

CARDIA ID
 FY1440AT

 date

CARDIA
 144 MONTH FOLLOW-UP QUESTIONNAIRE

We would like to ask you a few questions about yourself.

1. In the past year, have you been a patient in a hospital overnight?
 No Yes
 If yes, please give us the details regarding your hospital stay(s). If you need more space, please attach additional information on a separate page.

DATE ADMITTED	HOSPITAL NAME & LOCATION	REASON FOR STAY
FYMONTH, FYDAY, FYYEAR, AND FYDATE		FYREASON
A. <u> </u> / <u> </u> / <u> </u> FYH2NNUM=1	<u> </u> FYNAMELOC	<u> </u>
B. <u> </u> / <u> </u> / <u> </u> FYH2NNUM=2	<u> </u> FYNAMELOC	<u> </u> FYREASON
C. <u> </u> / <u> </u> / <u> </u> FYH2NNUM=3	<u> </u> FYNAMELOC	<u> </u> FYREASON

2. 1 No 2 Yes
 In the past year, have you had a coronary angiogram or heart catheterization?
 FY144ANUM

If this did NOT require an overnight hospital stay, please give us the details regarding your procedure(s). If you need more space, please attach additional information on a separate page.

DATE	HOSPITAL/CLINIC NAME & LOCATION	REASON FOR STAY
FYMONTH, FYDAY, FYYEAR, AND FYDATE		FYOPRSN
A. <u> </u> / <u> </u> / <u> </u> DATE	<u> </u> FYOPLOC	<u> </u>

- No Yes
 May we have your permission to obtain and review your records from each of the above hospitalizations or outpatient procedures?
 FY144DK

Yes, I give my permission for the above named medical facility(ies) to send to the CARDIA study a copy or summary of the record(s) of my hospitalization or hospital procedure as shown above. A photocopy of this signed permission is as valid as the original. This permission is valid as long as the CARDIA research continues.

Date of Birth / /
 SS# - -

Signature _____ Date _____
 Participant Name _____
 (Please Print)
 (GO TO NEXT PAGE)

3. In the past year, have you visited a doctor or clinic?

No Yes
 1 2
FY144DOC

3A. How many times? <u>FY144DOX</u>	
No	Yes
<input type="checkbox"/> 1	<input type="checkbox"/> 2
3B. Was any visit due to a referral from your CARDIA exam? <u>FY144REF</u>	
No	Yes
<input type="checkbox"/> 1	<input type="checkbox"/> 2

4. In the past year, has a doctor or nurse said that you have:

- No Yes
- A. 1 2 High blood pressure or hypertension? FY144HBP
- B. 1 2 High blood cholesterol? FY144UCH
- C. 1 2 Diabetes? FY144DST
- D. 1 2 Stroke or TIA (transient ischemic attack)? FY144TIA
- E. 1 2 Peripheral vascular disease (blocked arteries in your arms or legs)? FY144PVD

No Yes
F. 1 2 Heart problems?
FY144HRT

No	Yes
<input type="checkbox"/> 1	<input type="checkbox"/> 2
Was this angina or chest pain? <u>FY144AGA</u>	
<input type="checkbox"/> 1	<input type="checkbox"/> 2
Was this a heart attack? <u>FY144HAC</u>	
<input type="checkbox"/> 1	<input type="checkbox"/> 2
Was this heart failure? <u>FY144HFL</u>	

No Yes
G. 1 2 Lung disease?
FY144LD

No	Yes
<input type="checkbox"/> 1	<input type="checkbox"/> 2
Was this emphysema? <u>FY144EMP</u>	
<input type="checkbox"/> 1	<input type="checkbox"/> 2
Was this chronic bronchitis? <u>FY144BRD</u>	
<input type="checkbox"/> 1	<input type="checkbox"/> 2
Was this asthma? <u>FY144AST</u>	

No Yes
H. 1 2 Kidney problems?
FY144KID

No	Yes
<input type="checkbox"/> 1	<input type="checkbox"/> 2
Was this kidney failure? <u>FY144KFL</u>	

No Yes
I. 1 2 A blood clot?
FY144BLC

No	Yes
<input type="checkbox"/> 1	<input type="checkbox"/> 2
Lung (pulmonary embolus)? <u>FY144BLP</u>	
<input type="checkbox"/> 1	<input type="checkbox"/> 2
Legs (deep venous thrombosis)? <u>FY144BLV</u>	

5. FY144SMK On the average, how many cigarettes do you usually smoke per day?

THANK YOU FOR YOUR PARTICIPATION

FY144CDT
FY144CI
FY144C2
FY144C3
FY144CID

Hospitalization Coding

FY144ID INTERVIEWER ID