PROXY FOLLOW-UP QUESTIONNAIRE
CARDIA 324-Month Follow-Up Period

Date Completed: ___ ___/___ ___/___ ___ ___ ___ FY324ADAT

This questionnaire refers to hospitalizations, procedures, or events that have occurred since the participant’s last CARDIA contact or exam on [DATE]. This questionnaire is to be administered by telephone only.

Reason for using proxy: (CHECK ALL THAT APPLY)
1. Since [NAME’s] last CARDIA-related contact or exam, was he/she a patient in a hospital overnight?
2. Since [NAME’s] last CARDIA-related contact or exam, has he/she had a coronary angiogram or heart catheterization as an outpatient? (A coronary angiogram is a procedure in which dye is injected into an artery, usually in the upper thigh, to take pictures of the heart.)
3. Since [NAME’s] last CARDIA-related contact or exam, has he/she had an outpatient procedure to open a blocked artery or arteries, such as an artery in the heart (coronary artery), neck (carotid), or leg?
4. Since [NAME’s] last CARDIA-related contact or exam, has he/she had an overnight sleep test where tested for sleep apnea or any other sleep-related conditions?
5. Since [NAME’s] last CARDIA-related contact or exam, has he/she had a surgery or any procedure for weight loss (e.g., gastric bypass, LAP-BAND®, stomach stapling)?

2/17/2012
6. Since [NAME's] last CARDIA-related contact or exam, has a doctor or nurse said that he/she has...

| 6a. High blood pressure or hypertension FY324HBP | 1 □ No 2 □ Yes 8 □ UNK |
| 6b. Diabetes FY324DBT | 1 □ No 2 □ Yes 8 □ UNK |
| 6c. Stroke or TIA (transient ischemic attack) FY324TIA | 1 □ No 2 □ Yes 8 □ UNK |
| 6d. Peripheral vascular disease (blocked arteries in arms or legs) FY324PVD | 1 □ No 2 □ Yes 8 □ UNK |
| 6e. Heart problems FY324HRT | 1 □ No 2 □ Yes 8 □ UNK |

| 6e1. Was this angina or chest pain? FY324AGA | 1 □ No 2 □ Yes |
| 6e2. Was this a heart attack? FY324HAK | 1 □ No 2 □ Yes |
| 6e3. Was this heart failure? FY324HFL | 1 □ No 2 □ Yes |
| 6e4. Other (specify) _ FY324HOT ___________ FY324HOXT | 1 □ No 2 □ Yes |

| 6f. Lung disease FY324LD | 1 □ No 2 □ Yes 8 □ UNK |

| 6f1. Was this emphysema? FY324EMP | 1 □ No 2 □ Yes |
| 6f2. Was this COPD (chronic obstructive pulmonary disease)? FY324COPD | 1 □ No 2 □ Yes |
| 6f3. Was this chronic bronchitis? FY324BRO | 1 □ No 2 □ Yes |
| 6f4. Was this asthma? FY324AST | 1 □ No 2 □ Yes |
| 6f5. Other (specify) _ FY324AOT ___________ FY324AOXT | 1 □ No 2 □ Yes |

| 6g. Kidney problems FY324KID | 1 □ No 2 □ Yes 8 □ UNK |

| 6g1. FY324TPT |
| 6g2. FY324DIS |
| 6g3. FY324DION |
| 6g4. Other (specify) _ FY324KOT ___________ FY324KOXT | 1 □ No 2 □ Yes |

| 6h. Blood clot FY324BLC | 1 □ No 2 □ Yes 8 □ UNK |

| 6h1. FY324BLP |
| 6h2. FY324BLV |
| 6h3. Other (specify) _ FY324BCOT ____ FY324BCXOT | 1 □ No 2 □ Yes |

| 6i. Cancer FY324CACR | 1 □ No 2 □ Yes 8 □ UNK |

| 6i1. Lung FY324CLNG | 1 □ No 2 □ Yes |
| 6i2. Breast FY324CBRST | 1 □ No 2 □ Yes |
PROXY FOLLOW-UP QUESTIONNAIRE
CARDIA 324-Month Follow-Up Period

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Code</th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>6i3.</td>
<td>Blood/lymph glands</td>
<td>FY324CBLD</td>
<td>1</td>
<td>No</td>
<td>2</td>
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<tr>
<td>6i4.</td>
<td>Melanoma</td>
<td>FY324CMEN</td>
<td>1</td>
<td>No</td>
<td>2</td>
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<tr>
<td>6i5.</td>
<td>Skin (NOT melanoma)</td>
<td>FY324CSKN</td>
<td>1</td>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>6i6.</td>
<td>Colon</td>
<td>FY324COLN</td>
<td>1</td>
<td>No</td>
<td>2</td>
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<tr>
<td>6i7.</td>
<td>Prostate</td>
<td>FY324CPRS</td>
<td>1</td>
<td>No</td>
<td>2</td>
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<tr>
<td>6i8.</td>
<td>Other (specify)</td>
<td>FY324COTH</td>
<td>1</td>
<td>No</td>
<td>2</td>
</tr>
</tbody>
</table>

We would like to know about medications [NAME] is currently taking.

7. Does [NAME] currently take medication prescribed by a doctor...?

7a. To lower his/her blood pressure | FY324MHN | 1 | No | 2 | Yes | 8 | Don’t know
7b. To lower his/her blood cholesterol | FY324MCL | 1 | No | 2 | Yes | 8 | Don’t know
7c. For treatment of diabetes or high blood sugar | FY324MDM | 1 | No | 2 | Yes | 8 | Don’t know

If DO NOT have hospitalizations or procedures to record → END OF QUESTIONNAIRE
OR
If have hospitalizations/procedures to record → GO TO QUESTION 8 and/or QUESTION 9
INTERVIEWER READ TO PROXY:

Collecting medical records for hospitalizations and procedures is a very important part of the CARDIA Study. The medical records are kept confidential and are stored in locked facilities. Thank you for assisting CARDIA and efforts to advance scientific knowledge in the area of cardiovascular health.

HOSPITALIZATIONS

8. May we have your permission to obtain and review [NAME’s] medical records from the hospitalization(s) / procedure(s) listed below? FY324OK

1 □ No
2 □ Yes

8a. Is [NAME] able to sign a Medical Records Release Form?

FY324SIGN

2 □ Yes → Mail Medical Records Release Form to Participant
1 □ No

8a1. Do you have power of attorney for [NAME]?

FY324ATNY

2 □ Yes → Mail Medical Records Release Form to Proxy
1 □ No

8a1a. Does someone else have power of attorney for [NAME]?

FY324SATN

2 □ Yes → Mail Medical Records Release Form to Power of Attorney
1 □ No

Hospitalization 1
### Hospitalization 2

<table>
<thead>
<tr>
<th>Illness or reason:</th>
<th>FY324RSNSY2</th>
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</thead>
<tbody>
<tr>
<td>Hospital name:</td>
<td>FY324NM2</td>
</tr>
<tr>
<td>Street address:</td>
<td>FY324LN2</td>
</tr>
</tbody>
</table>

#### Date of admission: ___ ___/___ ___/___ ___ ___ ___ FY324HZNDT2

**After this hospitalization, was [NAME]...?** FY324HZNAH2

1. Discharged home
2. Transferred to a nursing home or rehabilitation hospital (inpatient facility)
3. Transferred to another acute care hospital

#### FOR CLINIC STAFF ONLY

<table>
<thead>
<tr>
<th>CARDIA CODES:</th>
<th>1.</th>
<th>2.</th>
<th>3.</th>
<th>CASE NO.:</th>
<th>3 2 4 0 1 H</th>
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<tbody>
<tr>
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<td></td>
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<td>FY324AH2CC1</td>
<td>FY324AH2CC2</td>
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### Hospitalization 3

<table>
<thead>
<tr>
<th>Illness or reason:</th>
<th>FY324RSNSY2</th>
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<tbody>
<tr>
<td>Hospital name:</td>
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<tr>
<td>Street address:</td>
<td>FY324LN2</td>
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</table>

#### Date of admission: ___ ___/___ ___/___ ___ ___ ___ FY324HZNDT2

**After this hospitalization, was [NAME]...?** FY324HZNAH2

1. Discharged home
2. Transferred to a nursing home or rehabilitation hospital (inpatient facility)
3. Transferred to another acute care hospital

#### FOR CLINIC STAFF ONLY

<table>
<thead>
<tr>
<th>CARDIA CODES:</th>
<th>1.</th>
<th>2.</th>
<th>3.</th>
<th>CASE NO.:</th>
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</thead>
<tbody>
<tr>
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<td></td>
<td></td>
<td></td>
<td>FY324AH2CC1</td>
<td>FY324AH2CC2</td>
</tr>
</tbody>
</table>
Illness or reason: FY324RSNSY3

Hospital name: FY324NM3

Street address: FY324LN3

Date of admission: ___ ___/___ ___/___ ___ ___ ___

After this hospitalization, was [NAME]...? FY324HZNAH3

1 □ Discharged home
2 □ Transferred to a nursing home or rehabilitation hospital (inpatient facility)
3 □ Transferred to another acute care hospital

FOR CLINIC STAFF ONLY

CARDIA CODES: 1. □ 2. □ 3. □ CASE NO.: 3 2 4 0 3 H

FY324AH3CC1 FY324AH3CC2 FY324AH3CC3 FY324AH3CN

☐ Check here if more than three hospitalizations are reported and use supplemental form FY324ASUPH1

CORONARY ANGIOGRAM, HEART CATHETERIZATIONS, OUTPATIENT PROCEDURES TO OPEN A BLOCKED ARTERY OR ARTERIES, WEIGHT LOSS SURGERY, BLOOD CLOTS, OR KIDNEY DIALYSIS

<table>
<thead>
<tr>
<th>Procedure 1</th>
<th>FOR CLINIC STAFF ONLY FY324AP1CN</th>
<th>CASE NO.: 3 2 4 0 1 P</th>
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</thead>
<tbody>
<tr>
<td>Procedure type:</td>
<td>FY324TYPRO1</td>
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<tr>
<td>Facility name:</td>
<td>FY324FNMP1</td>
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<tr>
<td>Street address:</td>
<td>FY324FAD1</td>
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<tr>
<td>Date of procedure:</td>
<td>___ <em><strong>/</strong></em> <em><strong>/</strong></em> ___ ___ ___</td>
<td>FY324PRDAT1</td>
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<table>
<thead>
<tr>
<th>Procedure 2</th>
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<tr>
<td>Facility name:</td>
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<td>Street address:</td>
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<td>Date of procedure:</td>
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2/17/2012
**Procedure type:** FY324TYPRO2  
**Facility name:** FY324FNMP2  
**Street address:** FY324FAD2  
<table>
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**Date of procedure:** ___ ___/___ ___/___ ___ ___ ___ FY324PRDAT2

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**Procedure 3**  
**FOR CLINIC STAFF ONLY**  
**CASE NO.:** FY324AP3CN

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<tbody>
<tr>
<td>Facility name:</td>
<td>FY324FNMP3</td>
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<td>City</td>
<td>State</td>
</tr>
<tr>
<td>------</td>
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**Date of procedure:** ___ ___/___ ___/___ ___ ___ ___ FY324PRDAT3

- Check here if more than three procedures are reported and use supplemental form FY324ASUPP1