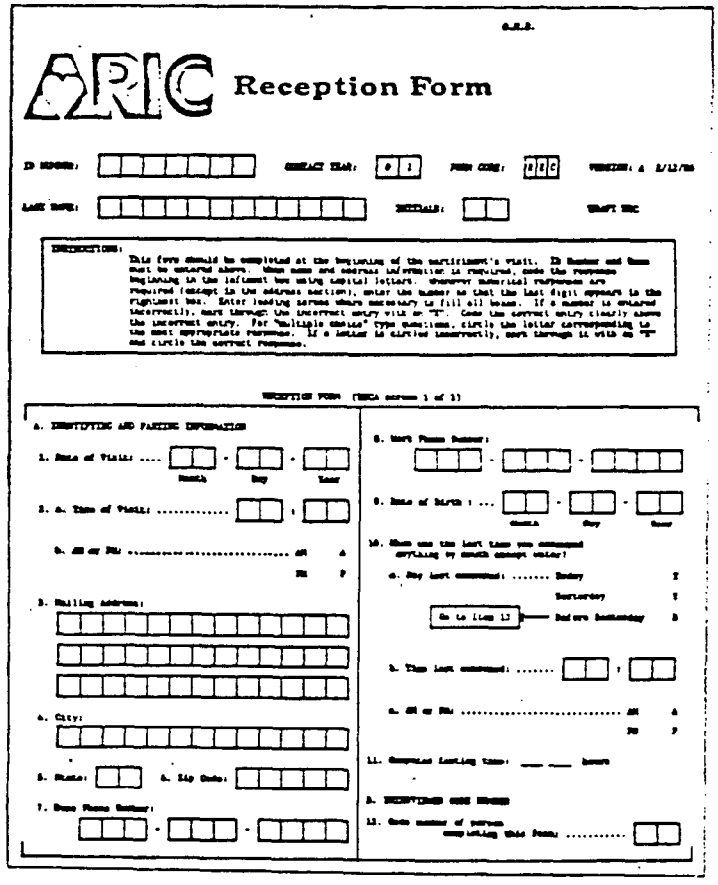
B. FORM STRUCTURE

The paper forms in ARIC are designed to correspond exactly to the computer screens used for data entry. For this reason, forms are organized by "screen" instead of by "page". Thus, any item on a paper form may be located in the same position on the corresponding computer screen, and vice versa. In general, the first page of the paper form contains one screen, and subsequent pages contain two screens each. Forms are structured as follows:

First page:

a. Form Title
b. "Header" Information
   1. Participant's ID Number
   2. Contact Year
   3. Form Code (preassigned 3-letter code)
   4. Version (1-letter code and date)
   5. Participant's Last Name and Initials
c. Summarized Instructions
d. First Screen of the Form

Example:

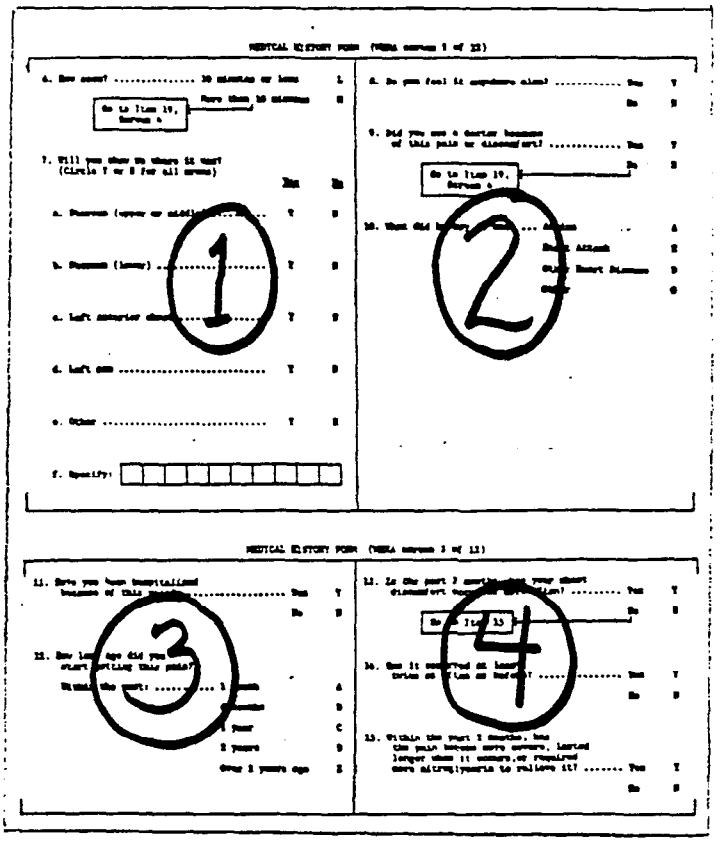


ARIC Reception Form

Following pages:

a. Form Title, Code, and Version
b. Successive Screens

Where two screens appear on the same page, both columns of the top screen should be completed in full before proceeding to the bottom screen. This order is illustrated in the following example:



C. GENERAL INSTRUCTIONS FOR COMPLETING AND CORRECTING ITEMS ON THE FORMS

All items fall into two main categories: (1) fill in the boxes, and (2) multiple choice. Techniques for completing each of these types of items, as well as making corrections, are described below. A general rule is to record information only in the spaces provided (except for some error corrections).

1. Fill In The Boxes: Recording Information

When alphabetic information is required, print the response beginning in the leftmost box using capital letters. Punctuation may be included.

Example: If the participant's last name were O'Reilly, it should be entered as follows:

LAST NAME: | O | ' | R | E | I | L | L | Y | | | | |

If the response contains more characters than there are boxes, beginning with the first character enter as many characters as there are boxes.

Example: If the subject's last name were Hobgoodnotting, it should be entered as follows:

LAST NAME: | H | O | B | G | O | O | D | N | O | T | T | I |

Whenever numerical responses are required, enter the number so that the last digit appears in the rightmost box. Enter leading zeroes where necessary to fill all boxes. (This does not apply to the address section or to any item which combines alphabetic and numeric information. Such items should be treated as alphabetic.)

Example: If the participant's diastolic blood pressure were 95, it should be coded as:

Diastolic: ..... 

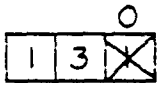
2. Fill In The Boxes: Correcting Mistakes

If a number or letter is entered incorrectly, mark through the incorrect entry with an "X". Code the correct entry clearly above the original incorrect entry.

Example: If the participant's systolic blood pressure was actually 130, but was incorrectly entered:

Systolic: ..... 

The correction would look like:

Systolic: ..... 

If a mistake is made, corrected, and then it is discovered that the correction is incorrect, make a second correction as shown below:

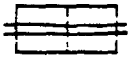
Systolic: ..... 

3. Fill In The Boxes: Unknown Or Inapplicable Information

If an item of this type (either alphabetic or numeric) does not apply to the subject being interviewed, leave it blank. For example, if the participant does not have a "work" phone number, that item is left blank. Similarly, if the form provides spaces for three measurements, but only two are taken, the third space is left blank.

If the item does apply, but the response is unknown, mark through the box(es) with <u>two</u> horizontal lines.

Example: The question "How old were you when you had your first heart attack?" is asked, but the participant does not recall how old he/she was. The question does apply because it has been established that the participant has had a heart attack, but the answer to this question is not known. In this case, the response would look like:

How old were you when you had your first heart attack? ..... 

4. Multiple Choice: Recording Information

In this type of question several alternatives are given for the answer, each having a corresponding letter. When it is decided which alternative is most appropriate, circle the corresponding letter in the space provided. Always circle <u>one letter only</u>.

Example: If the participant indicates that they have never had chest pain or discomfort, the response would look like:

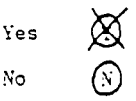
Have you ever had any pain or discomfort in your chest? ..... Yes Y

No (N)

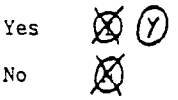
5. Multiple Choice: Correcting Mistakes

If a response is coded incorrectly, mark through the incorrectly coded response with an "X" and circle the correct response.

Example 1: The actual response is No, but Y was circled incorrectly. The correction looks like:



Example 2: If a mistake is made, corrected, and then it is discovered that the correction is incorrect, make a second correction as shown below:



D. COMPLETING "HEADER" INFORMATION

The following guidelines should be observed in filling out the "header" information located at the top of the first page on all forms:

ID NUMBER: Write in the participant's 7-digit ID. The first box contains the letter identifying the field center, followed by the 6-digit numeric portion of the ID number.

Example: ID NUMBER: | J | 9 | 9 | 9 | 9 | 9 | 9 |

CONTACT YEAR: Fill in the appropriate contact year for the form. Use leading zeroes. Note: This item may be pre-coded on some forms.

LAST NAME: Code the response beginning in the leftmost box using capital letters. If the name contains more letters than there are boxes, beginning with the first letter enter as many letters as there are boxes. Punctuation (e.g., apostrophes and hyphens) and blanks may be entered as part of the last name. Follow the guidelines and examples given above for alphabetic "fill in the boxes" items.

INITIALS: Record the participant's first initial in the first box and middle initial in the second box. If a female participant is married and uses a "maiden" name (father's surname) as a middle name, use that initial as the second initial. Otherwise, if the participant has more than one middle name, record only the first initial and the second initial. If there is no middle name, record the first initial in the first box and leave the second box blank.

Example 1: A participant's first initial is K, but he has no middle name. The entry would be as follows:

INITIALS: | K | |

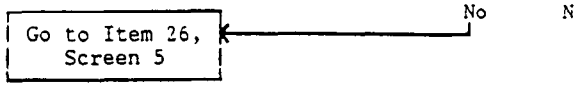
Example 2: If the participant's full name is John Oscar Van Camp, Jr., and the participant specifies that his last name is "Van Camp", it should be entered as:

LAST NAME: | V | A | N | | C | A | M | P | | | | | INITIALS: | J | O |

E. SKIP PATTERNS ("Go to" Boxes)

Skip patterns occur in many multiple choice type items. Here, if a certain response is selected, it is necessary to skip over one or more items to the next applicable item. This is indicated by an arrow from the response which necessitates a skip to a box containing a "go to" statement. If that response is selected, the next item to be asked is the one indicated in the box. If the other response is selected, always proceed to the next item unless otherwise directed.

Example: 1. Have you ever had any pain
or discomfort in your chest? ..... Yes Y



In this case, if the response is "No", skip to item 26 on screen 5. If the response is "Yes", proceed to the next question, item 2.

Occasionally, a skip pattern will occur in a fill-in type item. In those instances, specific instructions are provided on the form. Again, if the skip criteria are not satisfied, continue with the next item.

ARIC PARTICIPANT ITINERARY FORM

VERSION 11-1-86

ID NUMBER: _____ CONTACT YEAR: 01

NAME: _____ SEX: _____ RACE: _____

DATE OF BIRTH: ____ / ____ / ____ AGE: _____
Month Day Year

DATE OF VISIT: ____ / ____ / ____ TIME OF CHECK-IN: _____:_____
Month Day Year

SEQUENCE	PROCEDURE	TIME STARTED	TIME COMPLETED	OBSERVER CODE NUMBER
1	RECEPTION	____:____	____:____	_____
	Brought Medications? Yes___ No___			
	____Signed Informed Consent			
	____Identification Form			
	____Fasting / Tracking Form			
2	SITTING BLOOD PRESSURE Cuff Size: ____	____:____	____:____	_____
3	ANTHROPOMETRY Standing Height (cm): ___ ___ ___ . ___	____:____	____:____	_____
4	VENIPUNCTURE	____:____	____:____	_____
5	SNACK			
_____	PHYSICAL EXAM	____:____	____:____	_____
_____	PULMONARY FUNCTION	____:____	____:____	_____
_____	ULTRASOUND	____:____	____:____	_____
_____	ECG	____:____	____:____	_____
_____	INTERVIEW: Medical History	____:____	____:____	_____
_____	INTERVIEW: Stroke / TIA	____:____	____:____	_____
_____	INTERVIEW: Respiratory Symptoms / Physical Activity	____:____	____:____	_____
_____	INTERVIEW: Dietary Intake	____:____	____:____	_____
_____	INTERVIEW: Reproductive History (Females Only)	____:____	____:____	_____
_____	INTERVIEW: Medication Survey	____:____	____:____	_____
16	INVENTORY REVIEW	____:____	____:____	_____
17	MEDICAL DATA REVIEW	____:____	____:____	_____
18	EXIT INTERVIEW	____:____	____:____	_____

ARIC ALERT/REFERRAL LOG

ID NUMBER: [| | | | | |] CONTACT YEAR: [|] FORM CODE: A L T VERSION: A 10/9/86

LAST NAME: [| | | | | | | | | | |] INITIALS: [|]

Date Received:	Alert Value:	Referral/Action:	Date of Action:	Notes	Initials: __ __ __
___/___/___ mm dd yy	Item: ________ Value: ________	__No __Yes ——> __Immediate __Urgent __Routine	___/___/___ mm dd yy	________________	

Date Received:	Alert Value:	Referral/Action:	Date of Action	Notes	Initials: __ __ __
___/___/___ mm dd yy	Item: ________ Value: ________	__No __Yes ——> __Immediate __Urgent __Routine	___/___/___ mm dd yy	________________	

Date Received:	Alert Value:	Referral/Action:	Date of Action	Notes	Initials: __ __ __
___/___/___ mm dd yy	Item: ________ Value: ________	__No __Yes ——> __Immediate __Urgent __Routine	___/___/___ mm dd yy	________________	

Date Received:	Alert Value:	Referral/Action:	Date of Action	Notes	Initials: __ __ __
___/___/___ mm dd yy	Item: ________ Value: ________	__No __Yes ——> __Immediate __Urgent __Routine	___/___/___ mm dd yy	________________	

Date Received:	Alert Value:	Referral/Action:	Date of Action	Notes	Initials: __ __ __
___/___/___ mm dd yy	Item: ________ Value: ________	__No __Yes ——> __Immediate __Urgent __Routine	___/___/___ mm dd yy	________________	

APPENDIX X

List of ICD9 Codes for Chart Abstraction and Investigation of Deaths

Appendix X

List of ICD9-CM codes for event identification.

APPENDIX X

ICD9-CM Discharge Codes Leading to Hospital Chart Abstraction

Code	Title
Event: Myocardial Infarction	
402	Hypertensive Heart Disease
410	Acute Myocardial Infarction
411	Other Acute and Subacute Ischemic Heart Disease
412	Old Myocardial Infarction
413	Angina Pectoris
414	Other Chronic Ischemic Heart Disease
427	Cardiac Dysrhythmias
428	Heart Failure
518.4	Acute Edema of Lung, Unspecified
Event: Stroke	
430	Subarachnoid Hemorrhage
431	Intracerebral Hemorrhage
432	Other and Unspecified Intracranial Hemorrhage
433	Occlusion and Stenosis of Precerebral Arteries
434	Occlusion of Cerebral Arteries
435	Transient Cerebral Ischemia
436	Acute, Ill-Defined Cerebrovascular Disease
437	Other and Ill-Defined Cerebrovascular Disease
438	Late Effects of Cerebrovascular Disease

APPENDIX X

ICD9 Codes Leading to Special Investigation of Out-of-Hospital Deaths

Code	Title
Event: Coronary Heart Disease	
250	Diabetes Mellitus
401	Essential Hypertension
402	Hypertensive Heart Disease
410	Acute Myocardial Infarction
411	Other Acute and Subacute Ischemic Heart Disease
412	Old Myocardial Infarction
413	Angina Pectoris
414	Other Chronic Ischemic Heart Disease
427	Cardiac Dysrhythmias
428	Heart Failure
429	Ill-Defined Descriptions and Complications of Heart Disease
440	Atherosclerosis
518.4	Acute Edema of Lung
798	Sudden Death, Cause Unknown
799	Other Ill-Defined and Unknown Causes of Morbidity and Mortality

APPENDIX XI

Edit Checks for Forms not Available on the ARIC Direct Data Entry System

Appendix XI

Edit Checks for Forms Not Available on DES on January 1987

TRANSIENT ISCHEMIC ATTACK FORM (TIA) Version B

1. Question A1: Must be answered.
2. Question A2: Must be answered if the answer to A1 is yes.
3. Question B3: Must be answered.
4. Question B8: If answered, a,b, & c all must be answered.
5. Question B9: If answered, a,b,c,d,e,f,g,h & i all must be answered.
6. Question C10: Must be answered.
7. Question D17: Must be answered.
8. Question E23: Must be answered.
9. Question F32: Must be answered.
10. Question G40: Must be answered.

DIEARY INTAKE FORM

1. In section A - G, each food listed REQUIRES an answer (A - I).
2. In section H, for every food noted by the participant in questions 66 - 80, ensure that a code is entered and a portion size or brand is specified.