

CARDIA ID Label

CARDIA III
MEDICAL HISTORY

___ / ___ / ___
exam date

Has a doctor or nurse ever said that you have:

If yes, at what age
did it first begin?

- | | | | | | |
|-------------|----------------------------|----------------------------|----------------------------|---|----------------------|
| | No | Yes | Not Sure | | |
| C08HBP 1. | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 8 <input type="checkbox"/> | High blood pressure
or hypertension? | _____ years C08HBPAG |
| C08HCHOL 2. | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 8 <input type="checkbox"/> | High blood cholesterol? | _____ years C08CHOAG |
| C08HEART 3. | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 8 <input type="checkbox"/> | Heart problems? | |

	What type?	Age began?
C08HRTAK	2 <input type="checkbox"/> Heart attack	C08HRTAG _____ years
C08ANGIN	2 <input type="checkbox"/> Angina	C08ANGAG _____ years
C08RHD	2 <input type="checkbox"/> Rheumatic heart disease	C08RHDAG _____ years
C08MVP	2 <input type="checkbox"/> Mitral valve prolapse	C08MVPAG _____ years
C08OTHHT	2 <input type="checkbox"/> Other: Please specify	C08OTHAG _____ years

- | | | | | | |
|-------------|----------------------------|----------------------------|----------------------------|---|----------------------|
| | No | Yes | Not Sure | | |
| C08DIAB 4. | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 8 <input type="checkbox"/> | Diabetes (high sugar
in blood or urine)? | _____ years C08DIBAG |
| C08KIDNY 5. | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 8 <input type="checkbox"/> | Kidney problems? | |

	What type?	Age began?
C08URINE	2 <input type="checkbox"/> Urine infection from your kidney (pyelonephritis)	C08URNAG _____ years
C08KYS	2 <input type="checkbox"/> Kidney stone(s)	C08KYSAG _____ years
C08NEP	2 <input type="checkbox"/> Other kidney problem such as nephritis or glomerulonephritis	C08NEPAG _____ years
C08OTHKY	2 <input type="checkbox"/> Other: Please specify	C08OTKAG _____ years

	No	Yes	Not Sure		If yes, at what age did it first begin?
CO8HEP ⁶ .	1 <input type="checkbox"/>	2 <input type="checkbox"/>	8 <input type="checkbox"/>	Hepatitis?	CO8HEPAG _____ years
CO8CANC ⁷ .	1 <input type="checkbox"/>	2 <input type="checkbox"/>	8 <input type="checkbox"/>	Cancer or malignant tumor?	

	No	Yes	Not Sure	What type?	Age began?
CO8LUN	2 <input type="checkbox"/>			Lung	CO8LUNAG _____ years
CO8BRS	2 <input type="checkbox"/>			Breast	CO8BRSAG _____ years
CO8BLD	2 <input type="checkbox"/>			Blood/lymph glands	CO8BLDAG _____ years
CO8TES	2 <input type="checkbox"/>			Testes/scrotum	CO8TESAG _____ years
CO8BON	2 <input type="checkbox"/>			Bone	CO8BONAG _____ years
CO8MEL	2 <input type="checkbox"/>			Melanoma	CO8MELAG _____ years
CO8SKN	2 <input type="checkbox"/>			Skin (not melanoma)	CO8SKNAG _____ years
CO8BRN	2 <input type="checkbox"/>			Brain	CO8BRNAG _____ years
CO8STM	2 <input type="checkbox"/>			Stomach/colon	CO8STMAG _____ years
CO8OCA	2 <input type="checkbox"/>			Other: Please specify _____	CO8OCAAG _____ years

	No	Yes	Not Sure		If yes, at what age did it first begin?
CO8GALL ⁸ .	1 <input type="checkbox"/>	2 <input type="checkbox"/>	8 <input type="checkbox"/>	Gallstones or gallbladder disease?	CO8GALDA _____ years

CO80THDZ ⁹ .	1 <input type="checkbox"/>	2 <input type="checkbox"/>	8 <input type="checkbox"/>	Any other major diseases or health problems?	
				Please specify: _____	

	No	Yes	Not Sure	
CO8HBNOW ¹⁰ .	1 <input type="checkbox"/>	2 <input type="checkbox"/> *	8 <input type="checkbox"/>	Are you taking medications for high blood pressure?
CO8CHNOW ¹¹ .	1 <input type="checkbox"/>	2 <input type="checkbox"/> *	8 <input type="checkbox"/>	Are you taking medications to lower your blood cholesterol?
CO8ASMA ¹² .	1 <input type="checkbox"/>	2 <input type="checkbox"/> *	8 <input type="checkbox"/>	Are you taking medications for asthma or any breathing problem?
CO80TMED ¹³ .	1 <input type="checkbox"/>	2 <input type="checkbox"/> *	8 <input type="checkbox"/>	Are you currently taking any other prescription medications?

*COMPLETE A FOLLOW-UP FORM

Women only:

14. 1 No 2 Yes * 8 Not Sure
 C08PPREG Have you ever been pregnant?

C08PRGAG 14a. How old were you at the time of your first pregnancy?
 _____ years

C08BRSFD 14b. Are you currently breast feeding?
 No Yes
 1 2

C08PREG 14c. Are you currently pregnant?
 No Yes Not Sure
 1 2 8

SKIP TO QUESTION 15

C08OVYRM 15. 1 No 2 Yes 8 Not Sure
 Has either of your ovaries been removed?

C08NOVRM 15a. Was one ovary removed or both?
 One Two Not sure
 1 2 8

C08BCNOW 16. 1 No 2 Yes * 8 Not Sure
 Are you currently taking birth control pills?

C08HMNOW 17. 1 No 2 Yes * 8 Not Sure
 Are you currently taking hormones other than birth control pills?

*COMPLETE A FOLLOW-UP FORM

C08IVID __ INTERVIEWER ID