

192 MONTH FOLLOW-UP QUESTIONNAIRE

DATE **FY192DAT**

1. **In the past year**, have you been a patient in a hospital overnight? **FY192PT**

No **Yes**
 1 2

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
A. ____/____/____ FY192HN1	_____ FY192HL1	_____ FY192R1
	_____	_____
	_____	_____
B. ____/____/____ FY192HN2	_____ FY192HL2	_____ FY192HR2
	_____	_____
	_____	_____

2. **In the past year**, have you had a coronary angiogram or heart catheterization? (A **coronary angiogram** is a procedure in which dye is injected in an artery, usually from a needle stick in the upper thigh, to take pictures of the heart.)

No **Yes**
 1 2

FY192AHC

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	PROCEDURE DONE
A. ____/____/____ FY192PDT	_____ FY192LOC	_____ F192PCD
	_____	_____
	_____	_____

No **Yes**
 1 2

May we have your permission to obtain and review your records from each of the above hospitalizations or outpatient procedures?

FY192PMT

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 ____/____/____

Signature _____

Date _____

SS# _____ - _____ - _____

Participant Name **(Please Print)** _____

ID CARDIA ID

3. **In the past year**, have you visited a doctor or clinic? **FY192DOC**

No	Yes	
1 <input type="checkbox"/>	2 <input type="checkbox"/>	→
		3 A. How many times? _____ FY192DOX

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

- | | | |
|----------------------------|----------------------------|--|
| No | Yes | |
| 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | |
| A. | | High blood pressure or hypertension? FY192HBP |
| B. | | High blood cholesterol? FY192HCH |
| C. | | Diabetes? FY192DBT |
| D. | | Stroke or TIA (transient ischemic attack)? FY192TIA |
| E. | | Peripheral vascular disease (blocked arteries in your arms or legs)? FY192PVD |

No	Yes													
1 <input type="checkbox"/>	2 <input type="checkbox"/>													
F.		Heart problems? FY192HRT												
		<table border="0"> <tr> <td style="text-align: center;">No</td> <td style="text-align: center;">Yes</td> <td></td> </tr> <tr> <td style="text-align: center;">1 <input type="checkbox"/></td> <td style="text-align: center;">2 <input type="checkbox"/></td> <td>Was this angina or chest pain? FY192AGA</td> </tr> <tr> <td style="text-align: center;">1 <input type="checkbox"/></td> <td style="text-align: center;">2 <input type="checkbox"/></td> <td>Was this a heart attack? FY192HAK</td> </tr> <tr> <td style="text-align: center;">1 <input type="checkbox"/></td> <td style="text-align: center;">2 <input type="checkbox"/></td> <td>Was this heart failure? FY192HFL</td> </tr> </table>	No	Yes		1 <input type="checkbox"/>	2 <input type="checkbox"/>	Was this angina or chest pain? FY192AGA	1 <input type="checkbox"/>	2 <input type="checkbox"/>	Was this a heart attack? FY192HAK	1 <input type="checkbox"/>	2 <input type="checkbox"/>	Was this heart failure? FY192HFL
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No	Yes													
1 <input type="checkbox"/>	2 <input type="checkbox"/>													
G.		Lung disease? FY192LNG												
		<table border="0"> <tr> <td style="text-align: center;">No</td> <td style="text-align: center;">Yes</td> <td></td> </tr> <tr> <td style="text-align: center;">1 <input type="checkbox"/></td> <td style="text-align: center;">2 <input type="checkbox"/></td> <td>Was this emphysema? FY192EMP</td> </tr> <tr> <td style="text-align: center;">1 <input type="checkbox"/></td> <td style="text-align: center;">2 <input type="checkbox"/></td> <td>Was this chronic bronchitis? FY192CB</td> </tr> <tr> <td style="text-align: center;">1 <input type="checkbox"/></td> <td style="text-align: center;">2 <input type="checkbox"/></td> <td>Was this asthma? FY192ASM</td> </tr> </table>	No	Yes		1 <input type="checkbox"/>	2 <input type="checkbox"/>	Was this emphysema? FY192EMP	1 <input type="checkbox"/>	2 <input type="checkbox"/>	Was this chronic bronchitis? FY192CB	1 <input type="checkbox"/>	2 <input type="checkbox"/>	Was this asthma? FY192ASM
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No	Yes							
1 <input type="checkbox"/>	2 <input type="checkbox"/>							
H.		Kidney problems? FY192KDY						
		<table border="0"> <tr> <td style="text-align: center;">No</td> <td style="text-align: center;">Yes</td> <td></td> </tr> <tr> <td style="text-align: center;">1 <input type="checkbox"/></td> <td style="text-align: center;">2 <input type="checkbox"/></td> <td>Was this kidney failure? FY192KFL</td> </tr> </table>	No	Yes		1 <input type="checkbox"/>	2 <input type="checkbox"/>	Was this kidney failure? FY192KFL
No	Yes							
1 <input type="checkbox"/>	2 <input type="checkbox"/>	Was this kidney failure? FY192KFL						

No	Yes										
1 <input type="checkbox"/>	2 <input type="checkbox"/>										
I.		A blood clot? FY192BCL									
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5. _____ **On the average**, how many cigarettes do you usually smoke per day? **FY192SMK**

6. Has one of your parents or any of your brothers and sisters ever been on dialysis for more than one month? **FY192FHD**

1	No <input type="checkbox"/>	2	Yes <input type="checkbox"/>		
			→		
	1	No <input type="checkbox"/>	2	Yes <input type="checkbox"/>	Mother? FY192MD
	1	<input type="checkbox"/>	2	<input type="checkbox"/>	Father? FY192FD
	1	<input type="checkbox"/>	2	<input type="checkbox"/>	Brother? FY192BD
	1	<input type="checkbox"/>	2	<input type="checkbox"/>	Sister? FY192SD

7. Has one of your parents or any of your brothers and sisters ever had a kidney transplant? **FY192FKT**

1	No <input type="checkbox"/>	2	Yes <input type="checkbox"/>		
			→		
	1	No <input type="checkbox"/>	2	Yes <input type="checkbox"/>	Mother? FY192MKT
	1	<input type="checkbox"/>	2	<input type="checkbox"/>	Father? FY192FKT
	1	<input type="checkbox"/>	2	<input type="checkbox"/>	Brother? FY192BKT
	1	<input type="checkbox"/>	2	<input type="checkbox"/>	Sister? FY192SKT

THANK YOU FOR YOUR PARTICIPATION

FOR STAFF USE ONLY:	
Number of page 1's: _____	_____ INTERVIEWER ID

FY192NO1

FY192IV