



RSID

RECRUITMENT STATUS FORM

[Empty box for notes or additional information]

Interviewer ID #: **RSINTID**

RSBMAIL

Is the screenee part of a batch mailing? Yes No

Does the screenee live with someone contacted in a batch mailing?

RSLIVE Yes No

HCFA ID # of batch mailing contact: **RSBMCON**

(Interviewer Note: Please check only one)

**S
T
A
T
U
S**

- 1 Unable to contact (No phone # or unlisted #)
- 2 Unable to contact (No answer or No forwarding address)
- 3 Out of Area
- 4 Institutionalized
- 5 Deceased
- 6 Refused telephone screen or No telephone screen conducted
- 7 Ineligible on telephone screen
- 8 Refused home visit
- 9 Ineligible at home visit
- 10 Refused clinic visit

RSSTATUS

Go to RSF Addendum

RSTSDATE
Date telephone screen conducted
 / /
Month Day Year

RSHVDATE
Date home visit conducted
 / /
Month Day Year

RSCVDATE
Date clinic visit conducted
 / /
Month Day Year



HCFA Screening ID #	Acrostic	Date Form Completed	Staff ID#
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/> Month Day Year	<input type="text"/> <input type="text"/> <input type="text"/>
RAHCFAID	RAACROS	RADATE	RASTAFF

RECRUITMENT STATUS FORM ADDENDUM

Interviewer Note: Please check the MAIN reason the telephone screening interview was NOT conducted.

Refused Telephone Screen or No Telephone Screen Conducted

- 0 Not English-speaking
- 1 Cognitively impaired
- RAFAR** 2 Self-reported ineligible
- 3 Proxy-reported ineligible
- 7 Not interested / Refused telephone screen

Date Status Established

/
 /

RADATEST

Month Day Year



5. What is your birthdate? **TSBDATE**
(See note in Question #4.)

		/			/				
Month			Day			Year			

6. What is your marital status? Are you...?
(Read response options.)

- 1** Married
- 2** Widowed
- 3** Divorced
- 4** Separated
- 0** Never Married

TSMARSTA

7. Besides yourself, how many people who live with you are in their 70's?

TSPEOPLE

_	people
---	--------

7a. What are their names?

	First Name	Last Name
i.		
ii.		
iii.		
iv.		
v.		

Now I would like to ask you some questions about your health.

8. Do you have to use a cane, walker, crutches, or other special equipment to help you get around?

- 1** Yes → **INELIGIBLE**
- 0** No
- 8** Don't know → **INELIGIBLE**
- 7** Refused → **INELIGIBLE**

TSEQUIP

9. Because of a health or physical problem, do you have any difficulty walking for a quarter of a mile, that is about 2 or 3 blocks? **TS23BLOX**

- 1** Yes → **INELIGIBLE**
- 0** No (Probe)
- 8** Don't know → **INELIGIBLE**
- 7** Refused → **INELIGIBLE**

10. Because of a health or physical problem, do you have any difficulty walking up 10 steps, that is about one flight, without resting?

- 1** Yes → **INELIGIBLE**
- 0** No **TS1FLITE**
- 6** Don't do → **INELIGIBLE**
- 8** Don't know → **INELIGIBLE**
- 7** Refused → **INELIGIBLE**

11. Because of a health or physical problem, do you have any difficulty getting in and out of bed or chairs?

- 1** Yes → **INELIGIBLE**
- 0** No **TSDIFBED**
- 8** Don't know → **INELIGIBLE**
- 7** Refused → **INELIGIBLE**

12. Because of a health or physical problem, do you have any difficulty bathing or showering?

- 1** Yes → **INELIGIBLE**
- 0** No **TSBATHE**
- 8** Don't know → **INELIGIBLE**
- 7** Refused → **INELIGIBLE**



13. In the past three years, have you been treated for cancer or been told by a doctor that you had cancer or a malignant tumor? **TSCANCER**

- 1** Yes → Go to Question #13a
- 0** No → Go to Question #14
- 7** Refused → **INELIGIBLE**
Go to Question #14

13a. Please tell me what type of cancer you had. (Don't read list; Check all that apply.)

- 1** Acute Leukemia **TSCACLEUK** → **INELIGIBLE**
- 1** Brain **TSCNBRAN** → **INELIGIBLE**
- 1** Breast **TSCNBRST** → Go to Question #13b
- 1** Cervical **TSCNCERV** → Go to Question #13b
- 1** Chronic Leukemia **TSCNCRLK** → **INELIGIBLE**
- 1** Colon **TSCNCOLN** → Go to Question #13b
- 1** Esophagus **TSCNESOP** → **INELIGIBLE**
- 1** Liver **TSCNLIVR** → **INELIGIBLE**
- 1** Lung **TSCNLUNG** → **INELIGIBLE**
- 1** Lymphoma **TSCNLYMP** → **INELIGIBLE**
- 1** Melanoma **TSCNMEL** → **INELIGIBLE**
- 1** Multiple Myeloma **TSCNMUMY** → **INELIGIBLE**
- 1** Pancreas **TSCNPANC** → **INELIGIBLE**
- 1** Prostate **TSCNPRST** → Go to Question #13b
- 1** Rectal **TSCNRECT** → Go to Question #13b
- 1** Skin **TSCNSKIN**
- 1** Melanoma **TSCNSMLN** → **INELIGIBLE**
- 2** Nonmelanoma → Go to Question #14
- 1** Stomach **TSCNSTOM** → **INELIGIBLE**
- 1** Uterine **TSCNUTER** → Go to Question #13b
- 1** Other (Please specify. Check with Recruitment Coordinator about eligibility): **TSCNOT**

13b. Did you receive radiation treatment and/or chemotherapy for this cancer? (Interviewer Note: Tamoxifen for breast cancer is not chemotherapy.)

- 1** Yes → **INELIGIBLE**
- 0** No **TSCNRADI**
- 8** Don't know → **INELIGIBLE**
- 7** Refused → **INELIGIBLE**

13c. Was the cancer removed by surgery?

- 1** Yes **TSCNSURG**
- 0** No → **INELIGIBLE**
(Exception: If watchful waiting for prostate cancer, ELIGIBLE)
- 8** Don't know → **INELIGIBLE**
- 7** Refused → **INELIGIBLE**

14. Are you planning to move out of the (Memphis/ Pittsburgh) area in the next three years?

- 1** Yes → **INELIGIBLE**
- 0** No **TSMOV3YR**
- 8** Don't know
- 7** Refused → **INELIGIBLE**

15. Are you currently participating in any research study that includes taking any medications or changing your eating or exercise habits?

- 1** Yes → **INELIGIBLE**
Go to question #15a
- 0** No **TSRESSTD** Record name of study in #15a & refer to exclusion list at your clinic.
- 8** Don't know →
- 7** Refused → **INELIGIBLE**

- a.** Which study? _____
- b.** Record the medication, or type of diet or type of exercise: _____
- c.** When does the study end? _____



(Interviewer Note: Do NOT read this question to screenee. Review form and then read appropriate script.)

16. Is screenee eligible?

TSELIG

1 Yes

0 No

Thank you for your answers. The next step is for us to schedule a time for me to come to your home to talk with you. This interview may take up to 90 minutes depending on the sections that have been selected for you.

What date and time of the day is most convenient for you?

(Check available dates and times.)

How about _____(date)_____(time). How is that for you?
(If date and/or time doesn't work, find and alternate date/time.)

That's great. I will come to your home at____(time) on ____ (date)
I will have my University identification with me. Once again, my name is _____.

I will call you the day before or the morning of our visit to remind you about our appointment and to check directions to your home.

Do you have any questions? Please feel free to call me at (____)_____ if any questions should come up.

That's about all the information I need at this time. I'd like to thank you for taking the time to speak with me. I look forward to meeting you.

Go to question #18

(Interviewer Note: Do NOT read this question to screenee.)

Has a "home" visit been scheduled?

1 Yes

TSHOMESH

0 No

Date: / /
Month Day Year

Time:
1 am **2** pm

-1 Study Office/
Alternative Option Selected

TSHMDATE

TSHMAMP

TSCOS

STOP. You are finished with this form.

Why not? **TSWHYNOT**

1 Can't schedule now. Call back at a later date.

Date: / /
Month Day Year

TSCBDATE

Time:
1 am **2** pm

TSCBAMP

7 Refused to participate → Ask Questions #17- #21.



Health ABC TELEPHONE SCREENING INTERVIEW

17. Is there a specific reason you could share with us about why you don't want to participate in the study? *(Do not read the list. Please check only one.)*

- 1 No time/too busy
- 2 Don't want strangers in the house
- 3 Too much trouble
- 4 Illness (self) **TSNOWISH**
- 5 Illness (family member)
- 6 Afraid of potential medical findings during clinic visit
- 7 Don't like doctors/ health care professionals
- 9 Concerned about radiation exposure
- 8 Concerned about pain/discomfort during clinic visit
- 77 Refused
- 10 Other (Please specify):

18. Has a doctor ever told you that you have any of the following conditions...?

- | | YES | NO | DON'T KNOW |
|---|----------------------------|----------------------------|----------------------------|
| a) Arthritis TSARTH | <input type="checkbox"/> 1 | <input type="checkbox"/> 0 | <input type="checkbox"/> 8 |
| b) Diabetes or sugar diabetes TSDIABET | <input type="checkbox"/> 1 | <input type="checkbox"/> 0 | <input type="checkbox"/> 8 |
| c) Heart disease or a problem with your heart TSHEART | <input type="checkbox"/> 1 | <input type="checkbox"/> 0 | <input type="checkbox"/> 8 |

19. How tall are you without shoes? **TSFT** - **TSINCH**
Feet Inches

20. How much do you currently weigh? **TSLBS**
 If you are unsure, please make your best guess.
Pounds

21. What is the highest grade or year of school you completed? *(Please check only one response.)*

- 77 Refused
- 0 No formal education
- 1 Grade 1
- 2 Grade 2
- 3 Grade 3
- 4 Grade 4 **TSSCHOOL**
- 5 Grade 5
- 6 Grade 6
- 7 Grade 7
- 8 Grade 8
- 9 Grade 9
- 10 Grade 10
- 11 Grade 11
- 12 Grade 12
- 13 Vocational/tradeschool **WITHOUT** high school or the GED
- 14 Vocational/trade school **AFTER** high school
- 15 Some college/Associate degree
- 16 College graduate (4 or 5 year program)
- 17 Master's degree (or other post-graduate training)
- 18 Doctoral degree (PhD, MD, EdD, DVM, DDS, JD, etc.)

INTERVIEWER NOTE: IF SCREENEE IS INELIGIBLE READ THE FOLLOWING SCRIPT (Refer to Question #16 for eligibility)

Thank you very much for this information. It will be very useful in the study. Only a limited number of people are being selected to come to the clinical part of the study, but we greatly appreciate your time and effort in answering questions for us.



HCFA Screening ID #	Acrostic	Date Form Completed	Staff ID#
<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/> EAFORMC	<input type="text"/>
EAHCF AID	EAACROS	Month Day Year	EASTAFID

FINAL ELIGIBILITY ASSESSMENT

Now I am going to ask you about your ability to do several common daily activities.

1. Because of a health or physical problem, do you have any difficulty walking **EADWQMYN** for a quarter of a mile, that is about 2 or 3 blocks?

1 Yes **INELIGIBLE Continue Eligibility Assessment**

0 No →

How easy is it for you to walk for a quarter of a mile? Would you say...

- 1** Very easy
- 2** Somewhat easy **EADWQMEZ**
- 3** Or not that easy

How much difficulty do you have? Would you say...

EADWQMDF

- 1** A little difficulty
- 2** Some difficulty
- 3** A lot of difficulty

4 Or are you unable to do it?

Go to Question #2

Do you get tired when you walk for a quarter of a mile?

- 1** Yes
- 0** No **EADWQMT2**
- 9** Don't do
- 8** Don't know

Because of a health or physical problem, do you walk for a quarter of a mile less often compared to 12 months ago?

- 1** Yes
- 0** No **EADWQML2**
- 9** Don't do
- 8** Don't know

Do you get tired when you walk for a quarter of a mile ?

- 1** Yes
- 0** No **EASWQMT1**
- 9** Don't do
- 8** Don't know

Because of a health or physical problem, do you walk for a quarter of a mile less often compared to 12 months ago?

- 1** Yes
- 0** No **EADWQML1**
- 9** Don't do
- 8** Don't know

Because of a health or physical problem, do you have any difficulty walking a distance of one mile, that is about 8 to 12 blocks?

- 1** Yes
- 0** No **EADW1MYN**
- 8** Don't know

How easy is it for you to walk for one mile? Would you say...

- 1** Very easy
- 2** Somewhat easy **EADW1MEZ**
- 3** Or not that easy



FINAL ELIGIBILITY ASSESSMENT

2. Because of a health or physical problem, do you have any difficulty walking up 10 steps, that is about 1 flight, without resting? **EADW10YN**

1 Yes

**INELIGIBLE
Continue Eligibility
Assessment**

0 No

How easy is it for you to walk up 10 steps without resting? Would you say...

1 Very easy

2 Somewhat easy **EADW10EZ**

3 Or not that easy

How much difficulty do you have? Would you say... **EADIF**

1 A little difficulty

2 Some difficulty

3 A lot of difficulty

4 Or are you unable to do it?

Go to Question #3

Do you get tired or short of breath when you walk up 10 steps, without resting?

1 Yes

0 No

9 Don't do

8 Don't know

EADW10WR

Because of a health or physical problem, do you walk up 10 steps without resting less often compared to 12 months ago?

1 Yes

0 No

9 Don't do

8 Don't know

EADWWRLO

Do you get tired when you walk up 10 steps without resting?

1 Yes

0 No

9 Don't do

8 Don't know

EADW10WX

Because of a health or physical problem, do you walk up 10 steps without resting less often compared to 12 months ago?

1 Yes

0 No

9 Don't do

8 Don't know

EAD10LO

Because of a health or physical problem, do you have any difficulty walking up 20 steps, that is about 2 flights, without resting?

1 Yes

0 No

8 Don't know

EADW20YN

How easy is it for you to walk up 20 steps without resting? Would you say...

1 Very easy

2 Somewhat easy **EADW20EZ**

3 Or not that easy



3. Because of a health or physical problem, do you have any difficulty getting in and out of bed or chairs?

1 Yes **INELIGIBLE
Continue Eligibility
Assessment**

0 No **EADIOYN**

How much difficulty do you have?
Would you say... **EADIODIF**

1 A little difficulty

2 Some difficulty

3 A lot of difficulty

4 Or are you unable
to do it?

Do you usually receive help from
another person when you get in
and out of bed or chairs?

1 Yes **0** No

EADIORHY

4. Because of a health or physical problem, do you have any difficulty bathing or showering?

1 Yes **INELIGIBLE
Continue Eligibility
Assessment**

0 No **EABATHYN**

How much difficulty do you have?
Would you say... **EADDDIF**

1 A little difficulty

2 Some difficulty

3 A lot of difficulty

4 Or are you unable
to do it?

Do you usually receive help
from another person in
bathing or showering?

1 Yes **0** No

EADDRHYN



FINAL ELIGIBILITY ASSESSMENT

5. Because of a health or physical problem, do you have any difficulty dressing?

1 Yes

**INELIGIBLE
Continue Eligibility
Assessment**

0 No **EADDYN**

How much difficulty do you have?
Would you say... **EABATHDF**

- 1** A little difficulty
- 2** Some difficulty
- 3** A lot of difficulty
- 4** Or are you unable to do it?

Do you usually receive help from another person in dressing?

1 Yes **0** No

EABATHRH

6. Do you have any difficulty eating, for example, holding a fork, cutting up your food, or drinking from a glass?

1 Yes

**INELIGIBLE
Continue Eligibility
Assessment**

0 No **EAEATYN**

How much difficulty do you have?
Would you say... **EAEATDIF**

- 1** A little difficulty
- 2** Some difficulty
- 3** A lot of difficulty
- 4** Or are you unable to do it?

Do you usually receive help from another person in eating?

1 Yes **0** No

EAEATRH

7. Do you have to use a cane, walker, crutches, or other special equipment to help you get around?

1 Yes



INELIGIBLE

0 No

EAEQUIP

8 Don't know



INELIGIBLE

7 Refused



INELIGIBLE



FINAL ELIGIBILITY ASSESSMENT

8. (Interviewer Note: Do NOT ask screenee. Review this form.)
Is screenee eligible? **EASCRELG**

1 Yes

0 No

Did screenee sign informed consent form for Health ABC?

1 Yes

EACONSNT

0 No

Ask Questions #9 - #13

- ◆ STOP. You are finished with this form.
- ◆ Administer baseline questionnaire.

Go to Question #10

9. Is there a specific reason you could share with us about why you don't want to participate in the study?
(Do not read the list. Please check only one.) **EANOWISH**

- 1** No time/too busy
- 2** Don't want strangers in the house
- 3** Too much trouble
- 4** Illness (self)
- 5** Illness (family member)
- 6** Afraid of potential medical findings during clinic visit
- 7** Don't like doctors/ health care professionals
- 8** Concerned about radiation exposure
- 9** Concerned about pain/discomfort during clinic visit
- 77** Refused
- 10** Other (Please specify):

10. Has a doctor ever told you that you have any of the following conditions...?

YES NO DON'T KNOW

- a) Arthritis **1 0 8 EAARTH**
- b) Diabetes or sugar diabetes **1 0 8 EADIABET**
- c) Heart disease or a problem with your heart **1 0 8 EAHEART**

11. How tall are you without shoes? **EAINCH**
EAFT Feet Inches



12. How much do you currently weigh?
If you are unsure, please make your best guess.

--	--	--

Pounds

EALBS

13. What is the highest grade or year of school you completed?
(Please check only one response.)

EASCHOOL

- 77** Refused
- 0** No formal education
- 1** Grade 1
- 2** Grade 2
- 3** Grade 3
- 4** Grade 4
- 5** Grade 5
- 6** Grade 6
- 7** Grade 7
- 8** Grade 8
- 9** Grade 9
- 10** Grade 10
- 11** Grade 11
- 12** Grade 12
- 13** Vocational/tradeschool **WITHOUT**
high school or the GED
- 14** Vocational/trade school **AFTER** high school
- 15** Some college/Associate degree
- 16** College graduate (4 or 5 year program)
- 17** Master's degree (or other post-graduate training)
- 18** Doctoral degree
(PhD, MD, EdD, DVM, DDS, JD, etc.)

INTERVIEWER NOTE: IF SCREENER IS INELIGIBLE READ THE FOLLOWING SCRIPT

Thank you very much for this information. It will be very useful in the study. Only a limited number of people are being selected to come to the clinical part of the study, but we greatly appreciate your time and effort in answering questions for us.



6. What is your marital status? Are you...? *(Read response options.)*

- 1 Married
- 2 Widowed
- 3 Divorced
- 4 Separated
- 0 Never Married

EOMARSTA

Now I would like to ask you some questions about your health.

7. Do you have to use a cane, walker, crutches, or other special equipment to help you get around?

- 1 Yes → **INELIGIBLE. Continue Eligibility Assessment**
- 0 No EOEQUIP
- 8 Don't know → **INELIGIBLE. Continue Eligibility Assessment**
- 7 Refused → **INELIGIBLE. Continue Eligibility Assessment**

8. Because of a health or physical problem, do you have any difficulty walking **EODWQMYN** for a quarter of a mile, that is about 2 or 3 blocks?

1 Yes **INELIGIBLE
Continue Eligibility
Assessment**

0 No →

How easy is it for you to walk for a quarter of a mile? Would you say...

- 1** Very easy
- 2** Somewhat easy **EODWQMEZ**
- 3** Or not that easy

How much difficulty do you have? Would you say... **EODWQMDF**

- 1** A little difficulty
- 2** Some difficulty
- 3** A lot of difficulty

4 Or are you unable to do it?

Go to Question #9

Do you get tired when you walk for a quarter of a mile?

- 1** Yes
- 0** No **EODWQMT2**
- 9** Don't do
- 8** Don't know

Because of a health or physical problem, do you walk for a quarter of a mile less often compared to 12 months ago?

- 1** Yes
- 0** No **EODWQML2**
- 9** Don't do
- 8** Don't know

Do you get tired when you walk for a quarter of a mile ?

- 1** Yes
- 0** No **EOSWQMT1**
- 9** Don't do
- 8** Don't know

Because of a health or physical problem, do you walk for a quarter of a mile less often compared to 12 months ago?

- 1** Yes
- 0** No **EODWQML1**
- 9** Don't do
- 8** Don't know

Because of a health or physical problem, do you have any difficulty walking a distance of one mile, that is about 8 to 12 blocks?

- 1** Yes
- 0** No **EODW1MYN**
- 8** Don't know

How easy is it for you to walk for one mile? Would you say...

- 1** Very easy
- 2** Somewhat easy **EODW1MEZ**
- 3** Or not that easy



9. Because of a health or physical problem, do you have any difficulty walking up 10 steps, that is about one flight, without resting? **EODW10YN**

1 Yes

INELIGIBLE
Continue Eligibility Assessment

0 No

How easy is it for you to walk up 10 steps without resting? Would you say...

1 Very easy

2 Somewhat easy **EODW10EZ**

3 Or not that easy

How much difficulty do you have? Would you say... **EODIF**

1 A little difficulty

2 Some difficulty

3 A lot of difficulty

4 Or are you unable to do it?

Go to Question #10

Do you get tired when you walk up 10 steps without resting?

1 Yes

0 No

9 Don't do

8 Don't know

EODW10WX

Because of a health or physical problem, do you walk up 10 steps without resting less often compared to 12 months ago?

1 Yes

0 No

9 Don't do

8 Don't know

EOD10LO

Because of a health or physical problem, do you have any difficulty walking up 20 steps, that is about 2 flights, without resting?

1 Yes

0 No

8 Don't know

EODW20YN

Do you get tired or short of breath when you walk up 10 steps, without resting?

1 Yes

0 No

9 Don't do

8 Don't know

EODW10WR

Because of a health or physical problem, do you walk up 10 steps without resting less often compared to 12 months ago?

1 Yes

0 No

9 Don't do

8 Don't know

EODWWRLO

How easy is it for you to walk up 20 steps without resting? Would you say...

1 Very easy

2 Somewhat easy **EODW20EZ**

3 Or not that easy

10. Because of a health or physical problem, do you have any difficulty getting in and out of bed or chairs?

1 Yes **INELIGIBLE**
Continue Eligibility
Assessment

0 No **EODIOYN**

How much difficulty do you have?
Would you say... **EODIODIF**

- 1** A little difficulty
- 2** Some difficulty
- 3** A lot of difficulty
- 4** Or are you unable to do it?

Do you usually receive help from another person when you get in and out of bed or chairs?

1 Yes **0** No

EODIORHY

11. Because of a health or physical problem, do you have any difficulty bathing or showering?

1 Yes **INELIGIBLE**
Continue Eligibility
Assessment

0 No **EOBATHYN**

How much difficulty do you have?
Would you say... **EODDDIF**

- 1** A little difficulty
- 2** Some difficulty
- 3** A lot of difficulty
- 4** Or are you unable to do it?

Do you usually receive help from another person in bathing or showering?

EODDRHYN
1 Yes **0** No

12. Because of a health or physical problem, do you have any difficulty dressing?

1 Yes

INELIGIBLE
Continue Eligibility
Assessment

0 No **EODDYN**

How much difficulty do you have?
Would you say... **EOBATHDF**

- 1** A little difficulty
- 2** Some difficulty
- 3** A lot of difficulty
- 4** Or are you unable to do it?

Do you usually receive help from another person in dressing?

1 Yes **0** No

EOBATHRH

13. Do you have any difficulty eating, for example, holding a fork, cutting up your food, or drinking from a glass?

1 Yes

INELIGIBLE
Continue Eligibility
Assessment

0 No **EOEATYN**

How much difficulty do you have?
Would you say... **EOEATDIF**

- 1** A little difficulty
- 2** Some difficulty
- 3** A lot of difficulty
- 4** Or are you unable to do it?

Do you usually receive help from another person in eating?

1 Yes **0** No

EOEATRHR

14. In the past three years, have you been treated for cancer or been told by a doctor that you had cancer or a malignant tumor?

1 Yes



Go to Question #14a

0 No



Go to Question #15

7 Refused **EOCANCER**



INELIGIBLE
Go to Question #15

14a. Please tell me what type of cancer you had.
(Don't read list; Check all that apply.)

- 1** Acute Leukemia → **INELIGIBLE. Continue Eligibility Assessment** **EOACLEUK**
- 1** Brain → **INELIGIBLE. Continue Eligibility Assessment** **EOCNBRAN**
- 1** Breast → Go to Question #14b **EOCNBRST**
- 1** Cervical → Go to Question #14b **EOCNCERV**
- 1** Chronic Leukemia → **INELIGIBLE. Continue Eligibility Assessment** **EOCNCRLK**
- 1** Colon → Go to Question #14b **EOCNCOLN**
- 1** Esophagus → **INELIGIBLE. Continue Eligibility Assessment** **EOCNESOP**
- 1** Liver → **INELIGIBLE. Continue Eligibility Assessment** **EOCNLIVR**
- 1** Lung → **INELIGIBLE. Continue Eligibility Assessment** **EOCNLUNG**
- 1** Lymphoma → **INELIGIBLE. Continue Eligibility Assessment** **EOCNLYMP**
- 1** Melanoma → **INELIGIBLE. Continue Eligibility Assessment** **EOCNMEL**
- 1** Multiple Myeloma → **INELIGIBLE. Continue Eligibility Assessment** **EOCNMUMY**
- 1** Pancreas → **INELIGIBLE. Continue Eligibility Assessment** **EOCNPANC**
- 1** Prostate → Go to Question #14b **EOCNPRST**
- 1** Rectal → Go to Question #14b **EOCNRECT**
- 1** Skin **EOCNSKIN**
- EOCNSMLN** **1** Melanoma → **INELIGIBLE. Continue Eligibility Assessment**
- 2** Nonmelanoma → Go to Question #15
- 1** Stomach → **INELIGIBLE. Continue Eligibility Assessment** **EOCNSTOM**
- 1** Uterine → Go to Question #14b **EOCNUTER**
- 1** Other (Please specify. Check with Recruitment Coordinator about eligibility.):

EOCNOT



14b. Did you receive radiation treatment and/or chemotherapy for this cancer?
(Interviewer Note: Tamoxifen for breast cancer is not chemotherapy.)

- 1** Yes → **INELIGIBLE. Continue Eligibility Assessment**
- 0** No → **EOCNRADI**
- 8** Don't know → **INELIGIBLE. Continue Eligibility Assessment**
- 7** Refused → **INELIGIBLE. Continue Eligibility Assessment**

14c. Was the cancer removed by surgery?

- 1** Yes → **EOCNSURG**
- 0** No → **INELIGIBLE. (Exception: If watchful waiting for prostate cancer, ELIGIBLE.) Continue Eligibility Assessment**
- 8** Don't know → **INELIGIBLE. Continue Eligibility Assessment**
- 7** Refused → **INELIGIBLE. Continue Eligibility Assessment**

15. Are you planning to move out of the (Memphis/Pittsburgh) area in the next three years?

- 1** Yes → **INELIGIBLE. Continue Eligibility Assessment**
- 0** No → **EOMOV3YR**
- 8** Don't know → **INELIGIBLE. Continue Eligibility Assessment**
- 7** Refused → **INELIGIBLE. Continue Eligibility Assessment**

16. Are you currently participating in any research study that includes taking any medications or changing your eating or exercise habits? **EORESSTD**

- 1** Yes → **INELIGIBLE. Continue Eligibility Assessment**
Go to Question #16a
- 0** No
- 8** Don't know → Record name of study in Question #16a & refer to exclusion list at your clinic.
- 7** Refused → **INELIGIBLE. Continue Eligibility Assessment**

a. Which study?
(Please record name)

b. Record the medication,
or type of diet or type
of exercise.

c. When does the study end?

--

--



(Interviewer Note: Do NOT ask screenee. Review this form.)

17. Is screenee eligible? **EOELIG**

1 Yes

0 No

Did screenee sign informed consent form for Health ABC?

EOSCRELG

1 Yes

0 No

Go to Question #19

Ask Questions #18-22

- ◆ STOP. You are finished with this form.
- ◆ Administer baseline questionnaire.

18. Is there a specific reason you could share with us about why you don't want to participate in the study? *(Do not read the list. Please check only one.)*

- 1** No time/too busy
- 2** Don't want strangers in the house
- 3** Too much trouble
- 4** Illness (self)
- 5** Illness (family member)
- 6** Afraid of potential medical findings during clinic visit
- 7** Don't like doctors/ health care professionals
- 9** Concerned about radiation exposure
- 8** Concerned about pain/discomfort during clinic visit
- 77** Refused
- 10** Other (Please specify):

EONOWISH



19. Has a doctor ever told you that you have any of the following conditions...?

- | | YES | NO | DON'T KNOW | |
|---|----------------------------|----------------------------|----------------------------|-----------------|
| a) Arthritis | <input type="checkbox"/> 1 | <input type="checkbox"/> 0 | <input type="checkbox"/> 8 | EOARTH |
| b) Diabetes or sugar diabetes | <input type="checkbox"/> 1 | <input type="checkbox"/> 0 | <input type="checkbox"/> 8 | EODIABET |
| c) Heart disease or a problem with your heart | <input type="checkbox"/> 1 | <input type="checkbox"/> 0 | <input type="checkbox"/> 8 | EOHEART |

20. How tall are you without shoes?

EOFT - **EOINCH**
Feet Inches

21. How much do you currently weigh? If you are unsure, please make your best guess.

EOLBS
Pounds

22. What is the highest grade or year of school you completed? (*Please check only one response.*)

- | | | |
|--|--|-----------------|
| <input type="checkbox"/> 77 Refused | <input type="checkbox"/> 9 Grade 9 | |
| <input type="checkbox"/> 0 No formal education | <input type="checkbox"/> 10 Grade 10 | EOSCHOOL |
| <input type="checkbox"/> 1 Grade 1 | <input type="checkbox"/> 11 Grade 11 | |
| <input type="checkbox"/> 2 Grade 2 | <input type="checkbox"/> 12 Grade 12 | |
| <input type="checkbox"/> 3 Grade 3 | <input type="checkbox"/> 13 Vocational/tradeschool WITHOUT high school or the GED | |
| <input type="checkbox"/> 4 Grade 4 | <input type="checkbox"/> 14 Vocational/trade school AFTER high school | |
| <input type="checkbox"/> 5 Grade 5 | <input type="checkbox"/> 15 Some college/Associate degree | |
| <input type="checkbox"/> 6 Grade 6 | <input type="checkbox"/> 16 College graduate (4 or 5 year program) | |
| <input type="checkbox"/> 7 Grade 7 | <input type="checkbox"/> 17 Master's degree (or other post-graduate training) | |
| <input type="checkbox"/> 8 Grade 8 | <input type="checkbox"/> 18 Doctoral degree (PhD, MD, EdD, DVM, DDS, JD, etc.) | |

INTERVIEWER NOTE: IF SCREENER IS INELIGIBLE READ THE FOLLOWING SCRIPT

Thank you very much for this information. It will be very useful in the study. Only a limited number of people are being selected to come to the clinical part of the study, but we greatly appreciate your time and effort in answering questions for us.



First Name	Middle Initial	Last Name
------------	----------------	-----------

HCFA Screening ID #	Acrostic
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

FPHCFA2

FPACROS2

BASELINE QUESTIONNAIRE



HCFA Screening ID # [][][][][][][][][][] FPHCFAID	Acrostic [][][][][][][][][][] FPACROS	Date Form Completed [][] / [][] / [][][] Month / Day / Year FPFORMC	Staff ID# [][][][][][][][][][] FPSTAFID
--	--	--	--

CONTACT INFORMATION

1. Please tell me the name, address, and telephone number of someone who could provide information and answer questions for you in the event that you were unable to answer yourself. This person can be someone who lives with you.

First Name Middle Initial

Last Name

Street Address Apt/Room

City State

[][][][][][][][] **FPCIZIP**
Zip Code

Telephone: ([][][][]) [][][][] - [][][][][] **FPCITELE**
Area Code Number

How is this person related to you? **FPCIREL**

1 My son or daughter **5** My mother or father

2 My niece or nephew **6** Friend/neighbor

3 My grandchild **7** Someone else *(Please say how related:)*

4 My brother or sister _____

[]



CONTACT INFORMATION

2. Please tell me the name, address, and telephone number of two close friends or relatives who do not live with you and who would know how to reach you in case you move and we need to get in touch with you. These people do not have to be local people.

Contact #1

First Name

Middle
Initial

Last Name

Street Address

Apt/Room

City

State

--	--	--	--	--	--

FPC1ZIP

Zip Code

Telephone:

(

--	--	--	--

)

Area Code

--	--	--	--

Number

-

--	--	--	--	--	--

FPC1PHON

How is this person related to you? **FPC1REL**

1 My son or daughter

5 My mother or father

2 My niece or nephew

6 Friend/neighbor

3 My grandchild

7 Someone else *(Please say how related:)*

4 My brother or sister

--



CONTACT INFORMATION

Contact #2

First Name

Middle Initial

Last Name

Street Address

Apt/Room

City

State

--	--	--	--	--	--

FPC2ZIP

Zip Code

Telephone: (

--	--	--	--

Area Code

--	--	--	--

Number

-

--	--	--	--	--	--

FPC2PHON

How is this person related to you? **FPC2REL**

1 My son or daughter

5 My mother or father

2 My niece or nephew

6 Friend/neighbor

3 My grandchild

7 Someone else *(Please say how related:)*

4 My brother or sister

--



HEALTH STATUS

3. In general, how would you say your health is? Would you say it is...
(Interviewer Note: Read response options. OPTIONAL - Show card #1.)

- 1 Excellent
- 2 Very good
- 3 Good
- 4 Fair
- 5 Poor
- 6 Don't know
- 7 Refused

FPHSTAT

4. During the past 12 months, have you been a patient in a hospital for one or more nights?

- 1 Yes
 - 0 No
 - 8 Don't know
 - 7 Refused
- FPHOSP12**
- ↓ ↓ ↓ ↓
- Go to Question #5

How many different times during the past 12 months were you a patient in a hospital for one or more nights?

(Interviewer Note: Record number of different times a patient in a hospital for one or more nights, NOT number of days.)

FPHOSPX different times

5. During the past 12 months, did you stay in bed all or most of the day because of an illness or injury? Please include days that you were a patient in a hospital.

- 1 Yes
 - 0 No
 - 8 Don't know
 - 7 Refused
- FPBED12**
- ↓ ↓ ↓ ↓
- Go to Question #6

About how many days did you stay in bed all or most of the day because of an illness or injury? Please include days while you were a patient in a hospital.

FPBEDDAY days

6. During the past 12 months, did you cut down on the things you usually do, such as going to work or working around the house, because of illness or injury?

- 1 Yes
 - 0 No
 - 8 Don't know
 - 7 Refused
- FPCUT12**
- ↓ ↓ ↓ ↓
- Go to Question #7

How many days did you cut down on the things you usually do because of illness or injury?

FPCUTDAY days



HEALTH STATUS

7. During the past 12 months, did you have the flu or a flu-like illness that kept you in bed for at least a day? *(Interviewer Note: A flu-like illness includes at least one symptom such as fever, body-aches, chills, tiredness, headache AND at least one respiratory symptom, such as cough, sneezing, runny nose, scratchy throat.)*

- 1** Yes
 0 No
 8 Don't know
 7 Refused **FPFLU12**

8. Did you get a flu shot in the past 12 months?

- 1** Yes
 0 No
 8 Don't know
 7 Refused **FPFSHOT**

PHYSICAL FUNCTION

9. Because of a health or physical problem, do you have any difficulty standing up from a chair without using your arms?

- 1** Yes
 0 No
 8 Don't know
 7 Refused **FPDIFSTA**

How much difficulty do you have? Would you say...

FPDSTAMT

- 1** A little difficulty
- 2** Some difficulty
- 3** A lot of difficulty
- 4** Or are you unable to do it?

How easy is it for you to stand up from a chair without using your arms? Would you say...

FPEZSTA

- 1** Very easy
- 2** Somewhat easy
- 3** Or not that easy



PHYSICAL FUNCTION

10. Because of a health or physical problem, do you have any difficulty lifting or carrying something weighing 10 pounds, for example a small bag of groceries or an infant?

- FPDIF10** **1** Yes **0** No **8** Don't know **7** Refused

How much difficulty do you have? Would you say..

FPD10AMT

- 1** A little difficulty
- 2** Some difficulty
- 3** A lot of difficulty

4 Or are you unable to do it?

Go to Question #11

How easy is it for you to lift or carry something weighing 10 pounds? Would you say...

- 1** Very easy
- 2** Somewhat easy **FPEZ10LB**
- 3** Or not that easy

Because of a health or physical problem, do you lift or carry something weighing 10 pounds less often compared to 12 months ago?

- 1** Yes
- 0** No
- 9** Does not do
- 8** Does not know

FPLS12M0

Do you have any difficulty lifting or carrying something weighing 20 pounds, for example a large full bag of groceries?

1 Yes **0** No **FPD20LBS**

Go to Question #11

Because of a health or physical problem, do you lift or carry something weighing 10 pounds less often compared to 12 months ago?

- 1** Yes
- 0** No
- 9** Does not do
- 8** Does not know

FPLESS10

Do you have any difficulty lifting or carrying something weighing 20 pounds, for example a large full bag of groceries?

1 Yes **0** No **FPDIF20**

Go to Question #11

How easy is it for you to lift or carry something weighing 20 pounds? Would you say...

FPEZ20LB

- 1** Very easy
- 2** Somewhat easy
- 3** Or not that easy



PHYSICAL FUNCTION

11. Because of a health or physical problem, do you have any difficulty stooping, crouching or kneeling?
(Interviewer Note: "Difficulty" refers to difficulty getting down AND/OR getting back up.)

FPDIFSK **1** Yes

0 No

8 Don't know

7 Refused

How much difficulty do you have? Would you say...

FPDSCKAM

- 1** A little difficulty
- 2** Some difficulty
- 3** A lot of difficulty
- 4** Or are you unable to do it?

How easy is it for you to stoop, crouch, or kneel? Would you say...

FPEZSCK

- 1** Very easy
- 2** Somewhat easy
- 3** Or not that easy

12. Do you have any difficulty pulling or pushing large objects like a living room chair?

FPDIFPP **1** Yes

0 No

8 Don't know

7 Refused

How much difficulty do you have? Would you say...

FPDIFPAM

- 1** A little difficulty
- 2** Some difficulty
- 3** A lot of difficulty
- 4** Or are you unable to do it?



PHYSICAL FUNCTION

13. Do you have any difficulty doing heavy work around the house like vacuuming, shoveling snow, mowing or raking the lawn, gardening, or scrubbing windows, walls or floors?

FPDIFHW 1 Yes 0 No 8 Don't know 7 Refused

How much difficulty do you have? Would you say...

FPDHWAMT

- 1 A little difficulty
- 2 Some difficulty
- 3 A lot of difficulty

4 Or are you unable to do it?

Go to question #14

How easy is it for you to do heavy work around the house? Would you say...

FPEZHW

- 1 Very easy
- 2 Somewhat easy
- 3 Or not that easy

Do you do heavy work around the house less often compared to 12 months ago?

FPHW12MO

- 1 Yes
- 0 No
- 9 Does not do
- 8 Does not know

14. Do you have any difficulty using your fingers to grasp or handle?

FPDIFFN 1 Yes 0 No 8 Don't know 7 Refused

How much difficulty do you have? Would you say...

FPDIFNAM

- 1 A little difficulty
- 2 Some difficulty
- 3 A lot of difficulty
- 4 Or are you unable to do it?



PHYSICAL FUNCTION

15. Do you have any difficulty raising your arms up over your head?

FPDIFARM **1** Yes

0 No

8 Don't know

7 Refused

How much difficulty do you have? Would you say...

FPDARMAM

1 A little difficulty

2 Some difficulty

3 A lot of difficulty

4 Or are you unable to do it?

How easy is it for you to raise your arms up over your head?

Would you say... **FPEZARM**

1 Very easy

2 Somewhat easy

3 Or not that easy



Now I am going to ask some questions about the type and amount of physical activity that you did in the past 12 months and what you usually do in a typical week.

16. In the past 12 months, since last (*current month*), did you do gardening or yardwork, like mowing or raking the lawn, or weeding (or shoveling snow), at least 10 times?

FPPA12MO 1 Yes 0 No 8 Don't know 7 Refused

↓ ↓ ↓ ↓

Go to Question #17

a. In the past 7 days, since last (*current day*), did you do any gardening or yardwork?

1 Yes 0 No **FPPA7DAY**

↓

Go to Question #17

b. About how much time did you spend gardening or doing yardwork in the past 7 days (not counting rest periods)?
(*Interviewer Note: If less than one hour, record number of minutes.*)

FPPAHR **FPPAMIN**

Hours Minutes

17. In the past 12 months, did you do heavy or major chores like scrubbing windows or walls, vacuuming, mopping floors, or cleaning gutters; home maintenance activities like painting, scraping, hanging wall paper; or anything like these activities at least 10 times?

FPHC12MO 1 Yes 0 No 8 Don't know 7 Refused

↓ ↓ ↓ ↓

Go to Question #18

a. In the past 7 days, did you do heavy chores or home maintenance activities?

1 Yes 0 No **FPHC7DAY**

↓

Go to Question #18

b. About how much time did you spend doing heavy chores or home maintenance activities in the past 7 days (not counting rest periods)?
(*Interviewer Note: If less than one hour, record number of minutes.*)

FPHCHR **FPHCMIN**

Hours Minutes



PHYSICAL ACTIVITY and EXERCISE

22. In the past 12 months, did you go walking for exercise, at least 10 times?

FPEW12MO 1 Yes 0 No 8 Don't know 7 Refused

Go to Question #23

In the past 7 days, did you go walking for exercise?

1 Yes **FPEW7DAY** 0 No

a. How many times did you go walking for exercise in the past 7 days?

times **FPEWTIME**

b. About how much time, on average, did you spend walking each time you walked (excluding rest periods)?
(Interviewer Note: If less than 1 hour, record number of minutes.)

FPEWHRS **FPEWMINS**
Hours Minutes

c. When you walk for exercise, do you usually walk at a brisk pace (as fast as you can), a moderate pace, or at a leisurely stroll?

1 brisk
 2 moderate **FPEWPACE**
 3 stroll

d. About how many blocks, on average, did you walk each time?

blocks -1 Number of blocks unknown
FPEWBLOX **FPEWBLUK**

What is the main reason you did not go walking for exercise in the past 7 days? **FPEWREAS**
(Interviewer Note: **OPTIONAL - Show card #2.**)

- 1 bad weather
- 2 not enough time
- 3 injury
- 4 health problems
- 5 lost interest
- 6 felt unsafe
- 7 not necessary
- 8 other

Go to Question #23

Do you know how far you usually walk in something other than blocks, e.g., mall lengths, miles, laps around a track?

1 Yes **FPEWKNOW** 0 No

What is the unit of measure? **FPEWUNIT**

How many do you walk, on average?

units **FPEWNUMU**



23. In the past 12 months, did you do any other type of walking, such as walking to work, the store, to church, or walking the dog, at least 10 times?

FPOW12MO 1 Yes 0 No 8 Don't know 7 Refused

Go to Question #24

In the past 7 days, did you do other walking?

1 Yes **FPOW7DAY** 0 No

a. FPOWTIME How many times did you do other walking in the past 7 days?

times **FPOWTIME**

b. About how much time, on average, did you spend doing other walking each time you walked (excluding rest periods)?
(Interviewer Note: If less than 1 hour, record number of minutes.)

FPOWHRS **FPOWMINS**
Hours Minutes

c. When you do other walking, do you usually walk at a brisk pace (as fast as you can), a moderate pace, or at a leisurely stroll?

1 brisk
 2 moderate **FPOWPACE**
 3 stroll

d. About how many blocks, on average, did you walk each time?

blocks -1 Number of blocks unknown
FPOWBLUK

FPOWBLOX

Do you know how far you usually walk in something other than blocks, e.g., mall lengths, miles, laps around a track?

1 Yes 0 No **FPOWDIST**

What is the unit of measure? **FPOWUNIT**

How many do you walk, on average?

units **FPOWNUMU**

What is the main reason you did not do other walking in the past 7 days?

(Interviewer Note: OPTIONAL - Show card #2.) **FPOW7DNW**

- 1 bad weather
- 2 not enough time
- 3 injury
- 4 health problems
- 5 lost interest
- 6 felt unsafe
- 7 not necessary
- 8 other

Go to Question #24



26. In the past 12 months, did you do any high intensity exercise activities such as bicycling, swimming, jogging, racquet sports or using a stair-stepping, rowing or cross country ski machine or exercycle, at least 10 times?

FPHI12MO 1 Yes 0 No 8 Don't know 7 Refused

Go to Question #27

In the past 7 days, did you do high intensity exercise activities?
FPHI7DAY 1 Yes 0 No

a. What activity(ies) did you do?
(Interviewer Note: OPTIONAL - Show card #3. Check all that apply.)

- 1 bicycling/exercycle **FPHIABE**
- 1 swimming **FPHIASWM**
- 1 jogging **FPHIAJOG**
- 1 aerobics **FPHIAAER**
- 1 stair-stepping **FPHIASS**
- 1 racquet sports **FPHIARS**
- 1 rowing machine **FPHIAROW**
- 1 cross country ski machine **FPHIASKI**
- 1 other *(Please specify):* **FPHIAOTH**

b. In the past 7 days, about how much time did you spend doing *(first named activity)*?
(Interviewer Note: If less than 1 hour, record number of minutes.)

FPHIA1HR **FPHIA1MN**
Hours Minutes

Go to Question #26c

What is the main reason you have not done any high intensity exercise activities in the past 7 days?

(Interviewer Note: OPTIONAL - Show card #4.) **FPHINDEX**

- 1 bad weather
- 2 not enough time
- 3 injury
- 4 health problems
- 5 lost interest
- 6 felt unsafe
- 7 not necessary
- 8 other

Go to Question #27



26c. Did you do (*first named activity*) with a light, moderate, or vigorous effort?

1 light

2 moderate **FPHIA1EF**

3 vigorous

d. In the past 7 days, about how much time did you spend doing (*second named activity*)? (**Interviewer Note: If less than 1 hour, record number of minutes.**)

FPHIA2HR **FPHIA2MN**
Hours Minutes

e. Did you do (*second named activity*) with a light, moderate, or vigorous effort?

1 light

2 moderate **FPHIA2EF**

3 vigorous

f. In the past 7 days, about how much time did you spend doing (*third named activity*)? (**Interviewer Note: If less than 1 hour, record number of minutes.**)

FPHIA3HR **FPHIA3MN**
Hours Minutes

g. Did you do (*third named activity*) with a light, moderate, or vigorous effort?

1 light

2 moderate **FPHIA3EF**

3 vigorous

h. In the past 7 days, about how much time did you spend doing (*fourth named activity*)? (**Interviewer Note: If less than 1 hour, record number of minutes.**)

FPHIA4HR **FPHIA4MN**
Hours Minutes

i. Did you do (*fourth named activity*) with a light, moderate or vigorous effort?

1 light

2 moderate **FPHIA4EF**

3 vigorous



27. In the past 12 months, did you do any moderate intensity exercise activities such as golf, bowling, dancing, skating, bocce, table tennis, hunting, sailing or fishing, at least 10 times?

FPMI12MO 1 Yes 0 No 8 Don't know 7 Refused

↓ ↓ ↓ ↓

Go to Question #28

In the past 7 days, did you do moderate intensity exercise activities?

FPMI7DAY

1 Yes 0 No

a. What activity(ies) did you do?
(Interviewer Note: OPTIONAL - Show card #5. Check all that apply.)

- 1 golf **FPMIGOLF**
- 1 bowling **FPMIBOWL**
- 1 dancing **FPMIDANC**
- 1 skating **FPMISKAT**
- 1 bocce **FPMIBOCC**
- 1 table tennis **FPMITENN**
- 1 billiards/pool **FPMIPOOL**
- 1 hunting **FPMIHUNT**
- 1 sailing/boating **FPMIBOAT**
- 1 fishing **FPMIFISH**
- 1 other *(Please specify):* **FPMIOT1**

b. In the past 7 days, about how much time did you spend doing *(first named activity)?*
Interviewer Note: If less than 1 hour, record number of minutes.)

FPMIA1HR **FPMIA1MN**

Hours Minutes

What is the main reason you have not done any moderate intensity exercise activities in the past 7 days?
(Interviewer Note: OPTIONAL - Show card #6.) **FPMINDEX**

- 1 bad weather
- 2 not enough time
- 3 injury
- 4 health problems
- 5 lost interest
- 6 felt unsafe
- 7 not necessary
- 8 other

↓

Go to Question #28

Go to Question #27c

27c. Did you do (*first named activity*) with a light, moderate, or vigorous effort?

1 light

2 moderate **FPMIA1EF**

3 vigorous

d. In the past 7 days, about how much time did you spend doing (*second named activity*)? (*Interviewer Note: If less than 1 hour, record number of minutes.*)

FPMIA2HR **FPMIA2MIN**
Hours Minutes

e. Did you do (*second named activity*) with a light, moderate, or vigorous effort?

1 light

2 moderate **FPMIA2EF**

3 vigorous

f. In the past 7 days, about how much time did you spend doing (*third named activity*)? (*Interviewer Note: If less than 1 hour, record number of minutes.*)

FPMIA3HR **FPMIA3MN**
Hours Minutes

g. Did you do (*third named activity*) with a light, moderate, or vigorous effort?

1 light

2 moderate **FPMIA3EF**

3 vigorous

h. In the past 7 days, about how much time did you spend doing (*fourth named activity*)? (*Interviewer Note: If less than 1 hour, record number of minutes.*)

FPMIA4HR **FPMIA4MN**
Hours Minutes

i. Did you do (*fourth named activity*) with a light, moderate or vigorous effort?

1 light

2 moderate **FPMIA4EF**

3 vigorous



**WORK, VOLUNTEER,
&
CAREGIVING ACTIVITIES**

29b. How many months of the year do you do this?

months

FPVWMOV

c. Which of the following categories best describes the type of activity you do?
(Interviewer Note: **REQUIRED - Show card #7.**)

- 1** Mainly sitting
- 2** Sitting, some standing and/or walking
- 3** Mostly standing and/or walking
- 4** Mostly walking and lifting and/or carrying;
heavy manual work

FPVWVACT

30. Do you currently provide any regular care or assistance to a child or a disabled or sick adult?

- 1** Yes **0** No **8** Don't know **7** Refused **FPVWCURA**

Go to question #31

About how many hours per week do you provide care to another person?

hours

FPVWAHAW

31. About how many hours per week do you spend watching television?
(Interviewer Note: **REQUIRED - Show card #8.**)

- 0** Zero
- 1** More than 0 but less than 7 hours/week
- 2** At least 7, but less than 14 hours/week
- 3** At least 14, but less than 21 hours/week **FPVWTV**
- 4** 21 or more hours/week
- 8** Don't know
- 7** Refused

32. About how many hours per week do you spend reading, including books, newspapers, and magazines?

FPVWREAD

hours

8 Don't know

7 Refused **FPVWRDRF**



BQID

BQACROS

APPETITE AND EATING BEHAVIOR

Now I have some questions about your appetite.

33. In the past month, would you say that your appetite or desire to eat has been...?
(Interviewer Note: Read response options.)

- 1 Very good
- 2 Good
- 3 Moderate
- 4 Poor **BQAPPET**
- 5 Very poor
- 8 Don't know
- 7 Refused

34. Do you have an illness or physical condition that interferes with your appetite or ability to eat?

- 1 Yes
- 0 No
- 8 Don't know
- 7 Refused **BQAPPILL**

Please describe the illness or condition that interferes with your appetite or ability to eat? *(Interviewer Note: Check all that apply.)*

- 1 Problems with your teeth **BQAPPTD**
- 1 Swallowing problems **BQAPPSP**
- 1 Pain on chewing **BQAPPPC**
- 1 Poor taste **BQAPPPT**
- 1 Poor smell **BQAPPPS**
- 1 Stomach/abdominal pain **BQAPPSAP**
- 1 Gas/bloating **BQAPPGB**
- 1 Indigestion/heartburn **BQAPPIH**
- 1 Constipation **BQAPPCON**
- 1 Diarrhea **BQAPPDIA**
- 1 Other *(Please specify):* **BQAPPOTH**



35. Compared to one year ago, how would you rate your appetite or desire to eat?
Would you say that it is...

(Interviewer Note: Read response options. OPTIONAL - Show card #9.)

- 1 Much better now than one year ago
- 2 Somewhat better now than one year ago
- 3 About the same as one year ago
- 4 Somewhat worse now than one year ago
- 5 Much worse now than one year ago
- 8 Don't know
- 7 Refused

BQAPP1YR

36. Are there days when you don't feel like eating at all?

- 1 Yes
- 0 No
- 8 Don't know
- 7 Refused **BQNOFAT**

a. About how often? Would you say... *(Interviewer Note: Read response options.)*

- 1 About once a month
- 2 About once a week
- 3 More than once a week
- 4 Every day
- 8 Don't know
- 7 Refused

BQOFNEAT

b. What do you think are the reason(s) you do not feel like eating?

(Interviewer Note: Check all that apply.)

- 1 Taste of the food **BQNETAST**
- 1 Smell of the food **BQNESMEL**
- 1 Look of the food **BQNELOOK**
- 1 In general, food is not appealing to me **BQNENOAP**
- 1 Stomach pain **BQNESTPN**
- 1 Not hungry **BQNENOHG**
- 1 No specific reason **BQNENOSP**
- 1 Other *(Please specify:)* _____ **BQNENOTH**
- 1 Don't know **BQNEKD**
- 1 Refused **BQNEREF**



37. Thinking about a usual or normal week, how many days out of the seven days a week do you eat...
(Interviewer Note: A snack is anything you eat which you don't consider as part of a meal. Repeat "Thinking about a usual or normal week, how many days out the seven days a week do you eat..." after every three questions.)

- | | | | | | |
|-----------------|------------------------|---------------------------|---------------------|------------------|-----------------|
| BQWEATEM | a) Early morning snack | <input type="text"/> days | 8 Don't know | 7 Refused | BQEATEM2 |
| BQWEATBR | b) Breakfast | <input type="text"/> days | 8 Don't know | 7 Refused | BQEATBR2 |
| BQWEATMM | c) Mid-morning snack | <input type="text"/> days | 8 Don't know | 7 Refused | BQEATMM2 |
| BQWEATLN | d) Lunch | <input type="text"/> days | 8 Don't know | 7 Refused | BQEATLN2 |
| BQWEATAS | e) Afternoon snack | <input type="text"/> days | 8 Don't know | 7 Refused | BQEATAS2 |
| BQWEATDN | f) Dinner | <input type="text"/> days | 8 Don't know | 7 Refused | BQEATDN2 |
| BQWEATEV | g) Evening snack | <input type="text"/> days | 8 Don't know | 7 Refused | BQEATEV2 |

38. Is mealtime enjoyable? Would you say... *(Interviewer Note: Read response options.)*

- 1** Very enjoyable
- 2** Enjoyable
- 3** Unenjoyable
- 4** Very unenjoyable **BQEATJOY**
- 5** Neither enjoyable nor unenjoyable
- 8** Don't know
- 7** Refused

39. Do you usually eat meals alone? Would you say...

- | | |
|---------------------------|-------------------------------------|
| 1 All of the time | 9 Never |
| 2 Most of the time | 8 Don't know BQEATSIN |
| 3 Some of the time | 7 Refused |

40. Because of a health or physical problem, do you have any difficulty preparing meals?

- BQDFPREP** **1** Yes **0** No **9** Does not do **8** Don't know **7** Refused

41. Because of a health or physical problem, do you have any difficulty shopping for food?

- BQDFSHOP** **1** Yes **0** No **9** Does not do **8** Don't know **7** Refused



42. Do you get the groceries that you need? Would you say...

- 1 All of the time
- 2 Most of the time
- 3 Some of the time
- 4 None of the time
- 8 Don't know **BQGROC**
- 7 Refused

43. During the past month, have you had enough food to satisfy your hunger? Would you say...

- 1 All of the time
- 2 Most of the time
- 3 Some of the time
- 4 None of the time
- 8 Don't know **BQHUNGER**
- 7 Refused

44. Are you currently on a special diet?

- 1 Yes
- 0 No
- 8 Don't know
- 7 Refused **BQSPDIET**

a. What special diet are you following?

(Interviewer Note: Read response options.

OPTIONAL - Show card #10. Check all that apply.)

- 1 Reduced food intake (decreased quantities of all foods eaten) **BQSDRED**
- 1 Limiting your intake to only 1 or 2 types of foods (e.g., only grapefruit or only lean meats) **BQSDLIM**
- 1 Low fat intake **BQSDFAT**
- 1 Low salt diet **BQSDSALT**
- 1 Low cholesterol diet **BQSDCHL**
- 1 Low fiber diet **BQSDLOFB**
- 1 High fiber diet **BQSDHIFB**
- 1 Lactose free (dairy or milk-free) diet **BQSDLACT**
- 1 Diabetic diet to control blood sugar **BQSDDIAB**
- 1 Other type of diet *(Please describe:)* **BQSDOTH**

b. Was this diet recommended by a doctor, nutritionist or other health care professional? **BQDIETRC**

- 1 Yes
- 0 No
- 8 Don't know
- 7 Refused



WEIGHT HISTORY

45. What was your usual weight at about age 25 (women answer for a time when you were not pregnant)? If you don't remember exactly, please make your best guess.

pounds
BQWT25

8 Don't know/don't remember

7 Refused **BQWT252**

46. How tall were you without shoes at about age 25? If you don't remember exactly, please make your best guess.

BQHT25FT
 feet inches **BQHT25IN**

8 Don't know/don't remember

7 Refused **BQHT25RF**

47. What was your usual weight at about age 50? If you don't remember exactly, please make your best guess.

pounds
BQWT50

8 Don't know/don't remember

7 Refused **BQWT502**

48. What is the most you ever weighed (women answer for a time when you were not pregnant)? If you don't remember exactly, please make your best guess.

pounds
BQWTMAX

8 Don't know/don't remember

7 Refused **BQWTMAX2**

49. How old were you when you were at this maximum weight?
(Interviewer Note: Check all that apply.)

- 1** Less than 18 years old **BQMWLT18**
- 1** 18-25 years old **BQMW18**
- 1** 26-29 years old **BQMW25**
- 1** 30-39 years old **BQMW30**
- 1** 40-49 years old **BQMW40**
- 1** 50-59 years old **BQMW50**
- 1** 60-69 years old **BQMW60**
- 1** 70 years or older **BQMW70**
- 1** Don't know **BQMWDK**
- 1** Refused **BQMWREF**



WEIGHT HISTORY

52b. Were you trying to lose weight?

- 1** Yes **0** No **8** Don't know **7** Refused **BQTRYLOS**

Go to Question # 52d

C. What methods did you use to lose weight?

(Interviewer Note: Read response options.

OPTIONAL - Show card #11. Please check all that apply.)

- 1** Reduced food intake (decreased quantities of all foods eaten) **BQWLRED**
- 1** Limiting your intake to only 1 or 2 types of food (e.g., ate only grapefruit or only lean meats) **BQWLLIM**
- 1** Reduced fat intake **BQWLFMOD**
- 1** Use of fat/calorie modified foods (low fat, fat-free) **BQWLFREE**
- 1** Use of a liquid diet formula such as Slim-fast or Optifast **BQWLLIQ**
- 1** Commercial weight loss program **BQWLCWLP**
(e.g. Weight Watcher, Jenny Craig or self-help group ([Over Eaters Anonymous, TOPS])
- 1** Decreased alcohol intake **BQWLALC**
- 1** Increased exercise **BQWLEXIN**
- 1** Increased smoking **BQWLSMOK**
- 1** Diet pills (prescription or nonprescription) **BQWLPILL**
- 1** Stomach surgery/intestinal bypass **BQWLSUR**
- 1** Consulted with dietician/physician/other professional **BQWLDIET**
- 1** Other *(Please specify:)* **BQWLOTH** _____

Go to question # 53

52d. What do you think caused this weight loss?

(Interviewer Note: Please check all that apply.)

- 1** Illness *(Please specify:)* **BQLCILL** _____
- 1** Surgery *(Please specify:)* **BQLCSURG** _____
- 1** Medications **BQLCMED**
- 1** Stressful time **BQLCST**
- 1** Loss of appetite **BQLCAPP**
- 1** Change in eating habits **BQLCEAT**
- 1** Change in exercise habits/amount of physical activity **BQLCEX**
- 1** Other *(Please specify:)* **BQLCOTH** _____
- 1** Don't know **BQLCDK**



WEIGHT HISTORY

53. Did you gain 5 or more pounds at any time over the past 12 months?

- 1 Yes
 0 No
 8 Don't know
 7 Refused **BQGN5LB**

a. How much weight did you gain in the past 12 months?
If you are not sure, please make your best guess.

BQGN12MO

pounds

BQGNREF

- 8 Don't know/don't remember
 7 Refused

b. Were you trying to gain weight? **BQGNYN**

- 1 Yes
 0 No
 8 Don't know
 7 Refused

What do you think caused this weight gain?
(Interviewer Note: Please check all that apply.)

- 1 Illness *(Please specify:)* **BQGNCILL** _____
- 1 Surgery *(Please specify:)* **BQGNCSUR** _____
- 1 Medications **BQGNCMED**
- 1 Stressful time **BQGN CST**
- 1 Stopped smoking **BQGNCSM**
- 1 Change in eating habits **BQGNCEAT**
- 1 Change in exercise habits/amount of physical activity **BQGNCEX**
- 1 Other *(Please specify:)* **BQGN COT** _____
- 1 Don't know **BQGNCDK**

54. People's weights change during their adult lives. During your adult life, would you say that...
Women should not include times when you were pregnant.

(Interviewer Note: Read response options. OPTIONAL - Show card #12.)

- 1 Your weight has stayed about the same (within 10 pounds)
- 2 You have had a gradual gain in weight (more than 10 pounds)
- 3 You have had a gradual loss in weight
- 4 You have had a marked loss in weight and then kept it off **BQWTCHNG**
- 5 Your weight has repeatedly gone up and down again
- 8 Don't know
- 7 Refused



WEIGHT HISTORY

55. Do you have a scale in your home that you can use to weigh yourself?

1 Yes

0 No

8 Don't know

7 Refused **BQWSCALE**

On average, how often do you weigh yourself?
Would you say.... *(Interviewer Note: Read response options.)*

1 Daily

2 Weekly

3 Monthly

4 Only occasionally

9 Never

8 Don't know

BQOFTWT



WEIGHT HISTORY

56. How much do you currently weigh? If you are unsure, please make your best guess.

pounds
BQWTLBS

8 Don't know/don't remember

7 Refused **BQLBS2**

57. At this time, how satisfied are you with your weight? Would you say...
(Interviewer Note: Read response options.)

1 Very

2 Moderately

3 A little

BQWTSAT

4 Not at all

8 Don't know

7 Refused

58. At the present time, do you feel like you are underweight, about the right weight, or overweight?

1 Underweight

2 About the right weight

3 Overweight

BQUWOWRW

8 Don't know

7 Refused

59. At the present time, are you trying to lose weight?

1 Yes

0 No

8 Don't know

7 Refused **BQLOSEWT**

↓
Go to Question # 61

60. At the present time, are you trying to gain weight?

1 Yes

0 No

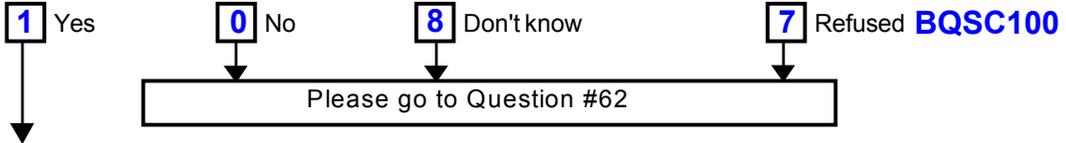
8 Don't know

7 Refused **BQGAINWT**



SMOKING HABITS

61. Have you smoked at least 100 cigarettes in your entire life?
(Interviewer Note: 100 cigarettes is equal to 5 packs.)



a. How old were you when you first started smoking cigarettes fairly regularly?

BQSCAGEB

I was years old

BQSCNSM

-1 I never smoked regularly

b. On the average of the entire time you have smoked, how many cigarettes did you usually smoke per day?

BQSCCGAV

cigarettes per day

c. Do you smoke cigarettes now?

1 Yes

0 No **BQSCSNOW**

How old were you when you stopped smoking?

I was years old

BQSCAGES

On the average, about how many cigarettes a day do you smoke now?

BQSCCGNO cigarettes per day



SMOKING HABITS

62. Have you ever smoked a pipe or cigars?

1 Yes

0 No

8 Don't know

7 Refused **BQSCPOC**

Please go to Question #63

a. How old were you when you first started smoking a pipe or cigars fairly regularly?

I was years old.

BQSCPCAG

-1 I never smoked regularly **BQSCPCNS**

b. Do you smoke a pipe or cigar now?

1 Yes

0 No **BQSCPCY**

How old were you when you stopped smoking a pipe or cigars?

I was years old.

BQSCPCSM



ALCOHOLIC BEVERAGES

These next questions are about drinking alcoholic beverages. Alcoholic beverages include beer, ale, wine, wine coolers, liquor such as whiskey, gin, rum or vodka, and cocktails and mixed drinks containing liquor, such as manhattans and martinis, and any other drink that contains alcohol.

Please answer for all types of alcoholic beverages together. Let's consider one drink to be equal to . . .

- one 12 ounce can of beer
- one five ounce glass of wine (a full glass),
- a drink containing a "shot", a "jigger" or a "finger of liquor" (approximately one and one quarter ounces.)

63. During the past 12 months, how many drinks did you have in a typical week? If you are unsure, please make your best guess. (*Interviewer Note: Do NOT read response categories.*)

1 None -- do not drink alcohol at all

2 An occasional drink, but less than once a week

3 1-3 drinks per week

4 4-7 drinks per week

5 8-14 drinks per week

6 15-21 drinks per week

BQDA12MO

9 22-27 drinks per week

10 28 or more drinks per week

8 Don't know

7 Refused

What is your primary reason for not drinking very much?

(*Interviewer Note: Do NOT read response options. Please check only one answer.*)

1 No need/not necessary

2 Don't care for it/dislike it

3 Medical/health reasons

4 Religious/moral reasons

BQDARND

5 Recovering alcoholic

6 Family member an alcoholic or problem drinker

7 Costs too much

8 Other reasons (*Please specify:*)

64. Did you ever drink more than you do now?

1 Yes

0 No

8 Don't know

7 Refused

BQMORE

65. Was there ever a time in your life when you drank 5 or more drinks of any kind of alcoholic beverage almost every day?

1 Yes

0 No

8 Don't know

7 Refused

BQDA5XDA

During the past 12 months, have you had 5 or more drinks almost every day?

1 Yes

0 No

BQDA5X12

SLEEP HABITS

66. How many hours of sleep do you usually get at night?

hours
BQSHHRS

8 Don't know

7 Refused **BQSHHRS2**

67. During a usual week, how many times do you nap for 5 minutes or more?
(Interviewer Note: Write in "0" if participant does not take any naps.)

naps
BQSHNAPS

8 Don't know

7 Refused **BQSHNAPS2**

68. Please indicate how often you experience each of the following:
(Interviewer Note: Read one question at a time. REQUIRED - Show card #13.)

	Never (0)	Rarely (1/month or less)	Sometimes (2-4/month)	Often (5-15/month)	Almost Always (16-30/ month)
a) Have trouble falling asleep. BQSHTFSS	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
b) Wake up during the night and have difficulty getting back to sleep. BQSHWUDN	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
c) Wake up too early in the morning and be unable to get back to sleep. BQSHWUTE	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
d) Feel unrested during the day, no matter how many hours of sleep you had. BQSHFUDD	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
e) Feel excessively (overly) sleepy during the day. BQSHFESD	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
f) Do not get enough sleep. BQSHDGES	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
g) Take sleeping pills or other medication to help you sleep. BQSHMED	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
h) Eat a snack or drink before bedtime to help you sleep. BQSHEAT	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4



The next question is about snoring during sleep. To answer these questions, please consider both what others have told you AND what you know about yourself.

69. Have you ever snored (now or at any time in the past)?

1 Yes 0 No 8 Don't know 7 Refused **BQSHSNOR**



a. How often do you snore now? Would you say...

(Interviewer Note: Read response options. REQUIRED - Show card #14.)

- 0 Never. I do not snore anymore.
- 1 Rarely - less than one night a week
- 2 Sometimes - 1 or 2 nights a week
- 3 Frequently - 3 to 5 nights a week
- 4 Always or almost always - 6 or 7 nights a week
- 8 Don't know

BQSHSFRQ



--	--	--	--	--	--

--	--	--	--

PQID

PQACROS

BODILY PAIN

The following questions are about the pain or pains you have experienced in the past 30 days. If you had more than one pain, answer the questions by describing your feelings of pain in general.

70. Did you experience any bodily pain in the past 30 days?
(*Interviewer Note: Headaches and stomach aches are considered bodily pain.*)

1 Yes

0 No

8 Don't know

7 Refused **PQBP30DA**

a. During the past 30 days, how often have you had pain?
Would you say. . . (*Interviewer Note: Read response options.
OPTIONAL - Show card #15.*)

1 Once or twice

2 A few times

3 Fairly often

4 Very often

PQBPFREQ

5 Every day or nearly every day

8 Don't know

7 Refused

b. During the past 30 days, how severe was the pain usually?
Would you say. . . (*Interviewer Note: Read response options.*)

1 Mild

2 Moderate

3 Severe

PQBPSEVR

4 Extreme

8 Don't know

7 Refused

c. During the past 30 days, on how many days did pain interfere with the things you usually do? Your answer may range from 0 to 30 days.

days **PQINTR**



71. Has a doctor ever told you that you have arthritis?

1 Yes 0 No 8 Don't know 7 Refused PQAJARTH

What kind of arthritis did the doctor say it was? Did the doctor say you had...

a. Rheumatoid arthritis? 1 Yes 0 No 8 Don't know PQAJARRA

b. Osteoarthritis or degenerative arthritis? 1 Yes 0 No 8 Don't know PQAJARDA

Did the doctor say it was...?

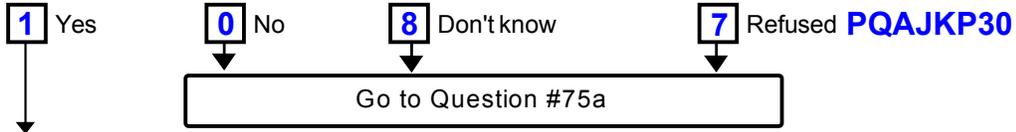
- i. Osteoarthritis or degenerative arthritis in your knee? 1 Yes 0 No 8 Don't know PQAJKNEE
- ii. Osteoarthritis or degenerative arthritis in your hip? PQAJHIP 1 Yes 0 No 8 Don't know
- iii. Osteoarthritis or degenerative arthritis in your hand or fingers? 1 Yes 0 No 8 Don't know PQAJHAND

c. Some other type of arthritis? PQAJOTH
(Interviewer Note: If participant is not sure of type of arthritis doctor said they had, check "Don't know".) 1 Yes 0 No 8 Don't know

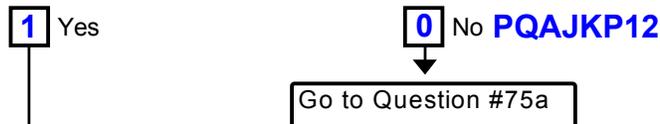
Please specify: _____



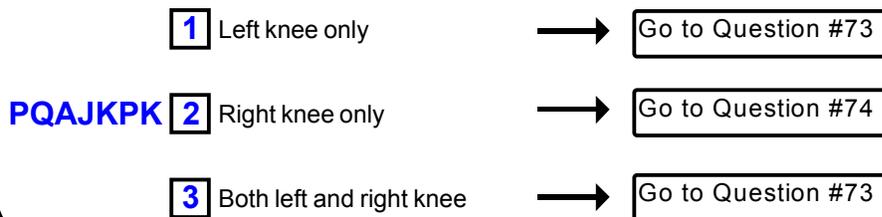
72. Have you ever had pain lasting at least one month in or around either knee? This includes pain in the front, back and sides of the knee. *(Interviewer Note: Pain lasting at least a month includes intermittent and/or continuous pain for at least 15 of 30 days.)*



a. In the past 12 months, have you had knee pain lasting at least one month?



b. In the past 12 months, have you had this pain in the left knee, right knee or both knees?



73. In the past 12 months, how severe was the pain in your left knee usually? Would you say... *(Interviewer Note: Read response options.)*

PQAJLK12 1 Mild 2 Moderate 3 Severe 4 Extreme 8 Don't know

a. Now, please think about the past 30 days. In the past 30 days how much pain have you had in your left knee during each situation I will describe? Would you say... *(Interviewer Note: Read each activity separately. REQUIRED - Show card #16.)*

	None	Mild	Moderate	Severe	Extreme	Don't know
a) Walking on a flat surface PQAJLKFS	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 8
b) Going up or down stairs PQAJLKST	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 8
c) At night while in bed PQAJLKBD	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 8
d) Standing upright PQAJLKUP	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 8
e) Getting in or out of a chair <i>(Interviewer Note: Relatively hard, supportive chair)</i> PQAJLKCH	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 8
f) Getting in or out of a car PQAJLKIN	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 8

Interviewer Note: If left knee only, skip to Question 75.



74. In the past 12 months, how severe was the pain in your right knee usually?
Would you say... *(Interviewer Note: Read response options.)*

- 1 Mild 2 Moderate 3 Severe 4 Extreme 8 Don't know **PQAJRK12**

a. Now, please think about the past 30 days. In the past 30 days how much pain have you had in your right knee during each situation I will describe? Would you say...
(Interviewer Note: Read each activity separately. REQUIRED - Show card #16.)

	None	Mild	Moderate	Severe	Extreme	Don't know
a) Walking on a flat surface PQAJRKFS	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 8
b) Going up or down stairs PQAJRKST	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 8
c) At night while in bed PQAJRKBD	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 8
d) Standing upright PQAJKRUP	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 8
e) Getting in or out of a chair <i>(Interviewer Note: Relatively hard, supportive chair)</i> PQAJRKCH	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 8
f) Getting in or out of a car PQAJRKIN	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 8

75. In the past 30 days, have you limited your activities because of pain in your knees?

- 1 Yes 0 No 8 Don't know 7 Refused **PQAJLACT**

Go to Question #76

On how many days did you limit your activities because of pain in your knees? Your answer may range from 0 to 30 days.

PQAJLDAY
days

75a. On most days, do you have pain, aching or stiffness in either of your knees?

- 1 Yes 0 No 8 Don't know 7 Refused **PQAJKMD**

Go to Question #76

Is this in the left knee, right knee, or both knees?

- 1 Left knee only 2 Right knee only 3 Both left and right knees **PQAJK**

76. Have you ever had pain lasting at least one month in or around either hip? This includes pain in the groin and either side of the upper thigh. Do not include pain that was only in your lower back or buttocks. *(Interviewer Note: REQUIRED - Show card #17.)*

1 Yes
 0 No
 8 Don't know
 7 Refused **PQAJH30D**

↓ ↓ ↓ ↓

Go to Question #77

a. In the past 12 months, have you had hip pain lasting at least one month?

1 Yes **PQAJH12M**
 0 No

↓

Go to Question #77

b. In the past 12 months, have you had this pain in the right hip, left hip or both hips?

2 Right hip only
 1 Left hip only **PQAJHPBH**
 3 Both right and left hip

c. How severe was that pain usually? Would you say...
(Interviewer Note: Read response options. If pain is in both right and left hip, say: "this time answer for worse hip".)

PQAJHP12

1 Mild 2 Moderate 3 Severe 4 Extreme 8 Don't know

d. Now, please think about the past 30 days. In the past 30 days how much pain have you had in your hips during each situation I will describe? Would you say...

(Interviewer Note: OPTIONAL - Show card #18. If pain is in both left and right hip, say: "again, answer for the worse hip.")

	None	Mild	Moderate	Severe	Extreme	Don't know
a) Walking on a flat surface PQAJHFS	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 8
b) Going up or down stairs PQAJHST	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 8
c) At night while in bed PQAJHBD	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 8
d) Standing upright PQAJHUP	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 8
e) Putting on socks PQAJHSOK	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 8
f) Getting in or out of a chair <i>(Interviewer Note: Relatively hard, supportive chair)</i> PQAJHCH	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 8
g) Getting in or out of a car PQAJHCAR	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 8

ARTHRITIS and JOINT PAIN

77. In the past 12 months, have you had pain lasting at least one month in your feet, toes or ankles?

1 Yes 0 No 8 Don't know 7 Refused **PQAJFT30**

Go to Question #78

a. Please show me on this diagram which toes or parts of your foot have been painful for at least a month in the past 12 months. (*Interviewer Note: REQUIRED - Show card #19. Check all that apply.*)

Left					Right				
<input type="checkbox"/> -1 1	<input type="checkbox"/> -1 2	<input type="checkbox"/> -1 3	<input type="checkbox"/> -1 4	<input type="checkbox"/> -1 5	<input type="checkbox"/> -1 5	<input type="checkbox"/> -1 4	<input type="checkbox"/> -1 3	<input type="checkbox"/> -1 2	<input type="checkbox"/> -1 1
PQAJLF1	PQAJLF2	PQAJLF3	PQAJLF4	PQAJLF5	PQAJRF5	PQAJRF4	PQAJRF3	PQAJRF2	PQAJRF1
<input type="checkbox"/> -1 6	<input type="checkbox"/> -1 7	<input type="checkbox"/> -1 8	<input type="checkbox"/> -1 9	<input type="checkbox"/> -1 10	<input type="checkbox"/> -1 6	<input type="checkbox"/> -1 7	<input type="checkbox"/> -1 8	<input type="checkbox"/> -1 9	<input type="checkbox"/> -1 10
PQAJLF6	PQAJLF7	PQAJLF8	PQAJLF9	PQAJLF10	PQAJRF6	PQAJRF7	PQAJRF8	PQAJRF9	PQAJRF10

b. Now think about the past 30 days. In the past 30 days how much pain have you had in your feet, ankles or toes during each situation I will describe? Would you say...
(*Interviewer Note: OPTIONAL - Show card #20. If pain on both right and left, say: "Answer for worse side".*)

	None	Mild	Moderate	Severe	Extreme	Don't know
i. Walking on a flat surface PQAJFTFS	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 8
ii. Going up or down stairs PQAJFTST	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 8
iii. Standing upright PQAJFTUP	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 8

78. In the past 12 months, have you had pain lasting for at least one month in the joints of your hands or wrists?

1 Yes 0 No 8 Don't know 7 Refused **PQAJWR30**

Go to Question #78b

a. In the past 12 months, have you had pain lasting less than one month in the joints of your hands or wrists?

1 Yes **PQAJWR12** 0 No

Go to Question #79

b. Please show me on this diagram which joints of your hand or wrist have been painful in the past 12 months. (*Interviewer Note: REQUIRED - Show card #21.*)

Left																Right															
<input type="checkbox"/> -1 1	<input type="checkbox"/> -1 2	<input type="checkbox"/> -1 3	<input type="checkbox"/> -1 4	<input type="checkbox"/> -1 5	<input type="checkbox"/> -1 5	<input type="checkbox"/> -1 4	<input type="checkbox"/> -1 3	<input type="checkbox"/> -1 2	<input type="checkbox"/> -1 1	<input type="checkbox"/> -1 1	<input type="checkbox"/> -1 2	<input type="checkbox"/> -1 3	<input type="checkbox"/> -1 4	<input type="checkbox"/> -1 5	<input type="checkbox"/> -1 5	<input type="checkbox"/> -1 4	<input type="checkbox"/> -1 3	<input type="checkbox"/> -1 2	<input type="checkbox"/> -1 1												
PQAJLW1	PQAJLW2	PQAJLW3	PQAJLW4	PQAJLW5	PQAJRW5	PQAJRW4	PQAJRW3	PQAJRW2	PQAJRW1	PQAJRW10	PQAJRW9	PQAJRW8	PQAJRW7	PQAJRW6	PQAJRW10	PQAJRW9	PQAJRW8	PQAJRW7	PQAJRW6												
<input type="checkbox"/> -1 6	<input type="checkbox"/> -1 7	<input type="checkbox"/> -1 8	<input type="checkbox"/> -1 9	<input type="checkbox"/> -1 10	<input type="checkbox"/> -1 10	<input type="checkbox"/> -1 9	<input type="checkbox"/> -1 8	<input type="checkbox"/> -1 7	<input type="checkbox"/> -1 6	<input type="checkbox"/> -1 11	<input type="checkbox"/> -1 12	<input type="checkbox"/> -1 13	<input type="checkbox"/> -1 14	<input type="checkbox"/> -1 15	<input type="checkbox"/> -1 16	<input type="checkbox"/> -1 15	<input type="checkbox"/> -1 14	<input type="checkbox"/> -1 13	<input type="checkbox"/> -1 12	<input type="checkbox"/> -1 11	<input type="checkbox"/> -1 16										
PQAJLW6	PQAJLW7	PQAJLW8	PQAJLW9	PQAJLW10	PQAJRW10	PQAJRW9	PQAJRW8	PQAJRW7	PQAJRW6	PQAJLW11	PQAJLW12	PQAJLW13	PQAJLW14	PQAJLW15	PQAJLW16	PQAJRW15	PQAJRW14	PQAJRW13	PQAJRW12	PQAJRW11	PQAJRW16										
PQAJLW11	PQAJLW12	PQAJLW13	PQAJLW14	PQAJLW15	PQAJLW16	PQAJRW15	PQAJRW14	PQAJRW13	PQAJRW12	PQAJRW14	PQAJRW15	PQAJRW16	PQAJRW17	PQAJRW18	PQAJRW19	PQAJRW20	PQAJRW21	PQAJRW22	PQAJRW23	PQAJRW24	PQAJRW25	PQAJRW26									

78c. How severe was the pain usually?
(Interviewer Note: Read response options. If pain on right and left, say: "Answer for the worse side.")

- 1 Mild 2 Moderate 3 Severe 4 Extreme 8 Don't know **PQAJWPSV**

79. In the past 12 months, have you had pain lasting at least one month in either shoulder?
(Interviewer Note: REQUIRED - Show card #22.)

- 1 Yes 0 No 8 Don't know 7 Refused **PQAJSH12**

Go to Question #80

a. In the past 12 months, have you had this pain in the right, left or both shoulders?

- 1 Right shoulder only
 2 Left shoulder only **PQAJSHPN**
 3 Both right and left shoulder

b. How severe was the pain usually?
(Interviewer Note: Read response options. If pain in both right and left shoulder, say: "Answer for the worse side.")

- 1 Mild 2 Moderate 3 Severe 4 Extreme 8 Don't know **PQAJSHSV**

80. In the past 12 months, have you had pain lasting at least one month in your neck?
(Interviewer Note: REQUIRED - Show card #22.)

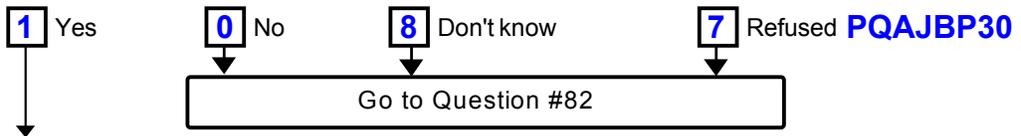
- 1 Yes 0 No 8 Don't know 7 Refused **PQAJNP30**

Go to Question #81

How severe was the pain usually? *(Interviewer Note: Read response options.)*

- 1 Mild 2 Moderate 3 Severe 4 Extreme 8 Don't know **PQAJNPSV**

81. In the past 12 months, have you had any pain in your back?



a. How often did you have back pain in the past 12 months?
Would you say...
(Interviewer Note: Read response options. OPTIONAL - Show card #23.)

- 1 Once or twice
- 2 A few times
- 3 Fairly often
- 4 Very often
- 5 Every day or nearly everyday
- 8 Don't know

PQAJBP12

b. How severe was the pain usually? *(Interviewer Note: Read response options.)*

- 1 Mild 2 Moderate 3 Severe 4 Extreme 8 Don't know **PQAJBPSV**

c. In what part of your back was the pain usually located?
(Interviewer Note: REQUIRED - Show card #24. Check all that apply.)

- 1 Upper -1 Middle -1 Lower -1 Buttocks -1 Don't know
- PQBKUP PQBK MID PQBKLWR PQBK BUT PQBKDN**

d. In the past 12 months, have you limited your activities because of pain in your back?

PQAJDLTD

- 1 Yes 0 No 8 Don't know

Go to question #82

On how many days did you limit your activities because of pain in your back? Your answer can range from 0 to 365 days.

PQAJBDAY

--	--	--

days

--



82. During the past 12 months, have you fallen and landed on the floor or ground?

- 1** Yes **0** No **8** Don't know **7** Refused **PQAJFALL**
- Please go to Question #83

How many times have you fallen in the past 12 months? If you are unsure, please make your best guess.

- 1** One
- 2** Two or Three
- 4** Four or Five **PQAJFNUM**
- 6** Six or more
- 7** Don't know

83. During the past 12 months, have you fainted, blacked out, or lost consciousness?

- 1** Yes **0** No **8** Don't know **7** Refused **PQAJBO12**
- Please go to Question #84

How many times has this happened to you in the past 12 months?

- 1** One
- 2** Two or three
- 4** Four or more **PQAJBONO**
- 8** Don't know

OSTEOPOROSIS

84. Has a doctor ever told you that you have osteoporosis, sometimes called thin or brittle bones?

- 1 Yes
 0 No
 8 Don't know
 7 Refused **PQOSDIAG**

85. Has a doctor ever told you that you broke or fractured a bone after the age of 45?

- 1 Yes
 0 No
 8 Don't know
 7 Refused **PQOSBR45**

Please go to Question #86

Has a doctor ever told you that you broke or fractured your hip?

- 1 Yes
 0 No
 8 Don't know **PQOSBRH**

How old were you when a doctor first told you this?
If you are unsure, please make your best guess.

PQOSBRHA I was years old. -1 Don't know **PQOSBRHD**

86. Has a doctor ever told you that you had a fracture of the spine or fracture of the vertebrae?

- 1 Yes
 0 No
 8 Don't know
 7 Refused **PQOSFRV**

Please go to question #87

How old were you when a doctor first told you this?
If you are unsure, please make your best guess.

PQOSFRVA I was years old. -1 Don't know **PQOSFRVD**

Interviewer Note: For male participants, skip to Question #93



FEMALE HISTORY

87. Have you ever been pregnant?

1 Yes
0 No
8 Don't know
7 Refused **MHFHPREG**

Please go to Question #88

a. How many of your pregnancies resulted in the birth of a live child?
(Interviewer Note: If "0", go to Question #88.)

pregnancies **MHFHNOPR**

b. How old were you when your first child was born?
 Do not include adopted children.

years old **MHFHACH1**

88. How old were you at the time of your last natural menstrual period?
 Do not include menstrual bleeding due to taking female hormone pills.

years old **MHFHALMP**

89. Have you ever had a hysterectomy (surgery to remove your uterus or womb)?

1 Yes
0 No
8 Don't know
7 Refused **MHFHHYS**

Please go to Question #90

How old were you when you had this surgery?

years old **MHFHAHYS**

90. Have you ever had an ovary removed?

1 Yes
0 No
8 Don't know
7 Refused **MHFHOVRM**

Please go to Question #91

a. How many ovaries were removed?

1 One
2 Two (both)
8 Don't know **MHFHOVNO**

b. At what age(s) did you have this done?

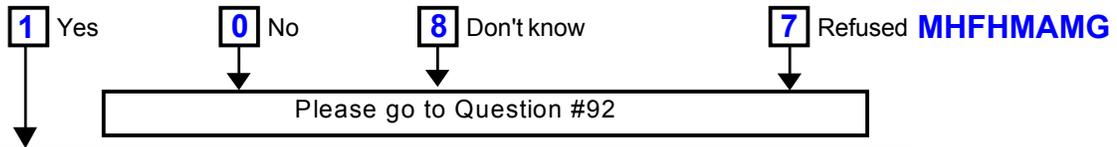
years old **MHFHOVA1**

years old **MHFHOVA2**



FEMALE HISTORY

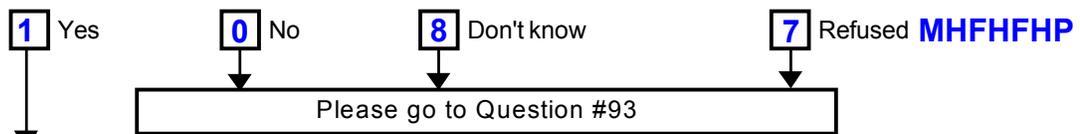
91. Have you ever had a mammogram?



When was the last mammogram that you had?
(Interviewer Note: Read response options.)

0 Less than one year ago
 1 1 to 2 years ago
 2 2 to 5 years ago **MHFHLMAM**
 5 More than 5 years ago
 8 Don't know/Don't remember

92. Since menopause, have you taken estrogen or female hormone pills by mouth, such as Premarin, Ogen, or Estrace?



a. How old were you when you started taking estrogen or female hormone pills? If you are unsure, please make your best guess.

years old **MHFHFHPA**

b. For how many years did you take estrogen or female hormone pills by mouth every day or nearly every day? If you are unsure, please make your best guess.

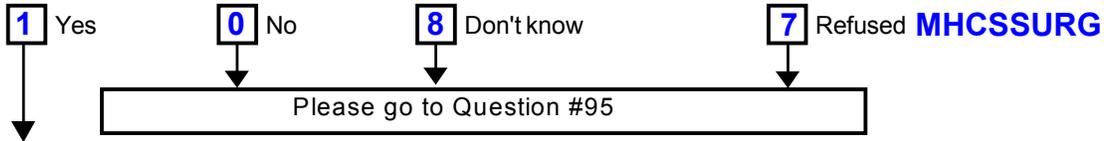
years **MHFHFHPY**

93. Has a doctor ever told you that you had...?

(Interviewer Note: Repeat "Has a doctor ever told you that you had..." after every three questions.)

	<u>Yes</u>	<u>No</u>	<u>Don't Know</u>	<u>Refused</u>
a. Heart attack or myocardial infarction? MHHCHAMI	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 8	<input type="checkbox"/> 7
b. Angina pectoris or chest pain due to heart disease? MHHCAPCP	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 8	<input type="checkbox"/> 7
c. Congestive heart failure? MHHCCHF	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 8	<input type="checkbox"/> 7
d. Intermittent claudication or pain in your legs from a blockage of the arteries? MHHICPL	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 8	<input type="checkbox"/> 7
e. TIA, transient ischemic attack, or mini-stroke? MHHCTIA	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 8	<input type="checkbox"/> 7
f. Stroke, CVA, or cerebrovascular accident? MHHCCVA	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 8	<input type="checkbox"/> 7
g. Rheumatic heart disease or valvular heart disease? MHHCRHD	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 8	<input type="checkbox"/> 7
h. Hypertension or high blood pressure? MHHCHBP	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 8	<input type="checkbox"/> 7

94. Have you ever had any medical or surgical procedure in your heart, neck or blood vessels, such as an angioplasty or bypass surgery?



Have you ever had any of the following medical or surgical procedures...?

	<u>Yes</u>	<u>No</u>	<u>Don't know</u>	<u>Refused</u>
a. Coronary bypass surgery, heart bypass, or CABG? MHCSCABG	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 8	<input type="checkbox"/> 7
b. Angioplasty of coronary arteries, which is a dilation of arteries of the heart with a balloon? MHCSACA	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 8	<input type="checkbox"/> 7
c. Carotid endarterectomy, which is surgery on the blood vessels in your neck? MHCSCEND	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 8	<input type="checkbox"/> 7
d. Bypass procedure on the arteries of your legs? MHC SBPAL	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 8	<input type="checkbox"/> 7
e. Angioplasty of lower extremity arteries which is dilation of arteries of the leg with a balloon? MHCSALEA	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 8	<input type="checkbox"/> 7
f. Pacemaker implant? MHCSPACE	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 8	<input type="checkbox"/> 7
g. Repair of an aortic aneurysm? MHC SRAA	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 8	<input type="checkbox"/> 7
h. Replacement of a heart valve? MHC SRHV	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 8	<input type="checkbox"/> 7



95. Have you ever had any pain or discomfort in your chest?

- 1 Yes 0 No 8 Don't know 7 Refused **MHCSCHPN**

↓
Go to Question #102

96. Do you get it when you walk up hill or hurry?

- MHCSPOP** 1 Yes 0 No 9 Never hurry or walk uphill 8 Don't know 7 Refused

↓
Go to Question #101

97. Do you get it when you walk at an ordinary pace on a level surface?

- 1 Yes 0 No 8 Don't know 7 Refused **MHCSPLS**

98. What do you do if you get it while you are walking? Do you...
(Interviewer Note: Read response options.)

- 1 Stop or slow down, or continue at same pace after taking nitroglycerine
 2 Continue at same pace
 8 Don't know **MHCSWALK**
 7 Refused

99. If you stand still, what happens to it? Is it relieved or not relieved?

- 1 Relieved 2 Not relieved 8 Don't know 7 Refused **MHCSSTIL**

↓
How soon is it relieved?

- 1 10 minutes or less
 2 More than 10 minutes **MHCSREL**
 8 Don't know

100. Where do you get this pain or discomfort?
(Interviewer Note: REQUIRED - Show card #25.)

- 1 Sternum, upper or middle
- 2 Sternum, lower
- 3 Left anterior chest
- 4 Left arm **MHCSPLOC**
- 5 Other *(Please specify:)* _____
- 8 Don't know
- 7 Refused

101. Have you ever had a severe pain across the front of your chest lasting for half an hour or more?

- 1 Yes
- 0 No
- 8 Don't know
- 7 Refused **MHCSSVPN**

a. Did you see a doctor because of this pain?

- 1 Yes
- 0 No
- 8 Don't know/don't remember **MHCSSPDR**

b. What did your doctor say it was?

- 1 Angina
 - 2 Heart attack
 - 3 Other *(Please specify:)* _____
 - 8 Don't know/don't remember
- MHCSDIAG**

102. Do you get a pain or discomfort in your leg(s) when you walk?

1 Yes 0 No 8 Don't know 7 Refused **MHCSLGPN**



a. Does this pain ever begin when you are standing still or sitting?

1 Yes 0 No 8 Don't know **MHCSLPSS**

b. Do you get it if you walk uphill or hurry?

1 Yes 0 No 8 Don't know **MHCSLPUP**

c. Do you get it when you walk at an ordinary pace on a level surface?

1 Yes 0 No 8 Don't know **MHCSLPLS**

d. What happens to it if you stand still?

1 Usually continues more than 10 minutes

2 Usually disappears in 10 minutes or less **MHCSSTST**

8 Don't know

e. Do you get this pain in your calf (or calves)?

1 Yes 0 No 8 Don't know **MHCSLPCV**

f. Were you hospitalized for this problem in your legs?

1 Yes 0 No 8 Don't know/don't remember **MHCSLPH**

LUNG CONDITIONS

103. Has a doctor ever told you that you had asthma?

1 Yes 0 No 8 Don't know 7 Refused **MHLCASTH**

Do you still have asthma?

1 Yes 0 No 8 Don't know **MHLCSHA**

104. Has a doctor ever told you that you had chronic bronchitis?

1 Yes 0 No 8 Don't know 7 Refused **MHLCCHBR**

Do you still have chronic bronchitis?

1 Yes 0 No 8 Don't know **MHLCSHCB**

105. Has a doctor ever told you that you had emphysema?

1 Yes 0 No 8 Don't know 7 Refused **MHLCEMPH**

106. Has a doctor ever told you that you had chronic obstructive lung disease or COPD?

1 Yes 0 No 8 Don't know 7 Refused **MHLCCOPD**

LUNG CONDITIONS

107. Has a doctor ever told you that you had pneumonia?

1 Yes 0 No 8 Don't know 7 Refused **MHLCPNEU**



Have you been treated for pneumonia in the past 12 months?

1 Yes 0 No 8 Don't know **MHLCPN12**

108. Have you had a shot to prevent pneumonia (the Pneumo-Vax vaccination) in the past 12 months?

1 Yes 0 No 8 Don't know 7 Refused **MHLCPS12**

109. Are you troubled by shortness of breath when hurrying on a level surface or walking up a slight hill?

1 Yes 0 No 8 Don't know 7 Refused **MHLCSBUP**



Go to Question #111

110. Do you ever have to stop for breath when walking at your own pace on a level surface?

1 Yes 0 No 8 Don't know 7 Refused **MHLCSBLS**

CANCER HISTORY

111. Has a doctor ever told you that you had cancer, a malignant growth, or malignant tumor?
(Interviewer Note: Women should not include "fibroids" of the uterus.)

1 Yes 0 No 8 Don't know 7 Refused **MHCHMGMT**

A. What kind of cancer or malignant growth did you have? *(Interviewer Note: Do NOT read list. Check all that apply.)*

- a) -1 Bladder **MHCHBD**
- b) -1 Blood (leukemia) **MHCHBL**
- c) -1 Bone **MHCHBO**
- d) -1 Brain **MHCHBR**
- e) -1 Breast **MHCHBS**
- f) -1 Cervix (opening to the uterus or womb) **MHCHCV**
- g) -1 Colon, rectum, bowel, or intestine **MHCHCO**
- h) -1 Endometrium (lining of the uterus or womb) **MHCHEN**
- i) -1 Hodgkin's **MHCHHO**
- j) -1 Liver **MHCHLV**
- k) -1 Lung **MHCHLU**
- l) -1 Lymphoma **MHCHLY**
- m) -1 Melanoma **MHCHMN**
- n) -1 Ovary **MHCHOV**
- o) -1 Pancreatic **MHCHPA**
- p) -1 Prostate **MHCHPR**
- q) -1 Skin cancer (not melanoma) **MHCHSC**
- r) -1 Stomach **MHCHST**
- s) -1 Thyroid **MHCHTH**
- t) -1 Other *(Please specify:)* **MHCHOT**

B. How old were you when a doctor first told you that you had this cancer? If you are unsure, please make your best guess.

<input type="text"/>	<input type="text"/>	years	MHCHBDYR
<input type="text"/>	<input type="text"/>	years	MHCHBLYR
<input type="text"/>	<input type="text"/>	years	MHCHBOYR
<input type="text"/>	<input type="text"/>	years	MHCHBRYR
<input type="text"/>	<input type="text"/>	years	MHCHBSYR
<input type="text"/>	<input type="text"/>	years	MHCHCVYR
<input type="text"/>	<input type="text"/>	years	MHCHCOYR
<input type="text"/>	<input type="text"/>	years	MHCHENYR
<input type="text"/>	<input type="text"/>	years	MHCHHOYR
<input type="text"/>	<input type="text"/>	years	MHCHLVYR
<input type="text"/>	<input type="text"/>	years	MHCHLUYR
<input type="text"/>	<input type="text"/>	years	MHCHLYYR
<input type="text"/>	<input type="text"/>	years	MHCHMNYR
<input type="text"/>	<input type="text"/>	years	MHCHOVYR
<input type="text"/>	<input type="text"/>	years	MHCHPAYR
<input type="text"/>	<input type="text"/>	years	MHCHPRYR
<input type="text"/>	<input type="text"/>	years	MHCHSCYR
<input type="text"/>	<input type="text"/>	years	MHCHSTYR
<input type="text"/>	<input type="text"/>	years	MHCHTHYR
<input type="text"/>	<input type="text"/>	years	MHCHOTYR

C. Did you lose 10 or more pounds as a result of cancer or treatment for cancer?
 1 Yes 0 No 8 Don't know 7 Refused **MHCHLB10**

LBID

LBACROS

STOMACH and GALLBLADDER PROBLEMS

112. Has a doctor ever told you that you had a stomach, or duodenal ulcer?

1 Yes 0 No 8 Don't know 7 Refused **LBSGULCR**

a. Where did the doctor say your ulcer was?

1 Stomach

2 Duodenum

3 Someplace else *(Please specify:)*

8 Don't know/don't remember

LBSGULOC

b. Have you ever had any of the following tests to help diagnose your ulcer?

An upper GI series (for an upper GI series, you drink a chalky white liquid called barium, and then x-rays are taken)?

1 Yes 0 No 8 Don't know 7 Refused **LBSGUGI**

An upper endoscopy (a long flexible tube with a light on the end is inserted down the throat so that the lining of the stomach and the upper intestine can be examined)? **LBSGUPEN**

1 Yes 0 No 8 Don't know 7 Refused

113. Have you ever seen a doctor for bleeding in the stomach or intestines?

1 Yes 0 No 8 Don't know 7 Refused **LBSGBLSI**

114. Have you ever had surgery to remove all or part of your stomach?

1 Yes 0 No 8 Don't know 7 Refused **LBSGSURG**

How old were you when you had this surgery?

LBSGSAGE years old



115. Has a doctor ever told you that you had gallstones?

1 Yes 0 No 8 Don't know 7 Refused **LBSGGALL**

Was your gallbladder surgically removed?

1 Yes 0 No 8 Don't know **LBSGGBSM**

116. Has a doctor ever told you that you have diabetes or sugar diabetes?

For women: Please do not include diabetes or sugar diabetes that occurred only during pregnancy.

1 Yes 0 No 8 Don't know 7 Refused **LBSGDIAB**

a. How old were you when a doctor first told you that you had diabetes or sugar diabetes? If you are unsure, please make your best guess.

LBSGDAGE years old **LBSGDADK** -1 Don't know/don't remember

b. Are you currently taking insulin?

1 Yes 0 No 8 Don't know **LBSGINSU**

c. Are you currently taking diabetes pills to lower your blood sugar (sometimes called oral agents or oral hypoglycemic agents)?

1 Yes 0 No 8 Don't know **LBSGMED**

OTHER MEDICAL CONDITIONS

Has a doctor ever told you that you had...?

(Interviewer Note: Repeat "Has a doctor ever told you that you had" after every 2 questions.)

117. High thyroid, Grave's disease, or an over active thyroid gland?

1 Yes 0 No 8 Don't know 7 Refused **LBOMOATH**

118. Low thyroid or hypothyroidism?

1 Yes 0 No 8 Don't know 7 Refused **LBOMLOTH**

119. Parkinson's Disease?

1 Yes 0 No 8 Don't know 7 Refused **LBOMPARK**

120. Kidney disease (do not include kidney stones or bladder infections)?

1 Yes 0 No 8 Don't know 7 Refused **LBDMKIDN**

121. Gout?

1 Yes 0 No 8 Don't know 7 Refused **LBOMGOUT**

122. During your adult life, have you had surgery to repair a hernia in your groin or abdomen?

1 Yes 0 No 8 Don't know 7 Refused **LBOMSURG**

123. Have you ever been treated for depression?

1 Yes 0 No 8 Don't know 7 Refused **LBOMDEPR**

URINARY HISTORY

The following questions concern your urinary or bladder habits. These questions are personal, but your answers are important in helping us better understand these health issues.

124. Many people complain that they leak urine unintentionally. In the past 12 months, have you leaked even a small amount of urine?

- 1 Yes
 0 No
 8 Don't know
 7 Refused **LBU12LK**

a. In the past 12 months, how often have you leaked urine?
(Interviewer Note: Read response options. OPTIONAL - Show card #26.)

- 0 Less than once per month
 1 One or more times per month
 2 One or more times per week **LBULKFRQ**
 3 Every day
 8 Don't know

b. In the past 12 months, when does your leakage of urine usually occur?
(Interviewer Note: OPTIONAL - Show card #27.)

- 1 With an activity like coughing, lifting, standing up or exercise
 2 When you have the urge to urinate and can't get to a toilet fast enough
 3 You leak urine unrelated to coughing, sneezing, lifting or urge
 8 Don't know **LBULKOCC**
 7 Refused

c. Do you wear any protection for when you leak urine?

- 1 Yes
 0 No
 8 Don't know
 7 Refused **LBULPROT**

During a typical day, how many times, on average, do you change your protection because it is wet?

- 0 None
 1 Once
 2 2 to 3 times **LBULDFR**
 3 4 or more times
 8 Don't know

d. How much does the leakage of urine interfere with your daily activities (such as work, exercise, shopping, or recreational activities)? Would you say...

- 1 Not at all
 2 Mildly
 3 Moderately **LBULDACT**
 4 Severely
 8 Don't know



URINARY HISTORY

124e. Have you ever told a doctor about your urine leakage?

- 1 Yes
 0 No
 8 Don't know
 7 Refused **LBURLK**

Why haven't you told your doctor about your urine leakage?

- 1 My problem is not that bothersome
 2 I'm embarrassed **LBURTLK**
 3 I consider it a part of getting older
 4 Other *(Please specify:)*

Interviewer Note: For female participants, skip to Question #134

125. During the past 30 days, how often have you had a sensation of not emptying your bladder completely after you finished urinating?

(Interviewer Note: Read response options. OPTIONAL - Show card #28.)

- 0 None of the time 4 All of the time
 1 A little of the time 8 Don't know **LBURNEB**
 2 Some of the time 7 Refused
 3 Most of the time

126. During the past 30 days, how often have you had to urinate again less than 2 hours after you finished urinating? *(Interviewer Note: Read response options. OPTIONAL - Show card #28.)*

- 0 None of the time 4 All of the time
 1 A little of the time 8 Don't know **LBU2HRS**
 2 Some of the time 7 Refused
 3 Most of the time



URINARY HISTORY

127. During the past 30 days, how often have you found you stopped and started again several times when you urinated? *(Interviewer Note: Read response options. OPTIONAL - Show card #28.)*

- | | |
|---|--|
| <input type="checkbox"/> 0 None of the time | <input type="checkbox"/> 4 All of the time |
| <input type="checkbox"/> 1 A little of the time | <input type="checkbox"/> 8 Don't know |
| <input type="checkbox"/> 2 Some of the time | <input type="checkbox"/> 7 Refused |
| <input type="checkbox"/> 3 Most of the time | |

LBUSTST

128. During the past 30 days, how often have you found it difficult to postpone urination? *(Interviewer Note: Read response options. OPTIONAL - Show card #28.)*

- | | |
|---|--|
| <input type="checkbox"/> 0 None of the time | <input type="checkbox"/> 4 All of the time |
| <input type="checkbox"/> 1 A little of the time | <input type="checkbox"/> 8 Don't know |
| <input type="checkbox"/> 2 Some of the time | <input type="checkbox"/> 7 Refused |
| <input type="checkbox"/> 3 Most of the time | |

LBUPOST

129. During the past 30 days, how often have you had a weak urinary stream? *(Interviewer Note: Read response options. OPTIONAL - Show card #28.)*

- | | |
|---|--|
| <input type="checkbox"/> 0 None of the time | <input type="checkbox"/> 4 All of the time |
| <input type="checkbox"/> 1 A little of the time | <input type="checkbox"/> 8 Don't know |
| <input type="checkbox"/> 2 Some of the time | <input type="checkbox"/> 7 Refused |
| <input type="checkbox"/> 3 Most of the time | |

LBUWEAK

130. During the past 30 days, how often have you had to push or strain to begin urination? *(Interviewer Note: Read response options. OPTIONAL - Show card #28.)*

- | | |
|---|--|
| <input type="checkbox"/> 0 None of the time | <input type="checkbox"/> 4 All of the time |
| <input type="checkbox"/> 1 A little of the time | <input type="checkbox"/> 8 Don't know |
| <input type="checkbox"/> 2 Some of the time | <input type="checkbox"/> 7 Refused |
| <input type="checkbox"/> 3 Most of the time | |

LBUPUSH



URINARY HISTORY

131. During the past 30 days, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?

- 0 None
 - 1 1 time
 - 2 2 times
 - 3 3 times
 - 4 4 times
 - 5 5 or more times
- LBUGETUP**

132. Have you ever had emergency treatment because you were unable to pass water or urinate?

- 1 Yes
- 0 No
- 8 Don't know
- 7 Refused **LBUTREAT**

How old were you when you first required emergency treatment for this problem?

LBUTEM years old

133. Has a doctor ever told you that you had an enlarged prostate?

- 1 Yes
- 0 No
- 8 Don't know
- 7 Refused **LBUENPR**

Have you ever had surgery for an enlarged prostate (do not include surgery for prostate cancer)?

- 1 Yes
- 0 No
- 8 Don't know **LBUEPSUR**

134. During the past 12 months, have you leaked or passed stool at unwanted times?

- 1 Yes
- 0 No
- 8 Don't know
- 7 Refused **LBUPASS**

How often did you leak or pass stool at unwanted times during the past 12 months?

(Interviewer Note: Read response options. OPTIONAL - Show card #29.)

- 9 Never
- 0 Less than once per month
- 1 One or more times per month **LBUPASSX**
- 2 One or more times per week
- 3 Every day



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OMID

OMACROS

ORAL HEALTH

135. Do you have any remaining natural teeth?

1 Yes **0** No **7** Refused **OMUTEETH**

136. Do you wear dentures?

1 Yes **0** No **7** Refused **OMUDENT**

Do you have problems with the fit or pain from your dentures?

1 Yes **0** No **OMUDPAIN**

137. Do you have pain when you chew?

1 Yes **0** No **7** Refused **OMUCHEW**



EYESIGHT

138. Do you have glasses or contact lenses?

1 Yes 0 No 7 Refused **OMESCON**

Do you wear them. . .? (*Interviewer Note: Read categories.*)

- 1 Most of the time
- 2 Sometimes
- 3 For special reasons, such as reading or driving **OMESWEAR**
- 9 Never
- 8 Don't know

139. Has a doctor ever told you that you had any of the following. . .?

a. A cataract in one eye? **OMESCAT1**

1 Yes 0 No 8 Don't know 7 Refused

b. Cataracts in both eyes, at the same time? **OMESCAT2**

1 Yes 0 No 8 Don't know 7 Refused

c. Glaucoma? **OMESGLAU**

1 Yes 0 No 8 Don't know 7 Refused

d. Problems with your retina, retinopathy, or retinal disease or changes?

1 Yes 0 No 8 Don't know 7 Refused

OMESRET

e. Macular degeneration?

1 Yes 0 No 8 Don't know 7 Refused

OMESMACD



140. At the present time, would you say your eyesight (with glasses or contact lenses, if you wear them) is excellent, good, fair, poor, or very poor or are you completely blind?
(Interviewer Note: Read categories. OPTIONAL Show card #30.)

- 1 Excellent
- 2 Good
- 3 Fair
- 4 Poor
- 5 Very poor
- 6 Completely blind
- 8 Don't know
- 7 Refused

OMESQUAL

141. How much of the time do you worry about your eyesight?
(Interviewer Note: Read categories. OPTIONAL - Show card #31.)

- 1 None of the time
- 2 A little of the time
- 3 Some of the time
- 4 Most of the time
- 5 All of the time
- 8 Don't know
- 7 Refused

OMESWORY

The next questions are about how much difficulty, if any, you have doing certain activities wearing your glasses or contact lenses if you use them.

142. Wearing glasses or contact lenses if you use them, how much difficulty do you have reading ordinary print in newspapers? Would you say you have. . .?

(Interviewer Note: Read categories. OPTIONAL - Show card #32.)

- 1 No difficulty at all
- 2 A little difficulty
- 3 Moderate difficulty
- 4 Extreme difficulty
- 5 Stopped doing it because of your eyesight
- 6 Stopped doing it for other reasons or not interested in doing this
- 8 Don't know
- 7 Refused

OMESREAD

143. How much difficulty do you have doing work or hobbies that require you to see well up close, such as cooking, sewing, fixing things around the house, or using hand tools? Would you say. . .

(Interviewer Note: Read categories as needed. OPTIONAL - Show card #32.)

- 1 No difficulty at all
- 2 A little difficulty
- 3 Moderate difficulty
- 4 Extreme difficulty
- 5 Stopped doing it because of your eyesight
- 6 Stopped doing it for other reasons or not interested in doing this
- 8 Don't know
- 7 Refused

OMESSWUC

144. Because of your eyesight, how much difficulty do you have recognizing people you know from across a room? (*Interviewer Note: Read categories as needed. OPTIONAL - Show card #33.*)

1 No difficulty at all

2 A little difficulty

3 Moderate difficulty

4 Extreme difficulty

8 Don't know

7 Refused

OMESRECG

145. The next question is about daily activities that may be affected by your vision, such as your job, housework, child care, school, or community activities.

Are you limited in the kinds or amount of work or other activities you can do?
(*Interviewer Note: Read categories. OPTIONAL - Show card #34.*)

1 All of the time

2 Most of the time

3 Some of the time

4 A little of the time

5 None of the time

8 Don't know

7 Refused

OMESACT

146. Now, I'd like to ask about driving a car. Are you currently driving, at least once in a while?

1 Yes **0** No **8** Don't know **7** Refused **OMESCAR**

Have you ever driven a car?

1 Yes **0** No **8** Don't know **OMESDRIV**

Go to Question #148

Go to Question #147

How much difficulty do you have driving during the daytime in familiar places?
Would you say you have. . . ?

(Interviewer Note: Read categories. OPTIONAL - Show card #35.)

- 1** No difficulty at all
- 2** A little difficulty
- 3** Moderate difficulty
- 4** Extreme difficulty
- 5** Stopped doing it because of your eyesight
- 6** Stopped doing it for other reasons or not interested in doing this
- 8** Don't know

OMESDDD

Go to Question #148

147. When did you stop driving?

1 Less than 6 months ago

2 6-12 months ago

3 More than 12 months ago

8 Don't know

OMESSTOP

a. Did you stop driving because of your eyesight?

1 Yes

0 No

8 Don't know **OMEBSITE**

Did you stop driving for health or for some other reason?

1 Health *(Please specify:)*

2 Other reason *(Please specify:)*

8 Don't know

OMESSDOR

Go to Question #148



HEARING

148. Do you wear a hearing aid?

- 1 Yes 0 No 8 Don't know 7 Refused **OMHHAID**

Do you wear it...? *(Interviewer Note: Read response options.)*

- 1 Most of the time
 2 Some of the time
 3 A little of the time
 8 Don't know

OMHWEAR

149. Can you hear well enough (with a hearing aid if necessary) to carry on a conversation in a crowded room?

- 1 Yes 0 No 8 Don't know 7 Refused **OMHCONV**

150. Do you feel that any difficulty with your hearing limits or hampers your personal or social life?

- 1 Yes 0 No 8 Don't know 7 Refused **OMHDIF**



151. Is there any other illness or condition for which you see a doctor or other health care professional?

1 Yes

0 No

8 Don't know

7 Refused **OMCONDR**

Please go to Question #152

Please describe for what:



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HQID

HQACROS

HEALTH CARE

152. Do you have a doctor or place that you usually go to for health care or advice about your health care?

1 Yes **0** No **8** Don't know **7** Refused **HQHCADV**

Go to Question #153

a. Where do you usually go to for health care or advice about health care?
(Interviewer Note: Read response options. Please check only one.)

1 Private doctor's office (individual or group practice)

2 Public clinic such as a neighborhood health center

3 Health Maintenance Organization (HMO)

HQHC SRC

4 Hospital outpatient clinic

5 Emergency room

6 Other (Please specify:)

b. Please tell me the name, address, and telephone number of the doctor or place that you usually go to for health care.

First Name

Last Name

Street Address

City

State

HQHC ZIP

Zip Code

Telephone:

()

Area Code

-

Number

HQHCTEL



153. In addition to Medicare, are you currently covered by any other federal government health insurance programs such as Medicaid, CHAMPUS/VA or other military programs?

1 Yes **0** No **8** Don't know **7** Refused **HQFEDINS**

Go to Question #154

What federal government health insurance program are you covered by?

- 1** Medicaid (TennCare in Tennessee)
- HQINPROG 2** CHAMPUS or CHAMP-VA (health insurance for family members of military personnel)
- 3** Other (*Please specify:*)

154. In addition to Medicare, do you have a health insurance plan, Medigap, or other supplemental coverage which pays for any part of a hospital, doctor's or surgeon's bill?

1 Yes **0** No **8** Don't know **7** Refused **HQSUPCOV**

Go to question #155

What type of health insurance do you have?
(*Interviewer Note: Please record all types below.*)

- 1** Private insurance (Examples: Blue Cross, Prudential) **HQPRIVIN**
(*Please specify:*) _____
- 1** Health Maintenance Organization (sometimes referred to as an HMO) **HQHMO**
(*Please specify:*) _____
- 1** Medigap **HQMGP**
- 1** Other **HQINOTH**
(*Please specify:*) _____



155. In addition to Medicare, do you have any health insurance plan that pays for prescription medicines?

1 Yes **0** No **8** Don't know **7** Refused **HQINMED**

We would like to understand how people's medical history and use of health care may change as they age. We need to obtain information about health care costs and diagnoses for statistical purposes. The best place to get this information without taking up a lot more of your time is in the Medicare files. We would like to record your Medicare number and Social Security number for that purpose. The information we collect will be kept strictly confidential and will be used for research purposes only.

156. What is your Medicare number?

HQMEDNUM

- - -

HQMEDREF

-1 Refused

157. What is your Social Security number?

HQSSN

- -

HQSSNREF

-1 Refused



158. Beside yourself, how many other people live in your household?
If no other people live in the household, record "00" and go to Question # 160.

HQSSOPIH other people in household HQSSOPRF Refused

159. Who else lives in your household?
(Interviewer Note: Fill in number of people in each category.)

HQSSPOUS Spouse Grandchildren HQSSGRCH
 HQSSPARE Parents Other relatives HQSSOTRL
 HQSSIBL Siblings Friends HQSSFRND
 HQSSCHIL Children/Children-in-law HQSSNONR Other non-relatives HQSSHREF Refused

160. Who is the head of household?

- Self
- Spouse
- Child/Child-in-law HQSSHEAD
- Other
- Refused

161. In a typical week, how often do you get together with friends or neighbors? Would you say...
(Interviewer Note: Read response options. REQUIRED - Show card #36.)

- At least once a day Less than once per week
- 4 to 6 times per week Don't know
- 2 to 3 times per week Refused HQSSFRNE
- 1 time per week

162. In a typical week, how often do you get together with your children or other relatives?
 Would you say... *(Interviewer Note: Read response options. REQUIRED - Show card #36.)*

- At least once a day Less than once per week
- 4 to 6 times per week Don't know
- 2 to 3 times per week Refused HQSSCHRE
- 1 time per week



163. About how many relatives do you see or hear from at least once a month?
Please include children, in-laws, etc.

HQSSRC1M relatives **HQSSRCDR**
 88 Don't know **77** Refused

164. For the one relative that you see or hear from most, how often do you see or hear from that person? Would you say... (*Interviewer Note: Read response options. REQUIRED - Show card #37.*)

- | | |
|--|--|
| <input type="checkbox"/> 1 Less than once a month | <input type="checkbox"/> 5 A few times a week |
| <input type="checkbox"/> 2 About once a month | <input type="checkbox"/> 6 Almost every day |
| <input type="checkbox"/> 3 2 to 3 times a month | <input type="checkbox"/> 8 Don't know |
| <input type="checkbox"/> 4 About every week | <input type="checkbox"/> 7 Refused |
- HQSSRCX**

165. About how many relatives do you feel close to, feel at ease with, can talk to about private matters, and can call on for help?

HQSSRCLO relatives **HQSSRD**
 88 Don't know **77** Refused

166. About how many friends do you feel close to, feel at ease with, can talk to about private matters, and can call on for help?

HQSSFCLO friends **HQSSDR**
 88 Don't know **77** Refused

167. About how many of these friends do you see or hear from at least once a month?

HQSSFC1M friends **HQSSFDR**
 88 Don't know **77** Refused

168. For the one friend that you see or hear from most, how often do you see or hear from that person? Would you say... *(Interviewer Note: Read response options. REQUIRED - Show card #37.)*

- 1 Less than once a month
- 2 About once a month
- 3 2 to 3 times a month
- 4 About every week
- 5 A few times a week
- 6 Almost every day
- 8 Don't know
- 7 Refused

HQSSFCX

169. When you have an important decision to make, do you have someone you can talk to about it? Would you say... *(Interviewer Note: Read response options. OPTIONAL - Show card #38.)*

- 1 Always or very often
- 2 Sometimes
- 3 Seldom
- 4 Never
- 8 Don't know
- 7 Refused

HQSSIDOP

170. When other people you know have an important decision to make, do they talk to you about it? Would you say... *(Interviewer Note: Read response options. OPTIONAL - Show card #38.)*

- 1 Always or very often
- 2 Sometimes
- 3 Seldom
- 4 Never
- 8 Don't know
- 7 Refused

HQSSOPID

171. Does anybody rely on you to do something for them each day, like shopping, cooking, cleaning, repairs, child care, etc?

- 1 Yes
- 0 No
- 7 Refused

HQSSRELY

Do you help anybody with things like shopping, house cleaning, cooking, providing child care, filling out forms, etc.? *(Interviewer Note: Read response options. OPTIONAL - Show card #38.)*

- 1 Always or very often
- 2 Sometimes
- 3 Seldom
- 9 Never

HQSSHELP



172. In the past year, could you have used more emotional support than you received?

1 Yes 0 No 8 Don't know 7 Refused **HQSSSPY**

Would you say you needed a lot more, some more, or a little more?

1 A lot more
 2 Some more **HQSSEAM**
 3 A little more
 8 Don't know

173. Using this card, where 0 is extremely dissatisfied and 10 is very satisfied, how satisfied are you with how often you see or talk to your family and friends?
(Interviewer Note: REQUIRED - Show card #39.)

HQSSFFST 88 Don't know 77 Refused **HQSSFFDR**

174. Using this card, where 0 is extremely dissatisfied and 10 is very satisfied, how satisfied are you with the help you get from your family and friends, for example, helping in an emergency, fixing your house, or doing errands? *(Interviewer Note: REQUIRED - Show card #39.)*

HQSSFFH 88 Don't know 77 Refused **HQSFHDR**

175. Using this card, where 0 is extremely dissatisfied and 10 is very satisfied, how satisfied are you with the meaning and purpose of your life? *(Interviewer Note: REQUIRED - Show card #39.)*

HQSSMEAN 88 Don't know 77 Refused **HQSFMDR**



176. Using this card, where 0 is extremely unhappy and 10 is very happy, please tell me how happy you are? *(Interviewer Note: REQUIRED - Show card #40.)*

HQSSHAPY

--	--

88 Don't know

77 Refused **HQSSHADR**

177. Please tell me whether you agree or disagree with this statement:
I can do just about anything I really set my mind to. Would you say you agree or disagree?

1 Agree

2 Disagree

8 Don't know

7 Refused **HQSSCAN**

Would you say you agree strongly or agree somewhat?

1 Agree strongly

2 Agree somewhat

8 Don't know

HQSSCANA

Would you say you disagree strongly or disagree somewhat?

1 Disagree strongly

2 Disagree somewhat

8 Don't know

HQSSCAND

178. Do you agree or disagree with this statement: I often feel helpless in dealing with the problems of life. Would you say you agree or disagree?

1 Agree

2 Disagree

8 Don't know

7 Refused **HQSSOFH**

Would you say you agree strongly or agree somewhat?

1 Agree strongly

2 Agree somewhat

8 Don't know

HQSSOFHA

Would you say you disagree strongly or disagree somewhat?

1 Disagree strongly

2 Disagree somewhat

8 Don't know

HQSSOFHD

--



179. During the past week, have you felt nervous or shaky inside?

1 Yes 0 No 8 Don't know 7 Refused **HQSSNRVS**

How nervous or shaky have you felt? Would you say a little, quite a bit, or extremely nervous and shaky inside?

1 A little
 2 Quite a bit
 3 Extremely
 8 Don't know

HQSSNDEG

180. During the past week, have you felt tense or keyed up?

1 Yes 0 No 8 Don't know 7 Refused **HQSSTENS**

How much have you felt tense or keyed up? Would you say a little, quite a bit, or extremely tense or keyed up?

1 A little
 2 Quite a bit
 3 Extremely
 8 Don't know

HQSSTDEG

181. During the past week, have you felt fearful?

1 Yes 0 No 8 Don't know 7 Refused **HQSSFEAR**

How much have you felt fearful? Would you say a little, quite a bit, or extremely fearful?

1 A little
 2 Quite a bit
 3 Extremely
 8 Don't know

HQSSFDEG

182. What is your religious preference?

- 1 Catholic
- 2 Jewish
- 3 Protestant
- 4 None
- 5 Other (Please specify): _____
- 8 Don't know
- 7 Refused

HQRRELIG

183. How often do you usually attend religious services, meetings or activities?
(Interviewer Note: **OPTIONAL - Show card #41.**)

- 1 Never
- 2 A few times a year
- 3 One to three times per month
- 4 Once per week
- 5 Two to three times per week
- 6 Nearly every day
- 8 Don't know
- 7 Refused

HQRSRVCS

184. How important is your spirituality or religious faith to you? Would you say...
(Interviewer Note: **Read response options.**)

- 1 Not important
- 2 Somewhat important
- 3 Important
- 4 Very important
- 8 Don't know
- 7 Refused

HQRFAITH



LPID

LPACROS

CES-D

185. Now I have some questions about your feelings during the past week. For each of the following statements, please tell me if you felt that way: Rarely or None of the time; Some of the time; Much of the time; Most or All of the time. *(Interviewer Note: REQUIRED - Show card #42.)*

	Rarely or None of the time (<1 day)	Some of the time (1-2 days)	Much of the time (3-4 days)	Most or All of the time	Don't know	Refused
a. I was bothered by things that usually don't bother me. LPFBOTHR	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="8"/>	<input type="text" value="7"/>
b. I did not feel like eating: my appetite was poor. LPFEAT	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="8"/>	<input type="text" value="7"/>
c. I felt that I could not shake off the blues even with help from my family and friends. LPFBLUES	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="8"/>	<input type="text" value="7"/>
d. I felt that I was just as good as other people. LPFGOOD	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="8"/>	<input type="text" value="7"/>
e. I had trouble keeping my mind on what I was doing. LPFMIND	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="8"/>	<input type="text" value="7"/>
f. I was depressed. LPFDOWN	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="8"/>	<input type="text" value="7"/>
g. I felt that everything I did was an effort. LPFEFFRT	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="8"/>	<input type="text" value="7"/>
h. I felt hopeful about the future. LPFHOPE	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="8"/>	<input type="text" value="7"/>
i. I thought my life had been a failure. LPFFAIL	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="8"/>	<input type="text" value="7"/>
j. I felt fearful. LPFFEAR	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="8"/>	<input type="text" value="7"/>
k. My sleep was restless. LPFSLEEP	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="8"/>	<input type="text" value="7"/>
l. I was happy. LPFHAPPY	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="8"/>	<input type="text" value="7"/>
m. It seemed that I talked less than usual. LPFTALK	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="8"/>	<input type="text" value="7"/>
n. I felt lonely. LPFLONE	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="8"/>	<input type="text" value="7"/>
o. People were unfriendly. LPFUNFR	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="8"/>	<input type="text" value="7"/>
p. I enjoyed life. LPFENJOY	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="8"/>	<input type="text" value="7"/>
q. I had crying spells. LPFCRY	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="8"/>	<input type="text" value="7"/>
r. I felt sad. LPFSAD	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="8"/>	<input type="text" value="7"/>
s. I felt that people disliked me. LPFDISME	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="8"/>	<input type="text" value="7"/>
t. I could not get going. LPFNOGO	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="8"/>	<input type="text" value="7"/>

Page Link #

LPLINK

Draft



LIFE EVENTS

186. Has a close friend or family member had a serious accident or illness in the past 12 months?

Yes No Refused **LPLEACC**

187. Did your spouse or partner die in the past 12 months?

Yes No Refused **LPLESDIE**

188. Did a child, grandchild, close friend or relative die in the past 12 months?

Yes No Refused **LPLERDIE**

189. Did a pet die in the past 12 months?

Yes No Refused **LPLEPDIE**

190. Has your relationship with a family member or close friend changed for the worse in the past 12 months?

Yes No Refused **LPLEREL**

191. Have you or a family member been assaulted or robbed in the past 12 months?

Yes No Refused **LPLEROB**

192. Has a close friend or family member been arrested or had trouble with the law in the past 12 months?

Yes No Refused **LPLELAW**



193. How would you describe your primary racial or ethnic group?
(Interviewer Note: Please check only one box.)

1 Asian/Pacific Islander

2 Black/African-American

3 White/Caucasian

4 Latino/Hispanic **LPRACE**

8 Don't know

6 Other *(Please specify:)* _____

7 Refused

194. What is the highest grade or year of school that you completed?
(Interviewer Note: Please check only one box.)

LPSCHOOL

0 No formal education

10 Grade 10

1 Grade 1

11 Grade 11

2 Grade 2

12 Grade 12

3 Grade 3

13 Vocational/tradeschool **WITHOUT**
high school or the GED

4 Grade 4

14 Vocational/trade school **AFTER** high school

5 Grade 5

15 Some college/Associate degree

6 Grade 6

16 College graduate (4 or 5 year program)

7 Grade 7

17 Master's degree (or other post-graduate training)

8 Grade 8

18 Doctoral degree
(PhD, MD, EdD, DVM, DDS, JD, etc.)

9 Grade 9

77 Refused



FINANCES AND INCOME

The next set of questions deals with income and family economic situations. Health ABC is a study of health but research shows that income and resources can affect health in ways that are sometimes important and surprising. We are asking a few questions for this reason.

195. The following question refers to your personal family income for the last year including all sources such as wages, salaries, Social Security or retirement benefits, help from relatives, rent from property and so forth.

Was it more than \$25,000?

1 Yes 0 No 8 Don't know 7 Refused **LPFIIN25**

\$10,000 or more? **LPFIIN10**

1 Yes 0 No 8 Don't know 7 Refused

a. \$50,000 or more? **LPFIIN50**

1 Yes 0 No 8 Don't know 7 Refused

b. \$100,000 or more? **LPFIINC**

1 Yes 0 No 8 Don't know 7 Refused

196. (*Interviewer Note: ASK THE FOLLOWING QUESTION ONLY IF THE PARTICIPANT LIVES IN A HOUSE.*) Do you (and your husband/wife/partner) own this house and the land immediately surrounding it?

1 Yes 0 No 8 Don't know 7 Refused **LPFIOWN**

Go to question #198

The following question refers to your house and the land immediately surrounding it. What is its present value? I mean, about what would it bring if it were sold today?

Is it more than \$100,000?

1 Yes 0 No 8 Don't know 7 Refused **LPFIVALU**

\$200,000 or more?

1 Yes
 0 No
 8 Don't know
 7 Refused

LPFIV200

\$50,000 or more?

1 Yes
 0 No
 8 Don't know
 7 Refused

LPFIV50



198. How well does the amount of money you (and your husband/wife/partner) have take care of your needs -- poorly, fairly well, or very well?

- 1 Poorly
- 2 Fairly well
- 3 Very well **LPFIFIN**
- 8 Don't know
- 7 Refused

199. Do you always have enough money to buy the food that you need?

- 1 Yes
- 0 No
- 8 Don't know
- 7 Refused **LPFIPOOD**

200. Are you receiving any free or subsidized food, such as food stamps or Meals on Wheels?

- 1 Yes
- 0 No
- 8 Don't know
- 7 Refused **LPFISUBF**

Please describe:



201. In general, how do your finances usually work out at the end of the month? Do you find that you usually end up with some money left over, just enough to make ends meet, or not enough money to make ends meet?

- 1 Some money left over
- 2 Just enough to make ends meet
- 3 Not enough to make ends meet **LPFIADQ**
- 8 Don't know
- 7 Refused

202. Our last question in this area involves savings and investments which may play an important part of family economic situations and may have an impact on health care. Please tell me if you (and your husband/wife/partner) own any of the following:

	Yes	No	Don't Know	Refused
a) Checking or savings account LPFICASA	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 8	<input type="checkbox"/> 7
b) Money market account LPFIMMA	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 8	<input type="checkbox"/> 7
c) CDs (Certificates of deposit), Savings Bonds, or Treasury Bills LPFICD	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 8	<input type="checkbox"/> 7
d) Investment property or housing other than where you currently live LPFIIP	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 8	<input type="checkbox"/> 7
e) A business or farm which you own LPFIBUS	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 8	<input type="checkbox"/> 7
f) Stock or stock mutual funds LPFIMF	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 8	<input type="checkbox"/> 7
g) An IRA or a KEOGH account LPFIIRA	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 8	<input type="checkbox"/> 7
h) Other investments LPFIOTI	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 8	<input type="checkbox"/> 7



BASELINE CLINIC VISIT WORKBOOK

HCFA Screening ID #	HABC Enrollment ID #	Acrostic	Date Form Completed	Staff ID #																																																																																																			
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Examiner Note: Write the HCFA Screening ID # in the boxes and fill in the circles below that correspond to these numbers. The circles are the scannable portions of this field, so it is essential that they are filled in.

Time of arrival: : P1TIME1

Time of departure: : P1TIME2

What is the status of the clinic visit?

Clinic visit completed

P1CKLST Clinic visit completed **except** for CT

Incomplete visit

Memphis Only:

Would you like us to send a copy of your test results to your doctor? P1DOC Yes No

P1LINK



Staff ID #		

BASELINE CLINIC VISIT PROCEDURE CHECKLIST

	Page Numbers	Please check if done		Comments
1. ECG Tracking	3	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 0 No	P1ECG
2. Phlebotomy	4	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 0 No	P1PHL
3. Oral Glucose Tolerance	5	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 0 No	P1OGTT
4. Laboratory Processing	6	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 0 No	P1LAB
5. Medication Inventory	7-11	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 0 No	P1MI
6. Standing Height	12	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 0 No	P1SH
7. Sitting Height	12	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 0 No	P1SIT
8. Sagittal Diameter	12	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 0 No	P1SD
9. Weight	12	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 0 No	P1WT
10. Blood Pressure	13	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 0 No	P1BP
11. Ankle-Arm Blood Pressure	14	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 0 No	P1AAP
12. Pulse Wave Velocity	15	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 0 No	P1APW
13. Side to Measure Assessment	16	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 0 No	P1SM
14. Isokinetic Strength (Kin-Com)	P1ISO 17-18	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Right leg <input type="checkbox"/> 2 Left leg
15. Bone Density Scan (DXA)	P1DXA 19-20	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Right leg <input type="checkbox"/> 2 Left leg
16. Thigh Circumference	P1THI 21	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Right leg <input type="checkbox"/> 2 Left leg
17. Abdominal Circumference	21	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 0 No	P1AB
18. Chair Stands	22-23	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 0 No	P1CH
19. Standing Balance	24-25	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 0 No	P1SB
20. Balance Walks	26	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 0 No	P1BAL
21. Long Distance Corridor Walk	27-31	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 0 No	P1LD
22. Teng Mini-Mental State	32-39	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 0 No	P1TENG
23. Digit Symbol Substitution	40-42	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 0 No	P1DIG
24. Grip Strength	43	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 0 No	P1GRIP
25. Finger Tapping	44	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 0 No	P1TAP
26. Pulmonary Function	45	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 0 No	P1PUL
27. CT	P1CT 46	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Right Thigh <input type="checkbox"/> 2 Left Thigh P1CTRL



--	--	--

1 Was an ECG obtained? 1 Yes 0 No P1OBT



Why wasn't an ECG obtained?

1 Equipment failure

2 Participant unable to understand instructions

4 Participant unable to physically cooperate P1WN

7 Participant refused

6 Other (*Please specify:*)

2 Was a hard copy of the ECG with no interpretation printed before the participant left?

1 Yes 0 No P1NOINT

3 Was a hard copy of the ECG with interpretation printed before the participant left?

1 Yes 0 No P1WINT

4 Was there any protocol deviation(s)?

1 Yes 0 No P1PRODV

Please describe:

--

PHLEBOTOMY

Bar Code Label

P1BRCDX

Staff ID #

--	--	--

P1STFID4

1 Do you bleed or bruise easily?

P1BLBR Yes No Don't know

2 Have you ever been told you have a disorder relating to blood clotting or coagulation?

P1BCT Yes No Don't know

3 Have you ever experienced fainting spells while having blood drawn?

P1FNT Yes No Don't know

4 Time at start of venipuncture?

P1VTM : am pm

Hours Minutes **P1AMPM2**

Was any blood drawn?

Yes No **P1BLDR**

↓

Please describe why not?

- Do NOT administer OGTT.
- Check N/A box next to #46 on Laboratory Processing Form.

5 Time blood draw completed:

P1BLDRTM : am pm

Hours Minutes **P1AMPM3**

6 Total tourniquet time:
(If tourniquet was reapplied, enter total time tourniquet was on. Note that 2 minutes is optimum.)

minutes **P1TOUR**

Comments on phlebotomy:

7 Quality of venipuncture:

Clean Traumatic **P1QVEN**

<input type="checkbox"/> Vein collapse	<input type="checkbox"/> Excessive duration of draw
<input type="checkbox"/> Hematoma	<input type="checkbox"/> Leakage at venipuncture site
<input type="checkbox"/> Vein hard to get	<input type="checkbox"/> Other <i>(Please specify:)</i>
<input type="checkbox"/> Multiple sticks	P1TRM

8 Were tubes filled to specified capacity? If not, comment why.

Blood Volume/Tube	Filled to Capacity?	Yes No		Comment
		Yes	No	
1. Serum 10ml	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	→ P1BV1
2. EDTA 10ml	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	→ P1BV2
3. SCAT-I 5ml	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	→ P1BV3
4. Citrate 4.5ml	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	→ P1BV4
5. Serum 10ml	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	→ P1BV5
6. Serum 10ml	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	→ P1BV6
9. Extra Serum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	→ P1BV9
7. EDTA 10ml	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	→ P1BV7
10. Extra EDTA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	→ P1BV10
Urine:				
1. Urine (15-20ml)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	→ P1BV8

9 What is the date and time you last ate or drank anything except water?

a. Date of last meal:

/ **P1LMD**

Month Day

b. Time of last meal:

P1MHM : am pm

Hours Minutes **P1LMAPM**

c. How many hours has participant fasted?

P1FAST hours **(Question 5 minus Question 9b. Round down to nearest hour)**

If less than 8 hours, do NOT administer OGTT, but draw blood.

LCBR Use only: Received Date: _____ Time: _____

Frozen? Yes No

Draft



Staff ID #		
P1STFID5		

1 Has a doctor ever told you that you have diabetes or sugar diabetes?

1 Yes **0** No **8** Don't know **P1DIAB**

Do you take insulin or oral hypoglycemic medications to control your diabetes? (Refer to the list to the right) **P1INOH**

1 Yes, insulin **2** Yes, oral hypoglycemics **0** No **8** Don't know

Check N/A box next to cryovial #26 on Laboratory Processing Form.

Do NOT administer OGTT.

Verify from Baseline Health Questionnaire Q#116 or Medication Inventory Form

Oral Hypoglycemics

Generic Name	Trade Name
Tolbutamide	Orinase
Acetohexamide	Dymelor
Tolazamide	Tolinase
Chloropropamide	Diabinese
Glipizide	Glucotrol
Glyburide	Diabeta, Micronase
Metformin	Glucophage
Acarbose	Precose
Glicazide	Diamicron
Glimepride	Amaryl
Troglitazone	Rezulin

2 Was the glucose tolerance test done?

P1GLU **1** Yes **0** No → Check N/A box next to cryovial #46 on Laboratory Processing Form.

Why wasn't the glucose tolerance test done?

- 1** Exclusion criteria (above)
- 2** Participant refused
- 3** Could not tolerate glucola **P1GLUNO**
- 4** No initial blood sample
- 5** Other (Please specify:)

3 Time glucose administered (first sip):

P1GLTM [] [] : [] [] **P1GLAPM**
Hours Minutes

1 am
2 pm

Add 2 hours to time glucose administered.

Time blood draw due:

[] [] : [] [] **P1GLBD**
Hours Minutes

4 Was entire glucose drink consumed?

1 Yes

P1GLDRK **2** No, but more than half

3 No, less than half - cancel 2-hour blood draw

Check N/A box next to cryovial #46 on Laboratory Processing Form.

5 Time glucose tolerance blood drawn:

P1GTBD [] [] : [] [] **P1GTAPM**
Hours Minutes

1 am
2 pm



LABORATORY PROCESSING

Staff ID #

--	--	--

P1STFID6

Bar Code Label

P1BRCD2

P1TIME

Time at start of processing:

--	--	--	--

① am
② pm

P1AMPM

Collection Tubes	Cryo #	Vol.	Type	To	Check "X"	Problems P101HP	Collection Tubes	N/A	Cryo #	Vol.	Type	To	Check "X"	Problems P125HP
#2 Whole blood	01	0.5	W/0.5	L	P101X -1	1 H 2 P	#1,5,6,9 Serum		25	0.5	R/0.5	L	P125X -1	1 H 2 P
#2, 7, (10) EDTA	02	1.0	W/2.0	L	P102X	H P	P126NA -1		26	0.5	R/0.5	L	P126X	H P
	03	0.5	W/0.5	M	P103X	H P			27	0.5	R/0.5	M	P127X	H P
	04	0.5	W/0.5	M	P104X	H P			28	0.5	R/0.5	M	P128X	H P
	05	0.5	W/0.5	M	P105X	H P			29	0.5	R/0.5	M	P129X	H P
	06	1.0	W/2.0	M	P106X	H P			30	0.5	R/0.5	M	P130X	H P
	07	1.0	W/2.0	M	P107X	H P			31	0.5	R/0.5	M	P131X	H P
	08	1.0	W/2.0	M	P108X	H P			32	0.5	R/0.5	M	P132X	H P
	09	1.0	W/2.0	M	P109X	H P			33	0.5	R/0.5	M	P133X	H P
	10	0.5	W/0.5	M	P110X	H P			34	1.0	R/2.0	M	P134X	H P
	11	0.5	W/0.5	M	P111X	H P			35	1.0	R/2.0	M	P135X	H P
	12	0.5	W/0.5	M	P112X	H P			36	1.0	R/2.0	M	P136X	H P
	13	0.5	W/0.5	M	P113X	H P			37	1.0	R/2.0	M	P137X	H P
	14	0.5	W/0.5	M	P114X	H P			38	1.0	R/2.0	M	P138X	H P
	#2, 7 Buffy	15	var	C/2.0	M	P115X		H P		39	1.0	R/2.0	M	P139X
#2, 7 RBC	16	2.0	W/2.0	M	P116X	H P		40	0.5	R/0.5	M	P140X	H P	
#3 SCAT-I	17	0.5	Y/0.5	M	P117X	H P		41	0.5	R/0.5	M	P141X	H P	
	18	0.5	Y/0.5	M	P118X	H P		42	0.5	R/0.5	M	P142X	H P	
	19	0.5	Y/0.5	M	P119X	H P		43	0.5	R/0.5	M	P143X	H P	
	20	0.5	Y/0.5	M	P120X	H P		44	0.5	R/0.5	M	P144X	H P	
#4 Citrate	21	0.5	B/0.5	M	P121X	H P	#8 OGTT		46	0.5	O/0.5	L	P146X	H P
	22	0.5	B/0.5	M	P122X	H P	P146NA -1		47	2.0	V/2.0	M	P147X	H P
	23	0.5	B/0.5	M	P123X	H P	URINE		48	2.0	V/2.0	M	P148X	H P
	24	0.5	B/0.5	M	P124X	H P	(acidified)		49	2.0	G/2.0	M	P149X	H P

L=LCBR; M=McKesson; H=Hemolyzed; P=Partial; W=white; C=clear; Y=yellow; B=blue; R=red; O=orange; V=violet
G=green *DO NOT FREEZE. To be shipped separately on wet ice.

Draft

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Section B Prescription Medication -- Continued

Medication Name (Generic Name or Trade Name) Strength Units Indicate Number Used & Circle Day, Week or Month PRN? Check "X": Yes or No Container Seen? Check "X": Yes or No

	MIFNAME	MIFSTREN	MIFUNITS	MIFDWM D W M	MIFPRN Y N	MIFSEEN Y N
6.					<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N
Reason for use:	MIFREAS		MIFNMUS 1 2 3	MIFMONTH / MIFYEAR	Formulation Code: MIFFORM	<input checked="" type="checkbox"/> Rx <input type="checkbox"/> Non Rx
7.					<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use:					Formulation Code:	<input type="checkbox"/> Rx <input type="checkbox"/> Non Rx
8.					<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use:					Formulation Code:	<input type="checkbox"/> Rx <input type="checkbox"/> Non Rx
9.					<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use:					Formulation Code:	<input type="checkbox"/> Rx <input type="checkbox"/> Non Rx
10.					<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use:					Formulation Code:	<input type="checkbox"/> Rx <input type="checkbox"/> Non Rx
11.					<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use:					Formulation Code:	<input type="checkbox"/> Rx <input type="checkbox"/> Non Rx
12.					<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use:					Formulation Code:	<input type="checkbox"/> Rx <input type="checkbox"/> Non Rx

Continued on MIF Supplement

Formulation Codes

0=unidentifiable, 1=oral tablet, 2=oral capsule, 3=oral liquid, 4=topical cream, lotion, or ointment, 5=other liquid, 6=ophthalmic, 7=missing, 8=rectal or vaginal, 9=inhaled or nasal, 10=injected, 11=transdermal patch, 12=powder, 99=other

Section C Over-the-counter Medications and Supplements

Copy the name of the over-the-counter medicine, the strength in milligrams (mg) or other units, the total number of doses taken per day, week or month. Indicate whether the medication is taken on an "as needed" basis, and whether or not the container was actually seen. In addition, record reason for use, date started, and formulation code.

Medication Name (Generic Name or Trade Name)	Strength	Units	Indicate Number Used & Circle Day, Week or Month	PRN? Check "X": Yes or No	Container Seen? Check "X": Yes or No
1. <input type="text" value="MIFNAME"/>	<input type="text" value="MIF STREN"/>	<input type="text" value="MIFUNIT"/>	<input type="text" value="MIFDWM"/> D W M	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: <input type="text" value="MIFREAS"/>			Date Started: <input type="text" value="MIFNMUS"/> / <input type="text" value="MIFMONTH"/> / <input type="text" value="MIFYEAR"/>	Formulation Code: <input type="text" value="MIFFORM"/>	<input checked="" type="checkbox"/> Rx <input type="checkbox"/> Non Rx
2. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: <input type="text"/>			Date Started: <input type="text"/> / <input type="text"/> / <input type="text"/>	Formulation Code: <input type="text"/>	<input type="checkbox"/> Rx <input type="checkbox"/> Non Rx
3. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: <input type="text"/>			Date Started: <input type="text"/> / <input type="text"/> / <input type="text"/>	Formulation Code: <input type="text"/>	<input type="checkbox"/> Rx <input type="checkbox"/> Non Rx
4. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: <input type="text"/>			Date Started: <input type="text"/> / <input type="text"/> / <input type="text"/>	Formulation Code: <input type="text"/>	<input type="checkbox"/> Rx <input type="checkbox"/> Non Rx
5. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: <input type="text"/>			Date Started: <input type="text"/> / <input type="text"/> / <input type="text"/>	Formulation Code: <input type="text"/>	<input type="checkbox"/> Rx <input type="checkbox"/> Non Rx
6. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: <input type="text"/>			Date Started: <input type="text"/> / <input type="text"/> / <input type="text"/>	Formulation Code: <input type="text"/>	<input type="checkbox"/> Rx <input type="checkbox"/> Non Rx
7. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: <input type="text"/>			Date Started: <input type="text"/> / <input type="text"/> / <input type="text"/>	Formulation Code: <input type="text"/>	<input type="checkbox"/> Rx <input type="checkbox"/> Non Rx

Section C Over-the-counter Medications and Supplements (continued)

Medication Name (Generic Name or Trade Name) Strength Units Indicate Number Used & Circle Day, Week or Month PRN? Check "X": Yes or No Container Seen? Check "X": Yes or No

8. Y N Y N

Reason for use: Date Started: Month Year 1 2 3 Formulation Code: Rx Non Rx

9. Y N Y N

Reason for use: Date Started: Month Year Formulation Code: Rx Non Rx

10. Y N Y N

Reason for use: Date Started: Month Year Formulation Code: Rx Non Rx

11. Y N Y N

Reason for use: Date Started: Month Year Formulation Code: Rx Non Rx

12. Y N Y N

Reason for use: Date Started: Month Year Formulation Code: Rx Non Rx

13. Y N Y N

Reason for use: Date Started: Month Year Formulation Code: Rx Non Rx

14. Y N Y N

Reason for use: Date Started: Month Year Formulation Code: Rx Non Rx

Continued on MIF Supplement

Formulation Codes

0=unidentifiable, 1=oral tablet, 2=oral capsule, 3=oral liquid, 4=topical cream, lotion, or ointment, 5=other liquid, 6=ophthalmic, 7=missing, 8=rectal or vaginal, 9=inhaled or nasal, 10=injected, 11=transdermal patch, 12=powder, 99=other



HABC Enrollment ID # <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MAID/MIFID	Acrostic <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MAACROS	Date Form Completed MIFDATE/MADATE <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> Month Day Year	Staff ID # <input type="text"/> <input type="text"/> <input type="text"/> MASTAFF
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MEDICATION INVENTORY FORM SUPPLEMENT

Prescription and Over-the-counter Medications and Supplements

Copy the name of the prescription or over-the-counter medicine, the strength in milligrams (mg) or other units and the total number of doses taken per day, week or month.

Medication Name (Generic Name or Trade Name)	Strength	Units	Indicate Number Used & Circle Day, Week or Month	PRN? Check "X": Yes or No	Container Seen? Check "X": Yes or No
1S. <input style="width: 90%;" type="text"/> MIFNAME	<input style="width: 50%;" type="text"/> MIFSTREN	<input style="width: 50%;" type="text"/> MIFUNIT	<input style="width: 50%;" type="text"/> MIFDWM D W M MIFNMUS 1 2 3 MIFMONTH / MIFYEAR	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N MIFPRN	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N MIFSEEN
Reason for use: <input style="width: 80%;" type="text"/> MIFREAS Date Started: <input style="width: 10%;" type="text"/> / <input style="width: 10%;" type="text"/> Formulation Code: <input style="width: 10%;" type="text"/> MIFFORM <input type="checkbox"/> Rx <input checked="" type="checkbox"/> Non Rx					
2S. <input style="width: 90%;" type="text"/>	<input style="width: 50%;" type="text"/>	<input style="width: 50%;" type="text"/>	<input style="width: 50%;" type="text"/> D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: _____ Date Started: <input style="width: 10%;" type="text"/> / <input style="width: 10%;" type="text"/> Formulation Code: <input style="width: 10%;" type="text"/> <input type="checkbox"/> Rx <input type="checkbox"/> Non Rx					
3S. <input style="width: 90%;" type="text"/>	<input style="width: 50%;" type="text"/>	<input style="width: 50%;" type="text"/>	<input style="width: 50%;" type="text"/> D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: _____ Date Started: <input style="width: 10%;" type="text"/> / <input style="width: 10%;" type="text"/> Formulation Code: <input style="width: 10%;" type="text"/> <input type="checkbox"/> Rx <input type="checkbox"/> Non Rx					
4S. <input style="width: 90%;" type="text"/>	<input style="width: 50%;" type="text"/>	<input style="width: 50%;" type="text"/>	<input style="width: 50%;" type="text"/> D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: _____ Date Started: <input style="width: 10%;" type="text"/> / <input style="width: 10%;" type="text"/> Formulation Code: <input style="width: 10%;" type="text"/> <input type="checkbox"/> Rx <input type="checkbox"/> Non Rx					
5S. <input style="width: 90%;" type="text"/>	<input style="width: 50%;" type="text"/>	<input style="width: 50%;" type="text"/>	<input style="width: 50%;" type="text"/> D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: _____ Date Started: <input style="width: 10%;" type="text"/> / <input style="width: 10%;" type="text"/> Formulation Code: <input style="width: 10%;" type="text"/> <input type="checkbox"/> Rx <input type="checkbox"/> Non Rx					
6S. <input style="width: 90%;" type="text"/>	<input style="width: 50%;" type="text"/>	<input style="width: 50%;" type="text"/>	<input style="width: 50%;" type="text"/> D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: _____ Date Started: <input style="width: 10%;" type="text"/> / <input style="width: 10%;" type="text"/> Formulation Code: <input style="width: 10%;" type="text"/> <input type="checkbox"/> Rx <input type="checkbox"/> Non Rx					
7S. <input style="width: 90%;" type="text"/>	<input style="width: 50%;" type="text"/>	<input style="width: 50%;" type="text"/>	<input style="width: 50%;" type="text"/> D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: _____ Date Started: <input style="width: 10%;" type="text"/> / <input style="width: 10%;" type="text"/> Formulation Code: <input style="width: 10%;" type="text"/> <input type="checkbox"/> Rx <input type="checkbox"/> Non Rx					

HABC Enrollment ID #	Acrostic	Date Form Completed	Staff ID #
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/> Month / Day / Year	<input type="text"/> <input type="text"/> <input type="text"/>
P2ID	P2ACROS	P2DATE	P2STFID

ANTHROPOMETRY

STANDING HEIGHT

- ① Measurement 1 mm **P2SH1**
- ② Measurement 2 mm **P2SH2**
- ③ Difference between Measurement 1 & Measurement 2 mm **P2SHDF**

If difference between Measurement 1 and Measurement 2 is ≥ 4 mm, do Measurement 3 and Measurement 4

- ④ Measurement 3 mm **P2SH3**
- ⑤ Measurement 4 mm **P2SH4**
- ⑥ Is participant standing sideways due to kyphosis? Yes No **P2KYP** Staff ID#:

SITTING HEIGHT

- ① Measurement 1 **P2SI1** mm
- ② Measurement 2 **P2SI2** mm
- ③ Difference between Measurement 1 & Measurement 2 **P2SIDF** mm
- ⑤ Measurement 4 **P2SI4** mm
- ⑥ Is participant sitting sideways due to kyphosis? Yes No **P2KYP2**
- ⑦ Was the designated seat used? Yes No **P2BEN**

If difference between Measurement 1 and Measurement 2 is > 4 mm, do Measurement 3 and Measurement 4

- ④ Measurement 3 **P2SI3** mm
- ⑧ Seat Height **P2ST** mm
- P2STFID2** Staff ID#:

WEIGHT

- ① **P2WTK** . kg **P2STFID3** Staff ID#

SAGITTAL DIAMETER

- ① Measurement 1 . cm **P2SG1**
- ② Measurement 2 . cm **P2SG2**
- ③ Difference between Measurement 1 & Measurement 2 . cm **P2SGDF**

If difference between Measurement 1 and Measurement 2 is > 1.0 cm, do Measurement 3 and Measurement 4

- ④ Measurement 3 . cm **P2SG3**
- ⑤ Measurement 4 . cm **P2SG4**
- P2STFID4** Staff ID#: Draft



Staff ID #

P2STFD7

1 Cuff Size **4** Small **1** Regular **2** Large **3** Thigh **P2OCUF**

Please explain why right arm was not used:

2 Arm Used **1** Right **2** Left → **P2ARMRL**

Pulse Obliteration Level

3 Palpated Systolic **P2POPS**

--	--	--

 mmHg

** Add +30 to Palpated Systolic to obtain Maximal Inflation Level.*

Add 30*

4 Maximal Inflation Level † (MIL) †

--	--	--

 mmHg
P2POMX

† If MIL is ≥ 300 mmHg, Repeat the MIL. If MIL is still ≥ 300 mmHg, terminate blood pressure measurements.

5 Was blood pressure measurement terminated because palpated systolic ≥ 270 mmHg after second reading?

P2BPYN **1** Yes **0** No

Sitting Blood Pressure Measurement #1

6 Systolic **P2SYS**

--	--	--

 mmHg

Comments (required for missing or unusual values):

7 Diastolic **P2DIA**

--	--	--

 mmHg

Sitting Blood Pressure Measurement #2

8 Systolic **P2SY2**

--	--	--

 mmHg

Comments (required for missing or unusual values):

9 Diastolic **P2DIA2**

--	--	--

 mmHg

Standing Blood Pressure Measurement

Analyst Note: This measurement was added in August, 1997.

Examiner note:

10 Systolic **P2SY3**

--	--	--

 mmHg

a) Perform Standing Blood Pressure Measurement after participant has been standing for one minute.

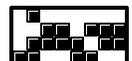
11 Diastolic **P2DIA3**

--	--	--

 mmHg

b) Record these measurements on Long Distance Corridor Walk Data Collection Form (pg. 31), in the "Before 2 Minute Walk" section, question #2.

Draft



1 Exclusion Criteria

1 Open wounds, ulcerations →

P2AADNT **2** Bilateral amputation →

3 Unable to lie at < 45 degree angle →

2 Cuff Size **P2AACF** **4** Small **1** Regular **2** Large **3** Thigh

3 Arm Used **P2AARL** **1** Right **2** Left → Please explain why right arm was not used

4 Doppler Systolic **P2AADOP** mmHg

Add 30* **Add +30 Doppler Systolic measurement to obtain maximal inflation level.*

5 Maximal Inflation Level **P2AAMX** mmHg

Systolic Measurement #1:

1 Brachial (arm) **P2AARB1** mmHg

2 Right Posterior Tibial **P2AARP1** mmHg

3 Left Posterior Tibial **P2AALP1** mmHg

Systolic Measurement #2:

4 Left Posterior Tibial **P2AALP2** mmHg

5 Right Posterior Tibial **P2AARP2** mmHg

6 Brachial (arm) **P2AARB2** mmHg

Was ankle-arm blood pressure measurement obtained?

1 Yes **2** No **P2AAPR**

Why wasn't the measurement obtained? Check all that apply.

Left Leg

- 1** Unable to occlude **P2AALLUO**
- 1** Ulceration **P2AALLUL**
- 1** Amputation **P2AALLAM**
- 1** Unable to locate tibial artery **P2AALLTA**
- 1** Other (Please specify:) **P2AALLOT**

Right Leg

- 1** Unable to occlude **P2AARLUO**
- 1** Ulceration **P2AARLUL**
- 1** Amputation **P2AARLAM**
- 1** Unable to locate tibial artery **P2AARLTA**
- 1** Other (Please specify:) **P2AARLOT**



Carotid bruit examination: Before palpating the artery, place the bell of a stethoscope over the artery close to the angle of the jaw. If a bruit is noted (the rushing sound produced by the turbulent blood flow) there is a distinct likelihood that there is a significant carotid plaque impairing blood flow.

1 Is there a carotid bruit? Yes No **P2CARBR**

2 Was the pulse wave velocity measurement obtained?

Yes No **P2PWV**

P2PW1EX

How many examiners performed the PWV test?

One examiner Two examiners

Why wasn't the measurement obtained? **Check all that apply.**

- Participant medically excluded **P2MEX**
- Could not locate carotid pulse **P2CARPL**
- Could not locate femoral pulse **P2FEMPL**
- Could not locate carotid or femoral pulse **P2CRFM**
- Could not obtain ECG **P2NOECG**
- Equipment down **P2EQUIP**

(Please check which equipment was down:)

- 9.5 Mhz Doppler **P295DOP**
- 8.0 Mhz Doppler **P280DOP**
- ECG **P2ECG**
- Computer **P2COMP**
- Participant refused **P2REF**
- Other *(Please specify:)* **P2OTH**



KIN-COM

DXA

1 Have you ever had an injury that has made one leg weaker than the other?

P2INYN 1 Yes 0 No → Test on right

Which side is stronger?

P2STR 1 Right 2 Left 3 Neither

Test on right unless contraindicated on Q# 2.

Test on left

Determine during testing

2 Is it difficult for you to bend or straighten your knees fully due to arthritis pain, injury, or some other condition?

P2KNEE 1 Yes 0 No → Test on right

Which side is better?

P2KNBET 1 Right 2 Left 3 Neither

Test on right

Test on left

Determine during testing

3 Have you ever had knee replacement surgery where all or part of your joint was replaced?

1 Yes, right 2 Yes, left 0 No

P2KNRP
No Kin-Com Test on right leg

P2KNL
No Kin-Com Test on left leg

P2KNDTR

Year of surgery?

Year of surgery?

P2KNDTL

Reason for surgery?
 1 Arthritis **P2RER**
 2 Fracture
 3 Other

Reason for surgery?
 1 Arthritis **P2REL**
 2 Fracture
 3 Other

Examiner Note: Is scar visible?
 1 Yes 0 No

Examiner Note: Is scar visible?
 1 Yes 0 No

P2SCR

P2SCL

1 Have you ever had hip replacement surgery where all or part of your joint was replaced?

1 Yes, right 2 Yes, left 0 No **P2HIP**

No hip BMD on right

No hip BMD on left

P2BMDRT

Year of surgery?

P2KBMLF

Year of surgery?

Reason for surgery?
 1 Arthritis **P2HPRR**
 2 Fracture
 3 Other

Reason for surgery?
 1 Arthritis **P2HPRL**
 2 Fracture
 3 Other

Examiner Note: Is scar visible?
 1 Yes 0 No

Examiner Note: Is scar visible?
 1 Yes 0 No

P2HPSR

P2HPSL

2 Have you ever fractured your hip? **P2HPFR**

1 Yes, right 2 Yes, left 0 No

No hip BMD on right

No hip BMD on left

Can KIN-COM and DXA be conducted on the same side?

(Examiner Note: Review this form.) **P2KCOX**

1 Yes 0 No 8 Don't know

1 Right (preferred)

Measure each on appropriate side

2 Left

P2RL

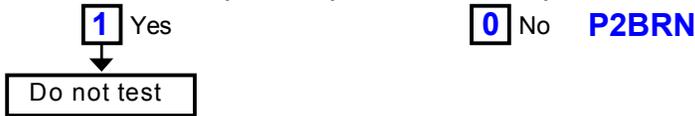


EXCLUSION CRITERIA

Does the participant's blood pressure exceed 199 mmHg (systolic) or 109 (diastolic) mmHg?
(Examiner Note: Refer to Blood Pressure Form.)



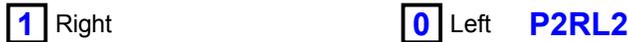
Has a doctor ever told you that you had an aneurysm in the brain or have had a stroke?



Manual Test

Examiner Note: Refer to Side to Measure Assessment Form to determine which side to test.

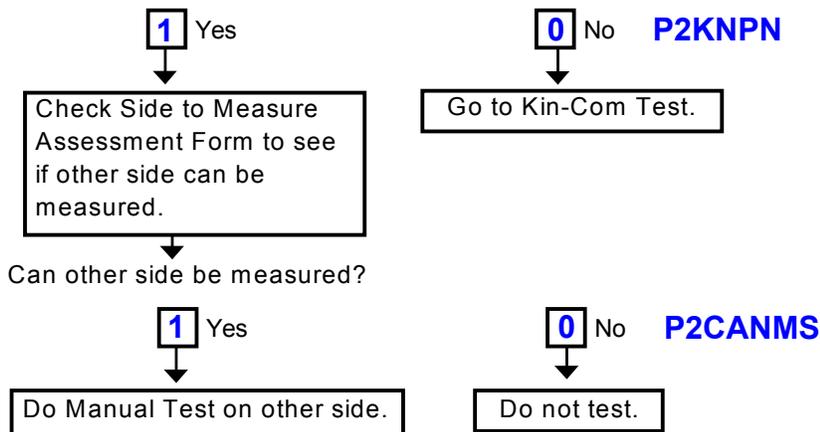
Which leg was tested?



Examiner Note: Put hands above the participant's ankle and ask the participant to press against your hands. Keep your elbows extended and use the weight of your upper body to resist the push.

After having tried the movement, the participant should be asked:

Script: "Did you have pain in your knee that stopped you from pushing hard?"



Kin Com Test

Which leg was tested?

1 Right

0 Left

3 Test not done **P2RL3**

1. How many trials were attempted?
 trials **P2TRAT**

2. How many trials were accepted?
 accepted **P2TRAC**

3. Peak Torque
 Nm **P2PKTORQ**

4. Average Torque
 Nm **P2AVTORQ**

Why was the test not done?
(Check all that apply)

-1 Blood pressure exclusions **P2BP**

-1 Kneereplacement **P2KR**

-1 Knee pain **P2KP**

-1 Participantrefused **P2KPRF**

-1 Other *(Please specify:)* **P2OTEX**

Manual Positioning Settings

a. Dynamometer tilt **P2DTLT** °

b. Dynamometer rotation **P2DROT** °

c. Lever arm green C stop **P2LEVGR**

d. Lever arm red D stop **P2LEV RD**

e. Seat rotation **P2STROT** °

f. Seat back angle **P2STBK** °

g. Seat bottom depth **P2STBOT** cm

h. Seat bottom angle **P2STBOTA** °

Maximum isometric effort to determine starting force ÷ **2** = → *Enter as Start Forward Force*
P2MAXFC **P2STFOR**

Was Kin Com test performed after the 2-hour blood draw?

1 Yes

0 No **P2KCDN**



Staff ID #			
<table border="1"><tr><td> </td><td> </td><td> </td></tr></table>			

P2STID11

1 Visit type:

Baseline clinic visit
P2VT

Non-routine clinic visit **Reason:** _____

2 Review Side to Measure Assessment Form to determine which hip to scan.

a. Has the participant had knee or hip replacement?

Yes No **P2JR2**

Indicate side & location on next page, section 5.

b. "Have you had any other joint replacement, such as shoulder, elbow?"

Yes No **P2JR**

Indicate side & location on next page, section 5.

3 "Do you have any metal objects in your body, such as a pacemaker, staples, screws, plates, etc.?"

Yes No **P2MO**

◆ Indicate side & location in the table on next page
◆ Flag scan for review by DXA Reading Center

4 "Do you have breast implants?"

Yes No **P2BI**

◆ Flag scan for review by DXA Reading Center

5 Indicate in the table below the location of joint replacement, hardware or other artifacts (sub regions are those defined by the whole body scan analysis.)

Sub	Hardware	Other Artifacts	Comments
Head	<input checked="" type="checkbox"/> 1	<input checked="" type="checkbox"/> 2 P2HEAD	_____
Left arm	<input checked="" type="checkbox"/> 1	<input checked="" type="checkbox"/> 2 P2LA	_____
Right arm	<input checked="" type="checkbox"/> 1	<input checked="" type="checkbox"/> 2 P2RA	_____
Left ribs	<input checked="" type="checkbox"/> 1	<input checked="" type="checkbox"/> 2 P2LR	_____
Right ribs	<input checked="" type="checkbox"/> 1	<input checked="" type="checkbox"/> 2 P2RR	_____
Thoracic spine	<input checked="" type="checkbox"/> 1	<input checked="" type="checkbox"/> 2 P2TS	_____
Lumbar spine	<input checked="" type="checkbox"/> 1	<input checked="" type="checkbox"/> 2 P2LS	_____
Pelvis	<input checked="" type="checkbox"/> 1	<input checked="" type="checkbox"/> 2 P2PEL	_____
Left leg	<input checked="" type="checkbox"/> 1	<input checked="" type="checkbox"/> 2 P2LL	_____
Right leg	<input checked="" type="checkbox"/> 1	<input checked="" type="checkbox"/> 2 P2RL4	_____

6 "Have you had any of the following tests within the past ten days?"

	Yes	No
a. Barium enema	<input checked="" type="checkbox"/> 1 *	<input type="checkbox"/> 0 P2BE
b. Upper GI X-ray series	<input checked="" type="checkbox"/> 1 *	<input type="checkbox"/> 0 P2UGI
c. Lower GI X-ray series	<input checked="" type="checkbox"/> 1 *	<input type="checkbox"/> 0 P2LGI
d. Nuclear medicine scan	<input checked="" type="checkbox"/> 1 *	<input type="checkbox"/> 0 P2NUKE
e. Other tests using contrast ("dye") or radioactive materials	<input checked="" type="checkbox"/> 1 *	<input type="checkbox"/> 0 P2OTH2

** (If yes to any, reschedule bone density measurement so that at least 10 days will have passed since the tests were performed.)*

7 Was a bone density measurement obtained for...?

QDR4500

a. Whole Body Yes No **P2WB**

Last 2 digits of scan ID# **P2SCAN1**

b. Hip Yes No **P2HIP2**

Right Left **P2RLHIP**
Last 2 digits of scan ID# **P2SCAN2**

QDR 1500

c. Whole Body Yes No **P2WB2**

Last 2 digits of scan ID# **P2SCAN3**

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HABC Enrollment ID #	Acrostic	Date Form Completed
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
P3ID	P3ACROS	P3DATE Month Day Year

THIGH AND ABDOMINAL CIRCUMFERENCE

THIGH CIRCUMFERENCE

① Which thigh was measured? 1 Right 2 Left **P3THRL**

② Distance between inguinal crease and proximal border of the patella **P3THDI** . cm $\div 2 =$ Midpoint: **P3THPA** . cm

③ Measurement 1 . cm **P3TH1**

④ Measurement 2 . cm **P3TH2**

⑤ Difference between Measurement 1 & Measurement 2 **P3THDF** . cm \rightarrow If difference between Measurement 1 and Measurement 2 is > 1.0 cm, do Measurement 3 and Measurement 4

⑥ Measurement 3 . cm **P3TH3**

⑦ Measurement 4 . cm **P3TH4** Staff ID#: **P3STFID5**

ABDOMINAL CIRCUMFERENCE

① Measurement 1 . cm **P3AB1**

② Measurement 2 . cm **P3AB2**

③ Difference between Measurement 1 & Measurement 2 **P3ABDF** . cm \rightarrow If difference between Measurement 1 and Measurement 2 is > 1.0 cm, do Measurement 3 and Measurement 4

④ Measurement 3 . cm **P3AB3**

⑤ Measurement 4 . cm **P3AB4**

⑥ Was maximal circumference at hip level? 1 Yes 0 No **P3THAYN**

⑦ Was largest circumference obstructed? 1 Yes 0 No **P3THAYN2** Staff ID#: **P3STFID6**

P3LINK



Introductory Script:

"I'm going to ask you to try to do several different movements of your body. I will first describe and show each movement to you. Then I'd like you to try to do it. If you cannot do a particular movement or you feel it would be unsafe to try to do it, tell me and we'll move on to the next one. Let me emphasize that I would like you to try each exercise. But I don't want you to try to do any exercise that you feel might be unsafe."

"Do you have any problems from recent surgery, injury, or other health conditions that might prevent you from standing up from a chair, standing on one leg, or walking?"

P3INYN 1 Yes 0 No apparent restrictions



"I will describe each test and then we can discuss whether you should attempt it."

Impairments/Appliances: (Assessment should be made by observation, or questioning, if appropriate.)

a. Currently uses orthosis(es):

1 Yes 0 No **P3ORTH**



1 Right 2 Left *Please specify:*
P3ORTHRL _____

b. Missing limb:

1 Yes 0 No **P3ML**



1 Right 2 Left *Please specify:*
P3MLRL _____

c. Uses prosthesis:

1 Yes 0 No **P3PRO**



1 Right 2 Left *Please specify:*
P3PRORL _____

d. Paralysis of extremity or side of body:

1 Yes 0 No **P3PAR**



1 Right 2 Left *Please specify:*
P3PARRL _____



Staff ID #		

P3STFID2

SINGLE CHAIR STAND

Describe: "This is a test of strength in your legs in which you stand up from sitting without using your arms."

Demonstrate and say: "Fold your arms across your chest, like this, and stand when I say GO, keeping your arms in this position. OK?"

Test: "Ready, Go!"

7	Not attempted/refused	(Please specify: _____)
9	Unable to stand	
1	Rises using arms	
2	Stands without using arms	→ Perform repeated chair stands

P3SCS

REPEATED CHAIR STANDS

Describe: "This time, I want you to stand up five times **as quickly as you can** keeping your arms folded across your chest."

Demonstrate and say: "When you stand up, come to a full standing position each time, and when you sit down, sit all the way down each time. I will demonstrate two chair stands to show you how it is done."

Examiner Note: Rise two times as quickly as you can, counting as you sit down each time.

Test: "When I say 'Go' stand five times in a row, **as quickly as you can**, without stopping. Stand up all the way, and sit all the way down each time."

Ready, Go!"

Examiner Note: Start timing as soon as the examiner says "Go." Count: "1, 2, 3, 4, 5" as the participant sits down each time.

7	Not attempted/refused	(Please specify: _____)
1	Attempted, unable to complete 5 stands	→ Number completed P3COMP
2	Completes 5 stands	→ . Seconds to complete P3SEC

P3RCS

Unusual values?	
1 Yes	0 No P3UN
Comments: <div style="border: 1px solid black; height: 40px; margin-top: 5px;"></div>	

Draft



INTRODUCTION: "I'm going to ask you to stand in several different positions that test your balance. I'll demonstrate each position and then ask you to try to stand in each position for 30 seconds. I'll be near you to provide support, and the wall is close enough to prevent you from falling if you lose your balance. Do you have any questions?"

SEMI-TANDEM STAND

Describe: "First I would like you to try to stand with the side of the heel of one foot touching the big toe of the other foot for about 30 seconds. Please watch while I demonstrate."

Demonstrate and say: "You may put either foot in front, whichever is more comfortable. You can use your arms and body to maintain your balance. Try to hold your feet in position until I say stop. If you lose your balance, take a step like this."

Examiner Note: Allow the participant to hold onto your arm to get balanced.

Test: "Hold onto my arm while you get in position. When you are ready, let go."

Examiner Note: Start timing when the participant lets go. If the participant does not hold onto your arm, start timing when they are in position. *Optional script: "Ready, begin."*

P3STS

- 7** Not attempted/refused *(Please comment):* _____
- 1** Unable to attain position or cannot hold for at least one second → STOP standing balance test. Go to next exam.
- 2** Holds position between 1 and 29 seconds →

		.			seconds
--	--	---	--	--	---------
- 3** Holds position for 30 seconds

P3STSTM

TANDEM STAND

Describe: "Now I would like you to try to stand with the heel of one foot in front of and touching the toes of the other foot. I'll demonstrate."

Demonstrate and say: "Again, you may use your arms and body to maintain your balance. Try to hold your feet in position until I say stop. If you lose your balance, take a step, like this."

Examiner Note: Allow the participant to hold onto your arm to get balanced.

Test: "Hold onto my arm while you get in position. When you are ready, let go."

Trial 1:

P3TS1

- 7** Not attempted/refused *(Please comment):* _____
- 1** Unable to attain position or cannot hold for at least one second
- 2** Holds position between 1 and 29 seconds →

		.			P3TSTM seconds. Go to Trial 2.
--	--	---	--	--	---------------------------------------
- 3** Holds position for 30 seconds → Go to One-Leg Stand.

Perform a second trial: "Now, let's do the same thing one more time."

Trial 2:

P3TS2

- 7** Not attempted/refused *(Please comment):* _____
- 1** Unable to attain position or cannot hold for at least one second
- 2** Holds position between 1 and 29 seconds →

		.			P3TS2TM seconds
--	--	---	--	--	------------------------
- 3** Holds position for 30 seconds → Go to One-Leg Stand.

STANDING BALANCE

ONE-LEG STAND

Describe: "For the last position, I would like you to try to stand on one leg for 30 seconds. You may stand on either leg, whichever is more comfortable. I'll demonstrate."

Demonstrate and say: "Try to hold your foot up until I say stop. If you lose your balance put your foot down."

Examiner Note: Allow the participant to hold onto your arm to get balanced.

Test: "Hold onto my arm while you get in position. When you are ready, let go."

Trial 1:

7 Notattempted/refused *(Please comment):* _____

P3TR1

1 Unable to attain position or cannot hold for at least one second

2 Holds position between 1 and 29 seconds

3 Holds position for 30 seconds

→ . **P3TR1TM**
seconds. Go to Trial 2.

→ Go to next exam

Perform a second trial: "Now, let's do the same thing one more time."

Trial 2:

7 Notattempted/refused *(Please comment):* _____

P3TR2

1 Unable to attain position or cannot hold for at least one second

2 Holds position between 1 and 29 seconds

3 Holds position for 30 seconds

→ . **P3TR2TM**
seconds



Staff ID #		

P3STFID4

Describe: "This is the balance walk test. First I want you to walk down the hall normally, at a comfortable pace, ignoring the colored lines. For the second walk, I will ask you to walk keeping your feet inside the lines. For the third walk, I want you to stay inside the lines. Each walk will be done at least twice."

USUAL PACE

Demonstrate and say: "Place your feet with your toes behind, but touching the starting line. Wait until I say 'GO.' Remember, I want you to walk at a comfortable pace ignoring the colored lines." (*Examiner Note: Demonstrate and return.*) "Walk a few steps past the finish line each time. Any questions."

Test: *Examiner Note: To start the test, drop your arm and say, "Ready, Go."*

Trial 1: **P3UPRU1** Not attempted/refused Time: · time (sec) **P3UPTM1**
 Unable to walk steps **P3UP1**

"OK, fine. Now turn around and when I say go, walk back the other way at a comfortable pace. Ready, GO."

Trial 2: **P3UPRU2** Not attempted/refused Time: · time (sec) **P3UPTM2**
 Unable to walk steps **P3UP2**

20 cm NARROW WALK

Describe: "Now for the second walk, I want to keep your feet inside the lines. It is important that you do your best to keep your feet inside the lines."

Demonstrate: "I'll demonstrate. Keep your feet inside the lines. Be sure to walk a few steps past the finish line. Any questions?"

Test: *Examiner Note: Time as before, but do not count steps. Drop your arm and say, "Ready, GO."*

P320CNA Not attempted/refused

Did the participant stay within the lines? (*Examiner Note: "Not staying within the lines" is defined as stepping on, or going outside of the colored tape two or more times. Perform up to 3 trials to obtain 2 valid times.*)

P320TR1 Trial 1: No (unable to assess time) Yes → · seconds **P320CT1**

P320TR2 Trial 2: No (unable to assess time) Yes → · seconds **P320CT2**

P320TR3 Trial 3: No (unable to assess time) Yes → · seconds **P320CT3**

LONG-DISTANCE CORRIDOR WALK INSTRUCTIONS & SCRIPT

Attachment of Heart Rate Monitor:

Script: "This device measures your pulse, or how often your heart beats."

After the heart monitor is attached, wait 10 seconds and obtain and record heart rate (record on Long-Distance Corridor Walk Data Collection Form.) If pulse is >110 or <40 bpm, do not test.

Record Standing Blood Pressure:

Record standing blood pressure from page #13 on Long-Distance Corridor Walk Data Collection Form (page #31)

If systolic is \geq to 200 or diastolic \geq to 110, do not test.

Explain Borg Perceived Exertion Scale:

Script: "During this exercise test, we want you to pay attention to how you are feeling."

Show the participant the Borg exertion scale which will be posted on the wall where they can see it as they walk the course.

Script: "After you walk, I want you to tell me the number that best matches how you were feeling. For example, the number '0' would be like doing nothing at all, and the number '10' would be like running a marathon. Do you understand?"

Demonstrate and Introduce Both Walks:

Demonstrate how to walk around the cone and describe the 2 minute walk.

Script: "This is a two-part walking test. For the first part I would like you to walk for 2 minutes, trying to cover as much ground as possible at a pace that is comfortable for you. Starting at this cone, walk to the cone at the other end of the hall, go around it and return, go around this cone and keep walking in the same fashion, until 2 minutes are up."

"When the 2 minutes are up I will tell you to stop. Please stay where you are so that I can record the distance you covered, check your heart rate, and ask you to rate how hard you felt you were working."

Describe the 400 meter walk.

Script: "For the second part, you will be walking 400 meters; that is, 10 complete laps around the course. This is about 1/4 mile or 1 lap around a standard outdoor running track. We would like you to walk as quickly as you can, without running, at a pace you can maintain comfortably over the 10 laps. After you complete the 10 laps I will tell you to stop, and measure your blood pressure and heart rate."

LONG-DISTANCE CORRIDOR WALK

INSTRUCTIONS & SCRIPT

Give the participant "stop" symptoms and final instructions:

Script: "Please tell me if you feel any chest pain, tightness or pressure in your chest, if you become short of breath or if you feel faint, lightheaded or dizzy, or if you feel leg pain. If you feel any of these symptoms, you may slow down or stop. During the walks, we ask that you don't talk, sing, hum, or whistle. Do you have any questions?"

2-Minute Walk:

Accompany participant to stand behind the starting line for the 2 minute walk.

Ready stop watch.

Script: "Now let's start the 2 minute walk. Cover as much ground as possible at a pace that is comfortable. Ready, GO."

Begin timing and counting participant's steps for first 20 meters. You will need to walk a few steps behind the participant for this portion of the test. Start timing with the first footfall over the starting line (participant's foot touches the floor on the first step). When the participant reaches the 20 meter mark, push the split-time button on the stop watch, and record the number of steps taken on the Long-Distance Corridor Walk Data Collection Form. (You will need to carry the form on a clipboard.)

Write the split-time on the form.

Press the LAP button again to continue timing the test.

Provide standard encouragement after each lap.

Suggested Scripts: "Keep up the good work." "You are doing well."

Throughout the test, draw a line through the number on the form that corresponds to each completed lap the participant walks.

If the participant's heart rate exceeds 135 bpm during the 2-Minute Walk, let the participant rest for 5 minutes. Then restart the test. The first 20 meter step count and split time measurements do not have to be repeated during the second trial. Cross off the numbers on the 'Trial 2' lap chart if the participant restarts the test. If the participant's pulse exceeds 135 a second time, note on the Long Distance Corridor Walk Data Collection Form and STOP the 2-minute walk. Do not go on to the 400 meter walk.

When the stopwatch reads 1:30, tell the participant, "30 seconds remaining."

At 1:50, tell the participant "10 seconds remaining." Approach the participant so that you meet them at the 2:00 stop time. When the stop watch reads 2:00, say, "STOP."

Record heart rate, number of laps and meter mark on form (each meter is marked with tape on the floor.) Assess perceived exertion.

Script: "What would you say your overall feeling of exertion is right now?"

Mark on form.

LONG-DISTANCE CORRIDOR WALK INSTRUCTIONS & SCRIPT

400 Meter Walk

Accompany the participant to the starting line for the 400 meter walk.

Tell the participant to resume walking when you say "GO" and to try and complete 10 laps at a pace they can maintain comfortably without running.

Script: "Resume walking when I say 'GO' and try to complete 10 laps as quickly as you can, without running, at a pace you can maintain comfortably. Ready, Go."

Start the stop watch.

Every lap offer standard encouragement, and call out each lap number as completed. Record each lap on form.

Suggested Script: "Keep up the good work." "You are doing well." "Looking good." "Well done." "Good job."
When the participant completes 400 meters (10 laps, first footfall across the finish line), stop the stop watch.

Record time, heart rate, and RPE. Restart the stopwatch to time the 2 minute recovery time.

Assess blood pressure. Record on form.

At 2 minutes, record heart rate again. Record on form.

Remove the heart rate monitor. Escort the participant to the next station.



**LONG-DISTANCE CORRIDOR WALK
DATA COLLECTION FORM**

Before 2-minute walk

1. Heart rate: **P3B2BPM** bpm
 a. Is heart rate > 110 or < 40 bpm? **P3B2PL** Yes No

Do not test

2. Initial standing blood pressure (from pg. #13):
 a. Systolic blood pressure **P3SYSB2** mm Hg

b. Diastolic blood pressure **P3DIAB2** mm Hg
 c. Is systolic ≥ 200? **P3SYSYN** Yes No

Do not test

d. Is diastolic ≥ 110? **P3SYDIYN** Yes No

Do not test

2-Minute Walk

1. First 20 meters
 a. Number of steps: **P32STP** steps
 b. Split-time **P32SPL** : .

2. Heart rate > 135 bpm? **P3SYDYN2** Yes No

Examiner Note: Wait 5 minutes and begin the walk again. Do not re-record the number of steps and split-time. Cross off the laps on the 'Trial 2' lap chart.

3a. Cross off as each lap is completed:

1	2	3	4	5	6	7	8	1	2	3	4	5	6	7	8
Trial 1								Trial 2							

b. Is heart rate > 135 bpm **P32PLS2** Yes No

Do not go on to 400m walk

c. Number of laps completed: **P32LAP** laps

d. Meter mark: **P32MTR** meters

e. Heart rate at end of 2-minute walk: **P32BPM** bpm

f. Is heart rate > 135 bpm **P32PLS** Yes No

Do not go on to 400m walk

g. Perceived exertion at end of 2-minute walk
 Borg Exertion #: **P32BORG**

400m Walk

1a. Cross off as each lap is completed:

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

b. Number of laps completed: **P34LAP** laps

c. (If walk is stopped before 400m): **P34MTR** meters

2. Record time at 400 m or at stop:
 : . seconds **P34TIME**

Restart stopwatch

3. Heart rate at 400m or at stop: **P34BPM** bpm

4. Perceived exertion at 400m or at stop:
 Borg Exertion #: **P34BORG**

5. Blood pressure at 400m or at stop:
 a. Systolic blood pressure: **P34SYS** mm Hg
 b. Diastolic blood pressure: **P34DIA** mm Hg

6. Heart rate 2 minutes after completion of 400 m walk: **P34HR** bpm

Stop Values:

If stop values are exceeded, circle value and stop walk. If symptoms are reported, check symptom and stop walk.

- Heart rate > 135 bpm
- Reports chest pain
- Reports shortness of breath **P3STOPV**
- Reports feeling faint
- Reports leg pain
- Other *(Please specify:)*



COGNITIVE FUNCTION

5. What three words did I ask you to remember earlier?

The words may be repeated in any order. If the participant cannot give the correct answer after a category cue, provide the three choices listed. If the participant still cannot give the correct answer from the three choices score "Unable to recall/refused" and provide the correct answer.

a. Shirt

1 Spontaneous recall

2 Correct word/incorrect form

3 After "Something to wear."

P4SHRM

4 After "Was it shirt, shoes, or socks?"

7 Unable to recall/refused
(provide the correct answer)

6 Not attempted/disabled

b. Blue

1 Spontaneous recall

2 Correct word/incorrect form

3 After "A color."

P4BLRM

4 After "Was it blue, black, or brown?"

7 Unable to recall/refused
(provide the correct answer)

6 Not attempted/disabled

c. Honesty

1 Spontaneous recall

2 Correct word/incorrect form

3 After "A good personal quality"

P4HNRM

4 After "Was it honesty, charity, modesty?"

7 Unable to recall/refused
(provide the correct answer)

6 Not attempted/disabled

6a. What is today's date?

/ /
 Month Day Year

P42DAY

If no response record '99' in each space provided.

b. What is the day of the week?

1 Correct

P4DAYWK

7 Error/refused

Day of the week

3 Not attempted/disabled

Record answer in error. Enter 'X' if no response.

c. What season of the year is it?

1 Correct

P4SEAS

7 Error/refused

Season

3 Not attempted/disabled

Record answer in error. Enter 'X' if no response.

7a. What state are we in?

1 Correct

7 Error/refused

State

3 Not attempted/disabled

Record answer in error. Enter 'X' if no response.

P4STAT

b. What county are we in?

1 Correct

7 Error/refused

County

3 Not attempted/disabled

Record answer in error. Enter 'X' if no response.

P4CNTY

c. What (city/town) are we in?

1 Correct

7 Error/refused

City/town

3 Not attempted/disabled

Record answer in error. Enter 'X' if no response.

P4CITN

d. Are we in a clinic, store, or home?

If correct answer is not among the three alternatives (e.g., hospital or nursing home), substitute it for the middle alternative (store). If the participant states that none is correct, ask them to make the best choice of the three options.

1 Correct

P4WHRE

7 Error/refused

3 Not attempted/disabled



COGNITIVE FUNCTION

8. Point to the object or a part of your own body and ask the participant to name it. Score "Error/Refused" if the participant cannot name it within 2 seconds or gives an incorrect name. Do not wait for the participant to mentally search for the name.

	Correct	Error/ Refused	Not attempted disabled
a. Pencil: What is this? P4PENC	1	7	3
b. Watch: What is this? P4WTCH	1	7	3
c. Forehead: What do you call this part of the face? P4FRHD	1	7	3
d. Chin: And this part? P4CHN	1	7	3
e. Shoulder: And this part of the body? P4SHLD	1	7	3
f. Elbow: And this part? P4ELB	1	7	3
g. Knuckle: And this part? P4KNK	1	7	3

9. What animals have four legs? Tell me as many as you can.

Discontinue after 30 seconds. Record the total number of correct responses. If the participant gives no response in 10 seconds and there are still at least 10 seconds remaining, gently remind them (once only): "What (other) animals have four legs?" The first time an incorrect answer is provided, say, "I want four-legged animals." Do not correct for subsequent errors.

P4SCR

Score (total correct responses):

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

(Write any additional correct answers on a separate sheet of paper.)

10a. In what way are an arm and a leg alike?

If the initial response is scored "Lesser correct answer" or "Error", coach the participant by saying "An arm and a leg are both limbs or extremities" to reinforce the correct answer. Coach only for Question 10a. No other prompting or coaching is allowed.

- 1** Limbs, extremities, appendages
P4ARLG
- 2** Lesser correct answer
(e.g., body parts, both bend, have joints)
- 7** Error/refused
(e.g. states differences, gives unrelated answer)
- 4** Notattempted/disabled

b. In what way are laughing and crying alike?

- 1** Expressions of feelings, emotions
P4LCRY
- 2** Lesser correct answer
(e.g., sounds, expressions, other similar responses)
- 7** Error/refused
(e.g. states differences, gives unrelated answer)
- 3** Notattempted/disabled

c. In what way are eating and sleeping alike?

- 1** Necessary bodily functions, essential for life
P4ETSL
- 2** Lesser correct answer
(e.g., bodily functions, relaxing, 'good for you or other similar responses)
- 7** Error/refused
(e.g. states differences, gives unrelated answer)
- 3** Notattempted/disabled

11. Repeat what I say: **I would like to go out.**

Pronounce the individual words distinctly but with normal tempo of a spoken sentence.

- 1** Correct
P4RPT
- 2** 1 or 2 words missed
- 7** 3 or more words missed/refused
- 4** Notattempted/disabled

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COGNITIVE FUNCTION

12. Now repeat: **No ifs, ands or buts.**

Pronounce the individual words distinctly but with normal tempo of a spoken sentence. Give no credit if the participant misses the "s."

	Correct	Error/ Refused	Not attempted/ disabled
a. no ifs P4IF	1	7	3
b. ands P4AND	1	7	3
c. or buts P4BUT	1	7	3

14. Please write the following sentence:

I would like to go out.

Hand participant a piece of blank paper and a #2 pencil with eraser. If necessary, repeat the sentence word by word as the participant writes. Allow a maximum of 1 minute after the first reading of the sentence for scoring the task.

Either printing or cursive writing is allowed. Score "Correct" for each correct word, but no credit for "I". For each word, score "Error/Refused" if there are spelling errors or incorrect mixed capitalizations (all letters printed in uppercase are permissible). Self-corrected errors are acceptable.

	Correct	Error/ Refused	Not attempted/ disabled
a. would P4WLD	1	7	3
b. like P4LKE	1	7	3
c. to P4TO	1	7	3
d. go P4GO	1	7	3
e. out P4OUT	1	7	3

Note which hand the participant uses to write. If this task is not done, ask participant if they are right or left handed. (Use in Question #16)

1 Right

P4HAND **2** Left

8 Unknown

13. Hold up Card # 1 and say, **"PLEASE DO THIS."**

If the participant does not close their eyes within 5 seconds, prompt by pointing to the sentence and saying "READ AND DO WHAT THIS SAYS." If the participant has already read the sentence aloud spontaneously, simply say, "DO WHAT THIS SAYS."

Allow 5 seconds for the response. Assign the appropriate score - See below. As soon as the participant closes their eyes, say "Open."

- 1** Closes eyes without prompting
- 2** Closes eyes after prompting
- 3** Reads aloud, but does not close eyes **P4CRD1**
- 7** Does not read aloud or close eyes/refused
- 5** Notattempted/disabled



COGNITIVE FUNCTION

15. Here is a drawing. Please copy the drawing onto this piece of paper.

Hand participant Card #2. Allow 1 minute for copying. For right-handed participants, present the sample on the left side; for left-handed participants, present the sample on the right side. Allow a maximum of 1 minute for response. Do not penalize for self-corrected errors, tremors, minor gaps, or overshoots.

a. Pentagon 1 **P4PENT1**

- 1** 5 approximately equal sized
- 2** 5 sides, but longest:shortest side is >2:1
- 3** nonpentagon enclosed figure
- 4** 2 or more lines, but it is not an enclosed figure
- 7** less than 2 lines/refused
- 6** notattempted/disabled

b. Pentagon 2 **P4PENT2**

- 1** 5 approximately equal sized
- 2** 5 sides, but longest:shortest side is >2:1
- 3** nonpentagon enclosed figure
- 4** 2 or more lines, but it is not an enclosed figure
- 7** less than 2 lines/refused
- 6** notattempted/disabled

c. Intersection **P4INT**

- 1** 4-cornered enclosure
- 2** not a 4-cornered enclosure
- 7** no enclosure/refused
- 4** notattempted/disabled

16. Refer to Question 14 to check whether the participant is right- or left-handed. Ask them to take the paper in their non-dominant hand.

Take this paper with your left (right for left handed person) hand, fold it in half using both hands, and hand it back to me.

After saying the whole command, hold the paper within reach of the participant. Do not repeat any part of the command. Do not move the paper toward the participant. The participant may hand back the paper with either hand.

	Correct	Error/ Refused	Not attempted/ disabled
a. Takes paper in correct hand P4PCOR	1	7	3
b. Folds paper in half P4PFLD	1	7	3
c. Hands paper back P4PHND	1	2	3



COGNITIVE FUNCTION

17. What three words did I ask you to remember earlier?

Administer this item even when the participant scored one or more "unable to recall/refused" on Question 5. The words may be repeated in any order. For each word not readily given, provide the category followed by multiple choices when necessary. Do not wait more than 3 seconds for spontaneous recall and do not wait more than 2 seconds after category cueing before providing the next level of help.

- a. Shirt**
- P4SH2**
- 1 Spontaneous recall
 - 2 Correct word/incorrect form
 - 3 After "Something to wear."
 - 4 After "Was it shirt, shoes, or socks?"
 - 7 Unable to recall/refused (provide the correct answer)
 - 6 Not attempted/disabled

- b. Blue**
- P4BLU2**
- 1 Spontaneous recall
 - 2 Correct word/incorrect form
 - 3 After "A color."
 - 4 After "Was it blue, black, or brown?"
 - 7 Unable to recall/refused (provide the correct answer)
 - 6 Not attempted/disabled

- c. Honesty**
- P4HON2**
- 1 Spontaneous recall
 - 2 Correct word/incorrect form
 - 3 After "A good personal quality"
 - 4 After "Was it honesty, charity, modesty?"
 - 7 Unable to recall/refused (provide the correct answer)
 - 6 Not attempted/disabled

18. Would you please tell me again where you were born?

Ask this question only when a response was given in Question 1d and 1e. Score the response by checking against the response in Question 1d and 1e.

Place of Birth?	Matches	Does not match/ Refused	Not attempted/ disabled
a. P4CITY2 City/town	<input type="checkbox"/> 1	<input type="checkbox"/> 7	<input type="checkbox"/> 3
b. P4STE2 State/Country	<input type="checkbox"/> 1	<input type="checkbox"/> 7	<input type="checkbox"/> 3

19. If physical/functional disabilities or other problems exist which cause the participant difficulty in completing any of the tasks, mark the box coded 'yes' and check the nature of the problem listed below **(Check all that apply.)**:

- 1 Vision **P4VIS**
- 1 Hearing **P4HEAR**
- 1 Writing problems due to injury or illness **P4WRITE**
- 1 Illiteracy or lack of education **P4ILLIT**
- 1 Language **P4LANG**
- 1 Other **(Please record the specific problem in the space provided.)**
P4OTH _____



Staff ID #		

P4STFD2

1 Determine if participant wears glasses for reading.

Script: "Do you usually wear glasses to read?" **-1** Yes → Ask the participant to put on their glasses.
0 No **P4GLS**

2 Place the task sheet before the participant and point to the task.

Script: "Look at these boxes across the top of the page. On the top of each box are numbers from one through nine. On the bottom part of each box there is a symbol. Each symbol is paired with a number."

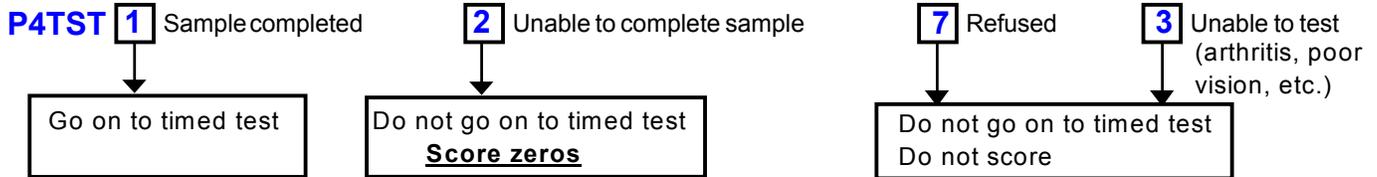
3 Point to the four rows of boxes.

Script: "Down here are boxes with numbers on the top, but the bottom part is blank. What I want you to do is to put the correct symbol in each box like this."

4 Fill in the first three sample boxes.

Script: "Now I want you to fill in all boxes up to this line."

5 Point to the line separating the samples from the test proper.



Script: "When I tell you to begin, start here and fill in the boxes in these four rows. Do them in order and don't skip any. Please try to work as quickly as possible. Let's begin."

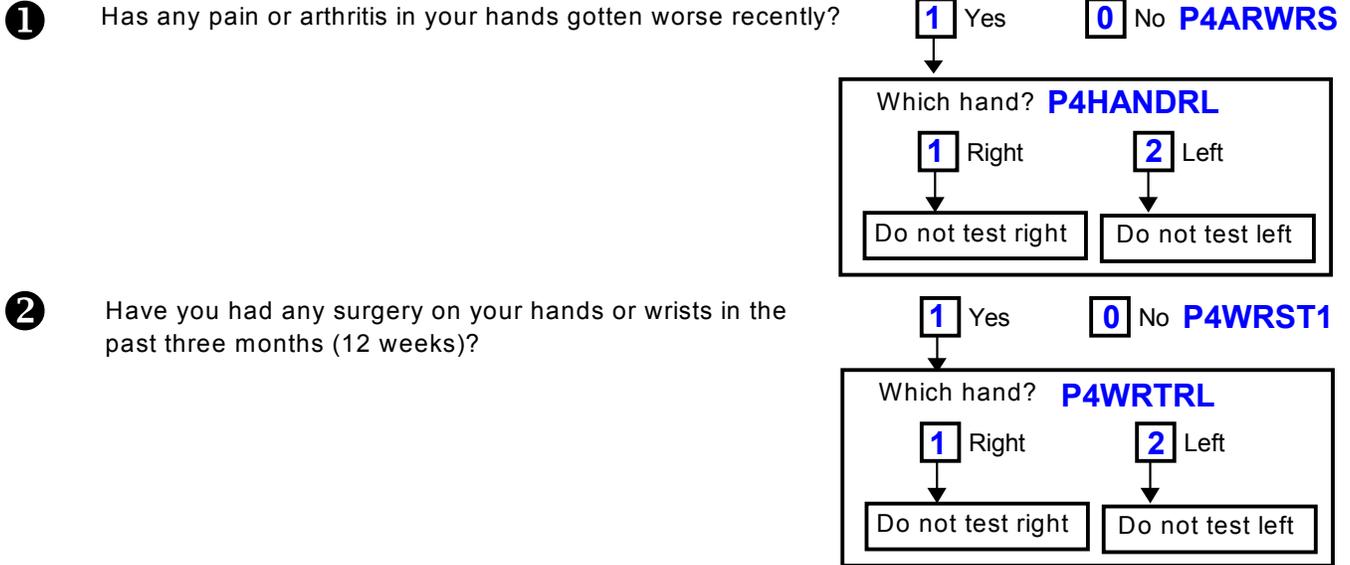
Stop the participant after 90 seconds. Say:

Script: "That's good. That completes this set of tasks."

Score: (DO NOT COUNT ANY SYMBOLS AFTER TWO BLANKS IN A ROW)

P4NC		P4NI	
Number Completed:	<input type="text"/> <input type="text"/>	Number Incorrect:	<input type="text"/> <input type="text"/>

Exclusion Criteria:



Script: "I'd like you to take your right/left, arm, rest it on the table, and bend your elbow. Grip the two bars in your hand, like this. You need to slowly squeeze the bars as hard as you can."

Hand the dynamometer to the participant. Adjust if needed.

Script: "Now try it once just to get the feel of it. For this practice, just squeeze gently. It won't feel like the bars are moving, but your strength will be recorded. Are the bars the right distance apart for a comfortable grip?"

Show dial to participant

Script: "We'll do this two times. This time it counts, so when I say squeeze, squeeze as hard as you can. Ready. Squeeze! Squeeze! Squeeze! Good, Relax."

Right **-1** Unable to test/exclusion **P4NOTST**

P4RTR1 Trial 1

--	--

 kg **P4RF1** **-1** Refused *Examiner Note: Wait 15-20 seconds before second trial.*

P4RTR2 Trial 2

--	--

 kg **-1** Refused
P4RF2

"Now, one more time. Squeeze as hard as you can. Ready. Squeeze! Squeeze! Squeeze!"

Left **-1** Unable to test/exclusion **P4LNTST**

P4LTR1 Trial 1

--	--

 kg **P4LRF1** **-1** Refused *Examiner Note: Wait 15-20 seconds before second trial.*

P4LTR2 Trial 2

--	--

 kg **-1** Refused
P4LRF2

Exclusion criteria:

1 Are you right or left handed? **1** Right **2** Left **P4RL2**

2 Do you have severe pain in or have you had recent surgery on your (dominant) hand?

1 Yes **0** No **P4PAIN**

↓ ↓

Go to question 3 Test dominant hand

3 Do you have severe pain in or have you had recent surgery on your (non-dominant) hand?

1 Yes **0** No **P4SURG**

↓ ↓

Do not test Test non-dominant hand

"We would like you to use the pad of your index finger to tap as fast as you can on the mouse for 15 seconds. After you begin tapping, the computer will automatically time you and count the number of taps you can do. Keep tapping as fast as you can until I tell you to stop. Let me demonstrate the procedure for you."

Demonstrate: Show the participant how to complete the procedure.

Examiner Note: Look at the fingertap menu on the computer screen and press the appropriate key before the participant begins tapping.

"Now place your hand on the mouse and when I say Ready! Go! begin tapping as fast as you can. Ready, Go! - keep going . . . keep going . . . okay, stop."

Side tested:

P4SIDE **1** Right **2** Left **3** Not tested due to exclusions above **7** Refused

Number of taps in 15 seconds:

P4TAP1

--	--

 Trial 1: taps

P4TAP2

--	--

 Trial 2: taps

Examiner Note: Wait 15-20 seconds before second trial.



Staff ID #

--	--	--

P4STFID5

1 Have you had any surgery on your chest or abdomen in the past 2 months? 1 Yes 0 No **P4SURG2**

1 Yes 0 No **P4SURG2**

Do not test

2 Have you had a heart attack in the past 2 months? 1 Yes 0 No **P4HA**

1 Yes 0 No **P4HA**

Do not test

3 Have you been hospitalized for any other heart problem in the past month? 1 Yes 0 No **P4HOSP**

1 Yes 0 No **P4HOSP**

Do not test

4 Do you have a detached retina or have you had eye surgery in the past 2 months? 1 Yes 0 No **P4RET**

1 Yes 0 No **P4RET**

Do not test

5 Have you had symptoms of a respiratory infection within the past 2 weeks? 1 Yes 0 No **P4RESP**

6 Does participant regularly use beta-agonist inhalers? 1 Yes 0 No **P4BETA**

Examiner Note: Check Medication Inventory Form or sack of medications being carried by participant. Common short-acting beta-agonist inhalers include: Albuterol, Brethair, Maxair, Proventil, Tornalate, Ventolin

1 Yes 0 No **P4BETA**

Have inhalers been used within last 4 hours?

1 Yes 0 No **P4INHALE**

Ask participant to use their own inhaler. EXCEPTION:

- 1) If they have used Serevent, a long-acting beta-agonist within the past 10 hours.
- 2) If they use an anticholinergic inhaler (such as Atrovent).

Did participant use inhaler before spirometry?

P4INHLE2 1 Yes 0 No → Why not? _____

7 Was the spirometry test completed? **P4SPIR**

1 Yes

0 No

Record the results:

FVC Best value: . liters
P4FVCBST

FVC Percent predicted: . percent
P4FVCPR

FEV₁ Best value: . liters
P4FEVBST

FEV₁ Percent predicted: . percent
P4FEVPR

FEV₁/FVC%: . percent
P4FEVPR2

Why wasn't the spirometry test completed?

- 1 Equipment failure
- 2 Participant unable to understand instructions
- 3 Participant medically excluded **P4SPWN**
- 4 Participant unable to physically cooperate
- 7 Participant refused
- 6 Other (*Please specify:*) _____

HABC Enrollment ID # <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> RT1ID	Acrostic <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> RT1ACROS	Date Form Completed <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> Month / Day / Year RT1DATE	Staff ID # <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> RT1STFID
---	--	--	--

RETURN VISIT PHLEBOTOMY

Bar Code Label
RT1BRCDX

1 Reason for return visit:

1 Urine collection (Go to Question #9)

2 Fasting blood draw **RT1RSVT**

3 Other (Please specify)

2 Do you bleed or bruise easily? **RT1BLBR**

1 Yes **0** No **8** Don't know

3 Have you ever been told you have a disorder relating to blood clotting or coagulation? **RT1BCT**

1 Yes **0** No **8** Don't know

4 Have you ever experienced fainting spells while having blood drawn? **RT1FNT**

1 Yes **0** No **8** Don't know

5 Time at start of venipuncture?

RT1VTM **1** am **2** pm
Hours Minutes **RT1AMPM2**

Was any blood drawn?

1 Yes **0** No **RT1BLDR**

↓

Please describe why not?

- Do NOT administer OGTT.
- Check N/A box next to cryovial #46 on Return Visit Laboratory Processing Form.

6 Time blood draw completed:

: **1** am **2** pm
Hours Minutes **RT1AMPM3**
RT1BLDTM

7 Total tourniquet time:
(If tourniquet was reapplied, enter total time tourniquet was on. Note that 2 minutes is optimum.)

RT1TOUR minutes

Comments on phlebotomy:

8 Quality of venipuncture:

1 Clean **2** Traumatic **RT1QVEN**

1 Vein collapse **5** Excessive duration of draw

2 Hematoma **6** Leakage at venipuncture site

3 Vein hard to get **7** Other (Please specify): **RT1TRM**

4 Multiple sticks

9 Were tubes filled to specified capacity? If not, comment why.

Blood Volume/Tube	Filled to Capacity?	Comment
	Yes	No
1. Serum 10ml	<input type="checkbox"/> 1	<input type="checkbox"/> 0 → RT1BV1
2. EDTA 10ml	<input type="checkbox"/> 1	<input type="checkbox"/> 0 → RT1BV2
Urine:		
1. Urine (15-20ml)	<input type="checkbox"/> 1	<input type="checkbox"/> 0 → RT1BV8

10 What is the date and time you last ate or drank anything except water?

a. Date of last meal:
 / **RT1LMD**
Month Day

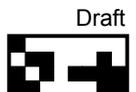
b. Time of last meal:
RT1MHM : **1** am **2** pm **RT1LMAPM**
Hours Minutes

c. How many hours has participant fasted?
RT1FAST hours (Question 6 minus Question 10b. Round down to nearest hour)

If less than 8 hours, do NOT administer OGTT or draw blood.

LCBR Use only: Received Date: _____ Time: _____

Frozen? Yes No



HABC Enrollment ID #	Acrostic	Date Form Completed	Staff ID #
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
RT2ID	RT2ACROS	Month / Day / Year RT2DATE	RT2STFID

RETURN VISIT ORAL GLUCOSE TOLERANCE TEST

1 Has a doctor ever told you that you have diabetes or sugar diabetes?

Yes No Don't know **RT2DIAB**

Oral Hypoglycemics

Generic Name	Trade Name
Tolbutamide	Orinase
Acetohexamide	Dymelor
Tolazamide	Tolinase
Chlorpropamide	Diabinese
Glipizide	Glucotrol
Glyburide	Diabeta, Micronase
Metformin	Glucophage
Acarbose	Precose
Glicazide	Diamicron
Glimepride	Amaryl
Troglitazone	Rezulin

Do you take insulin or oral hypoglycemic medications to control your diabetes? (Refer to the list to the right) **RT2INOH**

Yes, insulin Yes, oral hypoglycemics No Don't know

Yes, insulin → Check N/A box next to cryovial #26 on Return Visit Laboratory Processing Form. → Do NOT administer OGTT.

Yes, oral hypoglycemics → Do NOT administer OGTT.

No → Verify from Baseline Health Questionnaire Q#116 or Medication Inventory Form

Don't know → Verify from Baseline Health Questionnaire Q#116 or Medication Inventory Form

2 Was the glucose tolerance test done?

RT2GLU Yes No → Check N/A box next to cryovial #46 on Return Visit Laboratory Processing Form.

Why wasn't the glucose tolerance test done? **RT2GLUNO**

Exclusion criteria (above)

Participant refused

Could not tolerate glucola

Other (Please specify:)

3 Time glucose administered (first sip):

RT2GLTM : **RT2GLAPM** am pm → Add 2 hours to time glucose administered. → Time blood draw due: : **RT2GLBD**

4 Was entire glucose drink consumed?

Yes

RT2GLDRK No, but more than half

No, less than half - cancel 2-hour blood draw → Check N/A box next to cryovial #46 on Return Visit Laboratory Processing Form.

5 Time glucose tolerance blood drawn:

RT2GTBD : **RT2GTAPM** am pm





HABC Enrollment ID #	Acrostic	Date Form Completed			Staff ID #
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	
RT3ID	RT3ACROS	Month	Day	Year	RT3STFID

RETURN VISIT LABORATORY PROCESSING

Bar Code Label
RT3BRCD2

RT3TIME

Time at start of processing: : am pm

RT3AMPM

Collection Tubes	Cryo #	Vol.	Type	To	Check "X"	Problems	Collection Tubes	N/A	Cryo #	Vol.	Type	To	Check "X"	Problems
#2 Whole blood	01	0.5	W/0.5 L*		<input checked="" type="checkbox"/>	RT301HP <input type="checkbox"/> H <input type="checkbox"/> P	#1 Serum		25	0.5	R/0.5 L		<input checked="" type="checkbox"/>	RT325HP <input type="checkbox"/> H <input type="checkbox"/> P
#2 EDTA	02	1.0	W/2.0 L		<input type="checkbox"/>	RT302HP <input type="checkbox"/> H <input type="checkbox"/> P	RT326NA	<input checked="" type="checkbox"/>	26	0.5	R/0.5 L		<input type="checkbox"/>	RT326HP <input type="checkbox"/> H <input type="checkbox"/> P
							#8 OGTT	<input checked="" type="checkbox"/>	46	0.5	O/0.5 L		<input type="checkbox"/>	RT346HP <input type="checkbox"/> H <input type="checkbox"/> P
							URINE		47	2.0	V/2.0 M		<input type="checkbox"/>	RT347HP <input type="checkbox"/> H <input type="checkbox"/> P
									48	2.0	V/2.0 M		<input type="checkbox"/>	RT348HP <input type="checkbox"/> H <input type="checkbox"/> P
							(acidified)		49	2.0	G/2.0 M		<input type="checkbox"/>	RT349HP <input type="checkbox"/> H <input type="checkbox"/> P

L=LCBR; M=McKesson, H=Hemolyzed; P=Partial; W=white; R=red; O=orange; V=violet G=green
 *DO NOT FREEZE. To be shipped separately on wet ice.

Draft



HABC Enrollment ID #	Acrostic	Date Form Completed	Staff ID #
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> F1ID	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> F1ACROS	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> Month Day Year F1DATE	<input type="text"/> <input type="text"/> <input type="text"/> F1STFID

6-MONTH FOLLOW-UP CONTACT

Date of Baseline Clinic Visit: / /
Month Day Year

1 In general, how would you say your health is? Would you say it is. . .
(Interviewer Note: Read response options.)

- | | |
|---|--|
| <input type="checkbox"/> 1 Excellent | <input type="checkbox"/> 5 Poor |
| <input type="checkbox"/> 2 Very good | <input type="checkbox"/> 8 Don't know |
| <input type="checkbox"/> 3 Good | <input type="checkbox"/> 7 Refused |
| <input type="checkbox"/> 4 Fair | |
- F1HSTAT**

2 Since your clinic visit about 6 months ago, did you stay in bed all or most of the day because of an illness or injury? Please include days that you were a patient in a hospital.

- 1** Yes **0** No **8** Don't know **7** Refused **F1BED12**

About how many days did you stay in bed all or most of the day because of an illness or injury?
Please include days that you were a patient in a hospital.

F1BEDDAY
days

3 Since your clinic visit about 6 months ago, did you cut down on the things you usually do, such as going to work or working around the house, because of an illness or injury?

- 1** Yes **0** No **8** Don't know **7** Refused **F1CUT12**

How many days did you cut down on the things you usually do because of illness or injury?
(Interviewer Note: If necessary, probe - "If you are unsure, please make your best guess.")

F1CUTDAY
days



6-MONTH FOLLOW-UP CONTACT

4 Because of a health or physical problem, do you have any difficulty walking a quarter of a mile, that is about 2 or 3 blocks?

1 Yes
0 No
8 Don't know
7 Refused **F1DWQMYN**

Go to Question #4e

a. How much difficulty do you have? Would you say... *(Interviewer Note: Read response options.)*

- 1** A little difficulty
- 2** Some difficulty
- 3** A lot of difficulty **F1DWQMDF**
- 4** Or are you unable to do it? → Go to Question #4d
- 8** Don't know

b. Do you get tired when you walk a quarter of a mile ?

- 1** Yes **0** No **9** Don't do **8** Don't know **F1SWQMT1**

c. Because of a health or physical problem, do you walk a quarter of a mile less often now compared to 6 months ago?

- 1** Yes **0** No **9** Don't do **8** Don't know **F1DWQML1**

d. What is the main reason that you have difficulty? Is it because of arthritis, shortness of breath, heart disease, or some other reason?

(Interviewer Note: If "some other reason," probe for response. Do NOT read response options. Mark only ONE answer.)

- | | |
|---|---|
| <ul style="list-style-type: none"> 1 Arthritis 2 Back pain 3 Balance problems/unsteadiness on feet 4 Cancer 5 Chestpain/discomfort 6 Circulatoryproblems 7 Diabetes 8 Fatigue/tiredness (no specific disease) 9 Fall 10 Heart disease (including angina, congestive heart failure, etc) 11 High blood pressure/hypertension | <ul style="list-style-type: none"> 12 Hip fracture 13 Injury (Please specify: _____) 14 Joint pain 15 Lung disease (asthma, chronic bronchitis, emphysema, etc) 16 Old age (no mention of a specific condition) 17 Osteoporosis 18 Shortness of breath 19 Stroke |
|---|---|
- F1MNRS**
- 1** Other symptom (Please specify: _____) **F1MNRS4**

2 Multiple conditions/symptoms given; unable to determine MAIN reason

8 Don't know

Go to Question #5

Page Link #

Draft



6-MONTH FOLLOW-UP CONTACT

4e. How easy is it for you to walk a quarter of a mile? Would you say...
(Interviewer Note: Read response options.)

- 1 Very easy
 - 2 Somewhat easy
 - 3 Or not that easy
 - 8 Don't know
- F1DWQMEZ**

4f. Do you get tired when you walk a quarter of a mile?

- 1 Yes
 - 0 No
 - 9 Don't do
 - 8 Don't know
- F1DWQMT2**

4g. Because of a health or physical problem, do you walk a quarter of a mile less often now compared to 6 months ago?

- 1 Yes
 - 0 No
 - 9 Don't do
 - 8 Don't know
- F1DWQML2**

4h. Because of a health or physical problem, do you have any difficulty walking a distance of one mile, that is about 8 to 12 blocks?

- 1 Yes →
- F1DW1MYN** 0 No →
- 8 Don't know →

4i. How easy is it for you to walk one mile? Would you say...
(Interviewer Note: Read response options.)

- 1 Very easy
 - 2 Somewhat easy
 - 3 Or not that easy
 - 8 Don't know
- F1DW1MEZ**



6-MONTH FOLLOW-UP CONTACT

5 Because of a health or physical problem, do you have any difficulty walking up 10 steps, that is about 1 flight, without resting?

1 Yes
0 No
8 Don't know
7 Refused **F1DW10YN**

Go to Question #5e

a. How much difficulty do you have? Would you say...
(Interviewer Note: Read response options.)

- 1** A little difficulty
- 2** Some difficulty
- 3** A lot of difficulty **F1DIF**
- 4** Or are you unable to do it? → Go to Question #5d
- 8** Don't know

b. Do you get tired or short of breath when you walk up 10 steps, without resting?

- 1** Yes **0** No **9** Don't do **8** Don't know **F1DW10WR**

c. Because of a health or physical problem, do you walk up 10 steps without resting less often now compared to 6 months ago?

- 1** Yes **0** No **9** Don't do **8** Don't know **F1DWWRLO**

d. What is the main reason that you have difficulty? Is it because of arthritis, shortness of breath, heart disease, or some other reason?
(Interviewer Note: If "some other reason," probe for response. Do NOT read response options. Mark only ONE answer.)

- | | |
|---|--|
| <ul style="list-style-type: none"> 1 Arthritis F1MNRS2 2 Back pain 3 Balance problems/unsteadiness on feet 4 Cancer 5 Chestpain/discomfort 6 Circulatory problems 7 Diabetes 8 Fatigue/tiredness (no specific disease) 9 Fall 10 Heart disease (including angina, congestive heart failure, etc) 11 High blood pressure/hypertension | <ul style="list-style-type: none"> 12 Hip fracture 13 Injury (Please specify: _____) 14 Joint pain 15 Lung disease (asthma, chronic bronchitis, emphysema, etc) 16 Old age (no mention of a specific condition) 17 Osteoporosis 18 Shortness of breath 19 Stroke <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <ul style="list-style-type: none"> 1 Othersymptom (Please specify: F1MNRS3) 2 Multiple conditions/symptoms given; unable to determine MAIN reason 8 Don't know </div> |
|---|--|

Go to Question #6



6-MONTH FOLLOW-UP CONTACT

5e. How easy is it for you to walk up 10 steps without resting? Would you say...
(Interviewer Note: Read response options.)

- 1 Very easy
 - 2 Somewhat easy
 - 3 Or not that easy
 - 8 Don't know
- F1DW10EZ**

5f. Do you get tired when you walk up 10 steps without resting?

- 1 Yes
 - 0 No
 - 9 Don't do
 - 8 Don't know
- F1DW10WX**

5g. Because of a health or physical problem, do you walk up 10 steps without resting less often now compared to 6 months ago?

- 1 Yes
 - 0 No
 - 9 Don't do
 - 8 Don't know
- F1D10LO**

5h. Because of a health or physical problem, do you have any difficulty walking up 20 steps, that is about 2 flights, without resting?

- 1 Yes →
- F1DW20YN** 0 No →
- 8 Don't know →

5i. How easy is it for you to walk up 20 steps without resting? Would you say...
(Interviewer Note: Read response options.)

- 1 Very easy
 - 2 Somewhat easy
 - 3 Or not that easy
 - 8 Don't know
- F1DW20EZ**



6-MONTH FOLLOW-UP CONTACT

- 6 In general, would you say that your appetite or desire to eat has been. . . ?
(Interviewer Note: Read response options.)

1 Very good

5 Very poor

2 Good

8 Don't know

3 Moderate

7 Refused

4 Poor

F1APPET

- 7 How much do you currently weigh?
(Interviewer Note: If necessary, probe - "If you are unsure, please make your best guess.")

F1WTLBS

pounds

8 Don't know/don't remember

F1LBS2

7 Refused

- 8 Since your clinic visit about 6 months ago, has your weight changed by 5 or more pounds?

1 Yes

0 No

8 Don't know

7 Refused F1CHN5LB

- a. Did you gain or lose weight?

1 Gain

2 Lose

8 Don't know/don't remember

F1GNLS

- b. How many pounds did you gain/lose in the past 6 months?
(Interviewer Note: If necessary, probe - "If you are unsure, please make your best guess.")

F1HOW6

pounds

8 Don't know/don't remember

F1HOW6DN

7 Refused

- c. Were you trying to gain/lose weight?

1 Yes

0 No

8 Don't know

F1TRGNLS

6-MONTH FOLLOW-UP CONTACT

Now I'm going to ask you about any medical problems you might have had since we last saw you about 6 months ago, which was on

	/		/	
Month		Day		Year

9 Since your clinic visit about 6 months ago, has a doctor told you that you had a heart attack, angina, or chest pain due to heart disease?

- 1** Yes
 0 No
 8 Don't know
 7 Refused **F1HCHAMI**

Were you hospitalized overnight for this problem?

1 Yes
 0 No **F1HOSMI**

Complete a Health ABC Event Form(s), Section I, for each overnight hospitalization. Record reference #'s below:

a.

--	--	--	--	--

F1REF9A

b.

--	--	--	--	--

F1REF9B

c.

--	--	--	--	--

F1REF9C

Go to Question #10

10 Since your clinic visit about 6 months ago, has a doctor told you that you had a stroke, mini-stroke, or TIA ?

- 1** Yes
 0 No
 8 Don't know
 7 Refused **F1HCCVA**

Were you hospitalized overnight for this problem?

1 Yes
 0 No **F1HOSMI2**

Complete a Health ABC Event Form(s), Section I, for each overnight hospitalization. Record reference #'s below:

a.

--	--	--	--	--

F1REF10A

b.

--	--	--	--	--

F1REF10B

c.

--	--	--	--	--

F1REF10C

Go to Question #11



6-MONTH FOLLOW-UP CONTACT

- 11** Since your clinic visit about 6 months ago, has a doctor told you that you had cancer?
We are specifically interested in hearing about a cancer that your doctor diagnosed for the first time since your last clinic visit.

1 Yes

0 No

8 Don't know

7 Refused **F1CHMGMT**

Complete a Health ABC Event Form(s),
Section II, for each event.
Record reference #'s below:

a.

--	--	--	--	--

F1REF11A

b.

--	--	--	--	--

F1REF11B

c.

--	--	--	--	--

F1REF11C

- 12** Since your clinic visit about 6 months ago, has a doctor told you that you had pneumonia?

1 Yes

0 No

8 Don't know

7 Refused **F1LCPNEU**

Complete a Health ABC Event Form(s),
Section II, for each event.
Record reference #'s below:

a.

--	--	--	--	--

F1REF12A

b.

--	--	--	--	--

F1REF12B

c.

--	--	--	--	--

F1REF12C

- 13** Since your clinic visit about 6 months ago, have you been told by a doctor that you broke or fractured a bone(s)?

1 Yes

0 No

8 Don't know

7 Refused **F1OSBR45**

Complete a Health ABC Event Form(s),
Section II, for each event.
Record reference #'s below:

a.

--	--	--	--	--

F1REF13A

b.

--	--	--	--	--

F1REF13B

c.

--	--	--	--	--

F1REF13C

Page Link #

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6-MONTH FOLLOW-UP CONTACT

14 Were you hospitalized overnight for any other reasons since your clinic visit about 6 months ago?

1 Yes

0 No

8 Don't know

7 Refused **F1HOSP12**

**Complete a Health ABC Event Form(s), Section I, for each event.
Record reference #'s and reason for hospitalization below.**

a.

Reason for hospitalization:

F1REF14A

b.

Reason for hospitalization:

F1REF14B

c.

Reason for hospitalization:

F1REF14C

d.

Reason for hospitalization:

F1REF14D

e.

Reason for hospitalization:

F1REF14E

f.

Reason for hospitalization:

F1REF14F

15 Have you had any same day outpatient surgery since we last saw you about 6 months ago?

1 Yes

0 No

8 Don't know

7 Refused **F1OUTPA**

Was it for...?

a. A procedure to open a blocked artery

F1BLART

1 Yes

0 No

8 Don't know

Complete a Health ABC Event Form, Section III. Record reference #:

Reference #'s

F1REF15A

b. Gall bladder surgery

F1GALLBL

1 Yes

0 No

8 Don't know

Complete a Health ABC Event Form, Section III. Record reference #:

F1REF15B

c. Cataract surgery

F1CATAR

1 Yes

0 No

8 Don't know

Complete a Health ABC Event Form, Section III. Record reference #:

F1REF15C

d. Hernia repair

F1HERN

1 Yes

0 No

8 Don't know

Complete a Health ABC Event Form, Section III. Record reference #:

F1REF15D

e. TURP (MEN ONLY)
(transurethral resection of prostate)

F1TURP

1 Yes

0 No

8 Don't know

Complete a Health ABC Event Form, Section III. Record reference #:

F1REF15E

f. Other

F1OTH

1 Yes

0 No

8 Don't know

Complete a Health ABC Event Form, Section III. Please specify type of outpatient surgery and record reference #:

i. **F1RF15I**

ii. **F1RF15II**

iii. **F1RF15III**

<input type="text"/>					
<input type="text"/>					
<input type="text"/>					

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6-MONTH FOLLOW-UP CONTACT

16 Do you expect to move or have a different mailing address in the next 6 months?

Yes **1**

No **0**

Don't know **8**

Refused **7** **F1MOVE**

What will be your new mailing address?

New address:

Street Address

Apt/Room

City

State

Zip Code

1 Permanent address

2 Winter address **F1ADDRES**

3 Other (*Please describe:* _____)

Telephone: (_____)

Area Code

Number

Date new address/phone number effective:

Month

Day

Year

F1MOVDA

Page Link #



HABC Enrollment ID #	Acrostic	Date Form Completed	Staff ID #
H <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
BJID	BJACROS	Month Day Year	BJSTFID

MISSED FOLLOW-UP CONTACT **BJDATE**

Complete this form for each regularly scheduled follow-up clinic visit or telephone contact that has been missed and cannot be made-up.

1 Type of Follow-up Contact Missed

BJTYPE Annual Clinic Visit →

Which visit? **BJVISIT**

<input type="text"/> Year 02	<input type="text"/> Year 05
<input type="text"/> Year 03	<input type="text"/> Year 06
<input type="text"/> Year 04	<input type="text"/> Year 07

Phone Contact →

Which contact? **BJCONTAC**

<input type="text"/> 6-mo	<input type="text"/> 42-mo	<input type="text"/> 78-mo
<input type="text"/> 18-mo	<input type="text"/> 54-mo	
<input type="text"/> 30-mo	<input type="text"/> 66-mo	

2 Reason Follow-up Contact Missed

Please check the primary reason for the missed follow-up visit or telephone contact. Check **only one** reason. **BJREASON**

- | | |
|--|---|
| <input type="checkbox"/> 1 Illness/healthproblem(s) | <input type="checkbox"/> 10 Moved out of area |
| <input type="checkbox"/> 2 Hearing difficulties | <input type="checkbox"/> 11 Travelling/on vacation |
| <input type="checkbox"/> 3 Cognitive difficulties | <input type="checkbox"/> 12 Personalproblem(s) |
| <input type="checkbox"/> 4 In nursing home/long-term care facility | <input type="checkbox"/> 13 Unable to contact/unable to locate |
| <input type="checkbox"/> 5 Too busy; time and/or work conflict | <input type="checkbox"/> 14 Refused to give reason |
| <input type="checkbox"/> 6 Caregivingresponsibilities | <input type="checkbox"/> 15 Modified follow-up regimen (e.g. will only agree to one contact per year) |
| <input type="checkbox"/> 7 Physician's advice | <input type="checkbox"/> 16 Deceased |
| <input type="checkbox"/> 8 Family member's advice | <input type="checkbox"/> 17 Other (Please specify: _____) |
| <input type="checkbox"/> 9 Clinic too far/travel time | |

3 Was an alternate type of contact made?

Yes No **BJALTCON**

What type of contact was made? **BJCONTYP**

Home visit

Phone interview (for those unwilling to have a home visit)

Proxy interview (for deceased, too ill, or cognitive difficulties)

Other (Please specify: _____)

