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| HABC Enrollment ID # | Acrostic | Date Form Completed | Staff ID # |
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| CLID | CLACROS | Month Day Year | CLSTFID |

YEAR 3 QUESTIONNAIRE CLDATE

Date of last regularly scheduled contact: / / **CLDATES**

Month Day Year

(Interviewer Note: Refer to Data from Prior Visits Report.)

1. In general, how would you say your health is? Would you say it is. . . **CLHSTAT**
(Interviewer Note: Read response options.)

1 Excellent 5 Poor
 2 Very good 8 Don't know
 3 Good 7 Refused
 4 Fair

2. Since we last spoke to you 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. **CLBED12**

1 Yes 0 No 8 Don't know 7 Refused

1 Yes
 ↓
 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.
(Interviewer Note: If necessary, probe - "If you are unsure, please make your best guess.")
 days **CLBEDDAY**

3. Since we last spoke to you 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? Please include days in bed. **CLCUT12**

1 Yes 0 No 8 Don't know 7 Refused

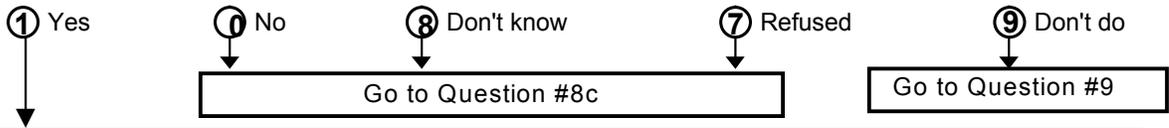
1 Yes
 ↓
 How many days did you cut down on the things you usually do because of illness or injury? Please include days in bed.
(Interviewer Note: If necessary, probe - "If you are unsure, please make your best guess.")
 days **CLCUTDAY**

CLLINK

Page Link #



8. 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? *(Interviewer Note: If the participant responds "Don't do," probe to determine whether this is because of a health or physical problem. If the participant doesn't walk because of a health or physical problem, check "Yes." If the participant doesn't walk for other reasons, check "Don't do.")* **CLDWQMYN**

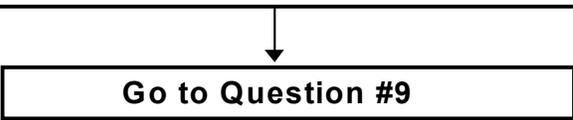


a. How much difficulty do you have? *(Interviewer Note: Read response options.)*

- ① A little difficulty
 - ② Some difficulty
 - ③ A lot of difficulty
 - ④ Or are you unable to do it?
 - ⑧ Don't know
- CLDWQMDF**

b. 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.)*

- | | | |
|--|---------------|--|
| ① Arthritis | CLMNRS | ⑪ Hip fracture |
| ② Back pain | | ⑬ Injury (Please specify: _____) |
| ③ Balance problems/unsteadiness on feet | | ⑭ Joint pain |
| ④ Cancer | | ⑮ Lung disease (asthma, chronic bronchitis, emphysema, etc) |
| ⑤ Chest pain/discomfort | | ⑯ Old age (no mention of a specific condition) |
| ⑥ Circulatory problems | | ⑰ Osteoporosis |
| ⑦ Diabetes | | ⑱ Shortness of breath |
| ⑧ Fatigue/tiredness (no specific disease) | | ⑲ Stroke |
| ⑨ Fall | | ⑳ Other symptom CLMNRS4 (Please specify: _____) |
| ⑩ Heart disease (including angina, congestive heart failure, etc) | | ㉑ Multiple conditions/symptoms given; unable to determine MAIN reason |
| ① High blood pressure/hypertension | | ㉒ Don't know |



8c. How easy is it for you to walk a quarter of a mile?
(Interviewer Note: Read response options.)

- ① Very easy
- ② Somewhat easy
- ③ Or not that easy
- ⑧ Don't know/Don't do

CLDWQMEZ

8d. Do you get tired when you walk a quarter of a mile?

- ① Yes
- ② No
- ⑧ Don't know/Don't do

CLDWQMT2

8e. 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?

CLDW1MYN

- ① Yes →
- ② No →
- ⑧ Don't know/Don't do →

8f. How easy is it for you to walk one mile?
(Interviewer Note: Read response options.)

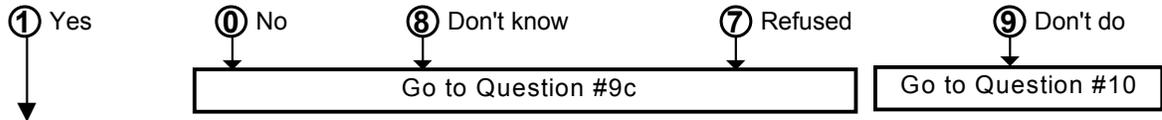
- ① Very easy
- ② Somewhat easy
- ③ Or not that easy
- ⑧ Don't know/Don't do

CLDW1MEZ



PHYSICAL FUNCTION

9. Because of a health or physical problem, do you have any difficulty walking up 10 steps, that is about 1 flight, without resting? (*Interviewer Note: If the participant responds "Don't do", probe to determine whether this is because of a health or physical problem. If the participant doesn't walk up 10 steps because of a health or physical problem, check "Yes". If the participant doesn't walk up steps for other reasons, such as there are simply no steps in the area, check "Don't do".*) **CLDW10YN**



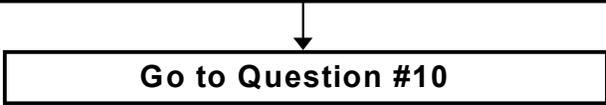
a. How much difficulty do you have?
(*Interviewer Note: Read response options.*)

- 1 A little difficulty
- 2 Some difficulty
- 3 A lot of difficulty
- 4 Or are you unable to do it?
- 8 Don't know

CLDIF

b. 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.*)

- | | | |
|---|----------------|--|
| 1 Arthritis | CLMNRS2 | 12 Hip fracture |
| 2 Back pain | | 13 Injury (Please specify: _____) |
| 3 Balance problems/unsteadiness on feet | | 14 Joint pain |
| 4 Cancer | | 15 Lung disease (asthma, chronic bronchitis, emphysema, etc) |
| 5 Chest pain/discomfort | | 16 Old age (no mention of a specific condition) |
| 6 Circulatory problems | | 17 Osteoporosis |
| 7 Diabetes | | 18 Shortness of breath |
| 8 Fatigue/tiredness (no specific disease) | | 19 Stroke |
| 9 Fall | | 1 Other symptom CLMNRS3 (Please specify: _____) |
| 10 Heart disease (including angina, congestive heart failure, etc) | | 2 Multiple conditions/symptoms given; unable to determine MAIN reason |
| 11 High blood pressure/hypertension | | 8 Don't know |



9c. How easy is it for you to walk up 10 steps without resting?
(Interviewer Note: Read response options.)

- ① Very easy
- ② Somewhat easy
- ③ Or not that easy
- ⑧ Don't know/Don't do

CLDW10EZ

9d. Do you get tired when you walk up 10 steps without resting?

- ① Yes
- ② No
- ⑧ Don't know/Don't do

CLDW10WX

9e. 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
- ② No
- ⑧ Don't know/Don't do

→

→

→

CLDW20YN

9f. How easy is it for you to walk up 20 steps without resting?
(Interviewer Note: Read response options.)

- ① Very easy
- ② Somewhat easy
- ③ Or not that easy
- ⑧ Don't know/Don't do

CLDW20EZ



10. Do you have to use a cane, walker, crutches, or other special equipment to help you get around?
CLEQUIP ① Yes ② No ③ Don't know ④ Refused

11. Because of a health or physical problem, do you have any difficulty getting in and out of bed or chairs?
CLDIOYN ① Yes ② No ③ Don't know ④ Refused

How much difficulty do you have?
(Interviewer Note: Read response options.)
 ① A little difficulty
 ② Some difficulty
 ③ A lot of difficulty
 ④ Or are you unable to do it?
 ⑤ Don't know **CLDIODIF**

Do you usually receive help from another person when you get in and out of bed or chairs?
 ① Yes ② No ③ Don't know
CLDIORHY

12. Do you have any difficulty bathing or showering?
CLBATHYN ① Yes ② No ③ Don't know ④ Refused

How much difficulty do you have?
(Interviewer Note: Read response options.)
 ① A little difficulty
 ② Some difficulty
 ③ A lot of difficulty
 ④ Or are you unable to do it?
 ⑤ Don't know **CLBATHDF**

Do you usually receive help from another person in bathing or showering?
 ① Yes ② No ③ Don't know
CLBATHRH

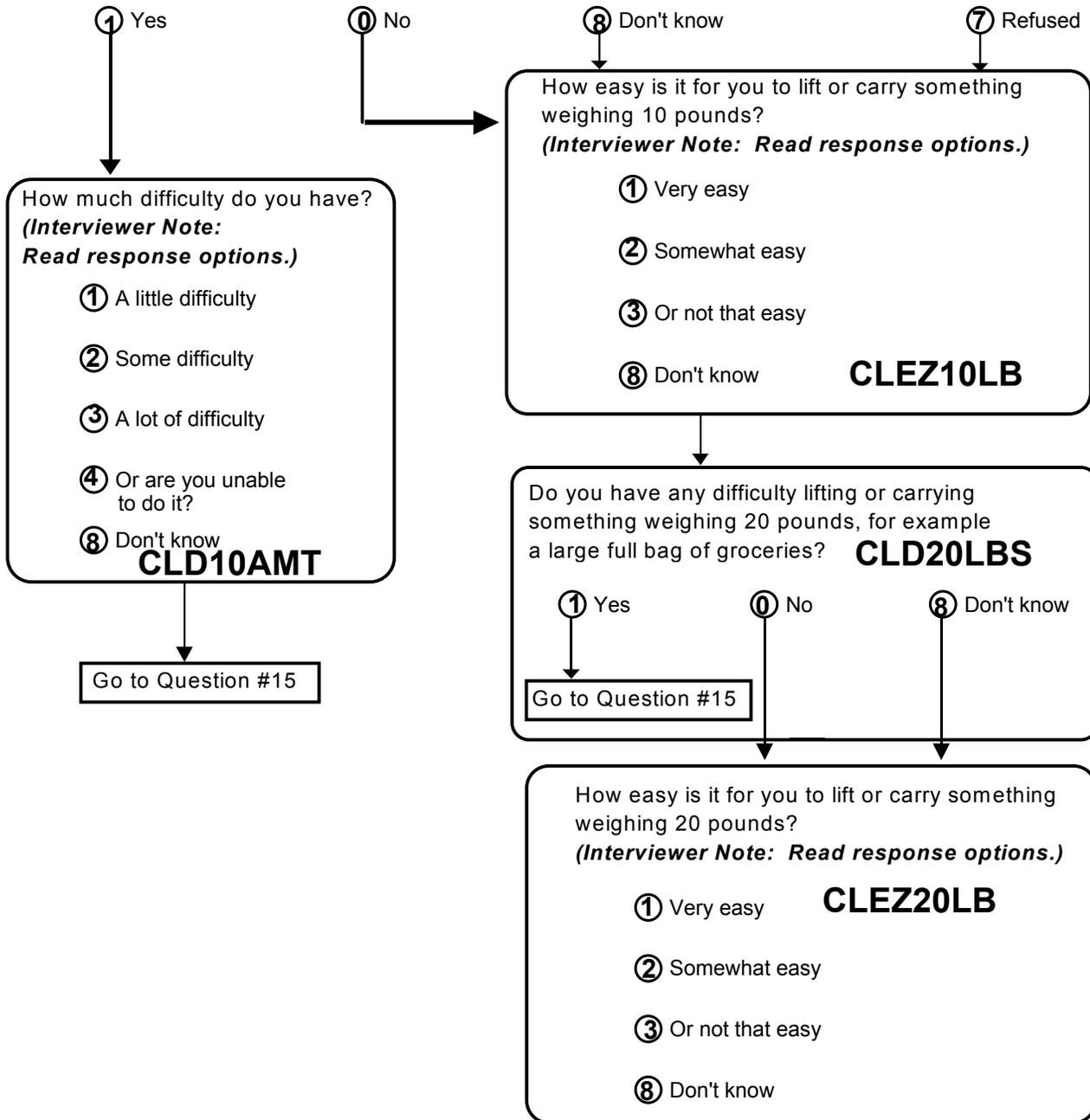
13. Do you have any difficulty dressing? **CLDDYN**
 ① Yes ② No ③ Don't know ④ Refused

How much difficulty do you have?
(Interviewer Note: Read response options.)
 ① A little difficulty
 ② Some difficulty
 ③ A lot of difficulty
 ④ Or are you unable to do it?
 ⑤ Don't know **CLDDDIF**

Do you usually receive help from another person in dressing?
 ① Yes ② No ③ Don't know
CLDDRHYN



14. 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? **CLDIF10**





PHYSICAL FUNCTION

15. 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?
(Interviewer Note: If a participant responds, "I can do them but my doctor says I'm not allowed," or "I could do them but I chose not to do them," probe by re-asking the stem question about whether they would have any difficulty doing heavy work around the house. If the participant responds, "No," check "No" and ask the follow-up question.)

CLDIFHW

① Yes ② No ③ Don't know ④ Refused

How much difficulty do you have?
(Interviewer Note: Read response options.)

- ① A little difficulty
- ② Some difficulty
- ③ A lot of difficulty
- ④ Or are you unable to do it?
- ⑤ Don't know

CLDHWAMT

How easy is it for you to do heavy work around the house?
(Interviewer Note: Read response options.)

- ① Very easy
- ② Somewhat easy
- ③ Or not that easy
- ④ Don't know

CLEZHW

16. Because of a health or physical problem, do you have any difficulty shopping for food?
 ① Yes ② No ③ Does not do ④ Don't know ⑤ Refused **CLDFSHOP**

17. Because of a health or physical problem, do you have any difficulty preparing meals?
 ① Yes ② No ③ Does not do ④ Don't know ⑤ Refused **CLDFPREP**

18. Because of a health or physical problem, do you have any difficulty taking medications by yourself?
 ① Yes ② No ③ Does not take medications ④ Don't know ⑤ Refused **CLDFMED**

Go to Question #20.

19. Do you usually receive help from another person in taking your medications?
 ① Yes ② No ③ Does not take medications ④ Don't know ⑤ Refused **CLRHMED**

20. Do you have any difficulty managing your money, for example, paying bills or keeping a bank account, by yourself and without help from another person?
 ① Yes ② No ③ Does not manage money ④ Don't know ⑤ Refused **CLDFBILL**

21. Are you less involved in managing your money than you used to be because your health or physical condition makes it difficult?
 ① Yes ② No ③ Does not manage money ④ Don't know ⑤ Refused **CLLIBILL**

22. Does another person usually help you with managing money?
 ① Yes ② No ③ Does not do ④ Don't know ⑤ Refused **CLRHBILL**



25. In the past 12 months, did you walk up a flight of stairs (a flight is about 10 steps), at least 10 times?

1 Yes
 0 No
 8 Don't know
 7 Refused

Go to Question #26

CLFS12MO

a. In the past 7 days, did you walk up a flight of stairs? **CLFS7DAY**

1 Yes
 0 No
 8 Don't know

Go to Question #26

b. About how many flights did you walk up in the past 7 days?
If you are unsure, please make your best guess.

flights
 1 Don't know
 CLFSNUMD

CLFSNUM

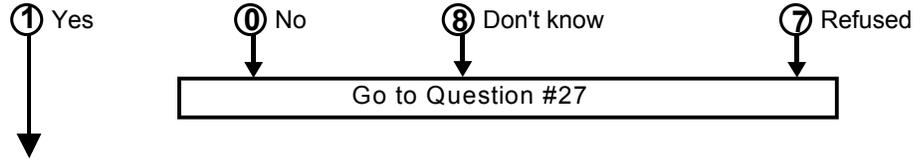
c. About how many of these flights did you walk up carrying a small load like laundry, groceries, or an infant?

flights
 1 Don't know
 CLFSLODK

CLFSLOAD



26. In the past 12 months, did you do any high intensity exercise such as bicycling, swimming, jogging, racquet sports or using a stair-stepping, rowing or cross country ski machine or exercycle, at least 10 times? **CLHI12MO**



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

1 Yes **CLHI7DAY** 0 No

a. What activity(ies) did you do?
(Interviewer Note: OPTIONAL - Show card #2. Check all that apply.)

- bicycling/exercycle **CLHIABE**
- swimming **CLHIASWM**
- jogging **CLHIAJOG**
- aerobics **CLHIAAER**
- stair-stepping **CLHIASS**
- racquet sports **CLHIARS**
- rowing machine **CLHIAROW**
- cross country ski machine **CLHIASKI**
- other *(Please specify):*

CLHIAOTH

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

Hours Minutes

CLHIA1DK
 Don't know

CLHIA1HR CLHIA1MN

c. 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.)

Hours Minutes

CLHIA2DK
 Don't know

CLHIA2HR CLHIA2MN

What is the main reason you have not done any high intensity exercise activities in the past 7 days?
(Interviewer Note: OPTIONAL - Show card #3.)

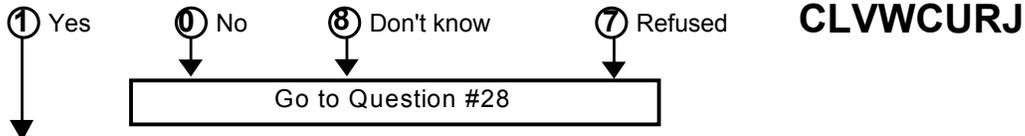
- 1 bad weather
- 2 not enough time
- 3 injury **CLHINDEX**
- 4 health problems
- 5 lost interest
- 6 felt unsafe
- 7 not necessary
- 8 other

Go to Question #27



The next set of questions concern any work, volunteer, caregiving and social activities that you do.

27. Do you currently work for pay, either at a regular job, consulting, or doing odd jobs?



a. On average, how many hours do you work per week?

hours **CLVWAHWR**

b. How many months of the year do you work?

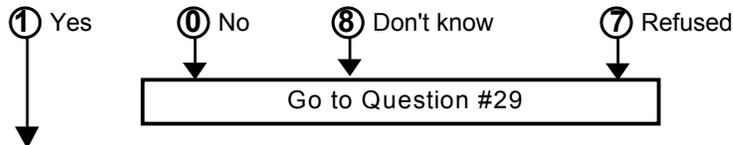
months **CLVWMOW**

c. Which of the following categories best describes the type of activity you do in your job? Would you say...

(Interviewer Note: REQUIRED - Show card #4.)

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

28. Do you currently do any volunteer work? **CLVWCURV**



a. On average, how many hours do you volunteer per week?

hours **CLVWAHVW**



28b. How many months of the year do you do this?

months **CLVWMOV**

c. Which of the following categories best describes the type of activity you do?
(Interviewer Note: **REQUIRED - Show card #4.**)

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

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

① Yes ② No ③ Don't know ④ Refused **CLVWCURA**

↓ ↓ ↓ ↓

Go to Question #30

About how many hours per week do you provide care to another person?
If you are unsure, please make your best guess.

hours ⑤ Don't know **CLVWDAHAW** ⑥ Refused **CLVWWDK**

30. About how many hours per week do you spend watching television?
(Interviewer Note: **REQUIRED - Show card #5.**)

- ⑦ Zero
- ⑧ More than 0 but less than 7 hours/week
- ⑨ At least 7, but less than 14 hours/week
- ⑩ At least 14, but less than 21 hours/week
- ⑪ At least 21, but less than 28 hours/week
- ⑫ At least 28, but less than 35 hours/week
- ⑬ 35 or more hours/week
- ⑭ Don't know **CLVWTV**
- ⑮ Refused

Do you usually use a remote control for your TV?
⑯ Yes ⑰ No ⑱ Don't know **CLVWTVRM**

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

hours ⑲ Don't know ⑳ Refused

CLVWREAD **CLVWRDRF**

32. During an average 24-hour day, about how many hours do you usually spend sleeping and lying down with your feet up? Be sure to include time sleeping at night or trying to sleep, resting or stretched out on the sofa watching T.V., etc.

CLSLEEP
hours a day sleeping and lying down

33. During an average 24-hour day, about how many hours do you usually spend sitting upright? Be sure to include time sitting at the table eating, driving or riding in a car or bus, sitting watching T.V. or talking, etc.

CLUP
hours a day sitting upright

Now I'm going to ask you about some medical problems that you might have had in the past 12 months.

In the past 12 months, has a doctor told you that you had...?

34. Hypertension or high blood pressure? We are specifically interested in hearing about hypertension or high blood pressure that was diagnosed for the first time in the past 12 months.

① Yes ② No ③ Don't know ④ Refused **CLHCHBP**

35. Diabetes or sugar diabetes? Again, we are specifically interested in hearing about diabetes that was diagnosed for the first time in the past 12 months.

① Yes ② No ③ Don't know ④ Refused **CLSGDIAB**

36. In the past 12 months, have you fallen and landed on the floor or ground? **CLAJFALL**

① Yes ② No ③ Don't know ④ Refused

Please go to Question #37

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

① One **CLAJFNUM**
② Two or three
③ Four or five
④ Six or more
⑤ Don't know

Now I'm going to ask you about any medical problems you might have had since we last spoke to you about 6 months ago, which was on

/ /
 Month Day Year

37. Since we last spoke to you 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 ② No ③ Don't know ④ Refused

CLHCHAMI

Were you hospitalized overnight for this problem?

① Yes ② No

CLHOSMI

Complete a Health ABC Event Form(s), Section I, for each overnight hospitalization. Record reference #'s below:

a.

b.

c.

Go to Question #38

CLREF37A
CLREF37B
CLREF37C

38. Since we last spoke to you about 6 months ago, has a doctor told you that you had a stroke, mini-stroke, or TIA ?
 CLHCCVA ① Yes ② No ③ Don't know ④ Refused

Were you hospitalized overnight for this problem?

① Yes ② No

CLHOSMI2

Complete a Health ABC Event Form(s), Section I, for each overnight hospitalization. Record reference #'s below:

a.

b.

c.

Go to Question #39

CLREF38A
CLREF38B
CLREF38C

39. Since we last spoke to you about 6 months ago, has a doctor told you that you had congestive heart failure?
 CLCHF ① Yes ② No ③ Don't know ④ Refused

Were you hospitalized overnight for this problem?

① Yes ② No

CLHOSMI3

Complete a Health ABC Event Form(s), Section I, for each overnight hospitalization. Record reference #'s below:

a.

b.

c.

Go to Question #40

CLREF39A
CLREF39B
CLREF39C



40. Since we last spoke to you 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 we last spoke to you.

CLCHMGMT

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

Complete a Health ABC Event Form(s), Section II, for each event.
Record reference #'s below:

a.

| | | | | |
|--|--|--|--|--|
| | | | | |
|--|--|--|--|--|

b.

| | | | | |
|--|--|--|--|--|
| | | | | |
|--|--|--|--|--|

c.

| | | | | |
|--|--|--|--|--|
| | | | | |
|--|--|--|--|--|

CLREF40A

CLREF40B

CLREF40C

41. Since we last spoke to you about 6 months ago, has a doctor told you that you had pneumonia?

CLLCPNEU

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

Complete a Health ABC Event Form(s), Section II, for each event.
Record reference #'s below:

a.

| | | | | |
|--|--|--|--|--|
| | | | | |
|--|--|--|--|--|

b.

| | | | | |
|--|--|--|--|--|
| | | | | |
|--|--|--|--|--|

c.

| | | | | |
|--|--|--|--|--|
| | | | | |
|--|--|--|--|--|

CLREF41A

CLREF41B

CLREF41C

42. Since we last spoke to you about 6 months ago, have you been told by a doctor that you broke or fractured a bone(s)?

CLOSBR45

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

Complete a Health ABC Event Form(s), Section II, for each event.
Record reference #'s below:

a.

| | | | | |
|--|--|--|--|--|
| | | | | |
|--|--|--|--|--|

b.

| | | | | |
|--|--|--|--|--|
| | | | | |
|--|--|--|--|--|

c.

| | | | | |
|--|--|--|--|--|
| | | | | |
|--|--|--|--|--|

CLREF42A

CLREF42B

CLREF42C



Health ABC MEDICAL CONDITIONS IN PAST 6 MONTHS

43. Were you hospitalized overnight for any other reasons since we last spoke to you about 6 months ago?
CLHOSP12 Yes No Don't know Refused

*Complete a Health ABC Event Form(s), Section I, for each event.
 Record reference #'s and reason for hospitalization below.*

| | | |
|---|---|---|
| <p>a. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>Reason for hospitalization: <u>CLREF43A</u></p> | <p>b. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>Reason for hospitalization: <u>CLREF43B</u></p> | <p>c. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>Reason for hospitalization: <u>CLREF43C</u></p> |
| <p>d. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>Reason for hospitalization: <u>CLREF43D</u></p> | <p>e. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>Reason for hospitalization: <u>CLREF43E</u></p> | <p>f. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>Reason for hospitalization: <u>CLREF43F</u></p> |

44. Have you had any same day outpatient surgery since we last spoke to you about 6 months ago?
CLOUTPA Yes No Don't know Refused

| | | |
|--|--|---|
| | | <i>Reference #'s</i> |
| <p>a. Was it for...? A procedure to open a blocked artery CLBLART</p> | <p><input checked="" type="radio"/> Yes → <input type="radio"/> No <input type="radio"/> Don't know</p> | <p><i>Complete a Health ABC Event form, Section III. Record reference #:</i></p> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> CLREF44A |
| <p>b. Gall bladder surgery CLGALLBL</p> | <p><input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know</p> | |
| <p>c. Cataract surgery CLCATAR</p> | <p><input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know</p> | |
| <p>d. Hernia repair (Inguinal abdominal hernia.) CLHERN</p> | <p><input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know</p> | |
| <p>e. TURP (MEN ONLY) (transurethral resection of prostate) CLTURP</p> | <p><input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know</p> | |
| <p>f. Other CLOTH</p> | <p><input checked="" type="radio"/> Yes → <input type="radio"/> No <input type="radio"/> Don't know</p> | <p><i>Please specify the type of outpatient surgery.</i></p> <p>i. _____</p> <p>ii. _____</p> <p>iii. _____</p> |



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

① Yes ② No ③ Don't know ④ Refused **CLOTILL**

Please go to Question #46

Please describe for what:

46. This next question refers to the past month. In the past month, on the average, have you been feeling unusually tired during the day?

① Yes ② No ③ Don't know ④ Refused

Have you been feeling unusually tired...?
(Interviewer Note: Read response options.)

① All of the time
② Most of the time
③ Some of the time
④ Don't know
⑤ Refused

CLELOFTN

CLELTIRE

47. Using this card, please choose the category that best describes your usual energy level in the past month on a scale of 0 to 10 where 0 is no energy and 10 is the most energy that you have ever had. *(Interviewer Note: REQUIRED - Show card #6.)*

Energy level

③ Don't know ④ Refused

CLELEV

CLELEVRF



| | | | |
|--|---|---|---|
| HABC Enrollment ID # H [] [] [] [] [] CMID | Acrostic [] [] [] [] [] CMACROS | Date Form Completed [] / [] / [] [] [] [] Month Day Year CMDATE | Staff ID # [] [] [] [] CMSTFID |
|--|---|---|---|

**ASSESSMENT OF ARTHRITIS
and KNEE PAIN**

48. In the past 12 months, has a doctor told you that you have osteoarthritis or degenerative arthritis? We are specifically interested in learning about osteoarthritis or degenerative arthritis that was diagnosed for the first time in the past 12 months.

1 Yes
 0 No
 8 Don't know
 7 Refused
CMAJARTH1

| | |
|---|---|
| a. Did the doctor say it was...? | |
| i. Osteoarthritis or degenerative arthritis in your <u>knee</u> ? CMAJKNEE | <input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Don't know |
| ii. Osteoarthritis or degenerative arthritis in your <u>hip</u> ? CMAJHIP | <input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Don't know |
| b. Do you take any medicines for arthritis or joint pain? CMAJMEDS | <input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Don't know |

Now I am going to ask you some questions about pain, aching or stiffness in, or around your knee. This includes the front, back and sides of the knee.

49. In the past 12 months, have you had any pain, aching or stiffness in either knee?

CMAJK12
 1 Yes
 0 No †
 8 Don't know
 7 Refused

Go to Question #51

In the past 12 months, have you had pain, aching or stiffness in either knee on most days for at least one month? **CMAJKMD**

1 Yes *
 0 No †
 8 Don't know

Have you had this pain in your right knee, left knee, or both knees?
(Interviewer Note: Check only one response.)

1 Right knee only
 2 Left knee only
 3 Both right and left knee
 8 Don't know
CMAJLRB1

* Interviewer Note: Year 3 Knee MRI and X-ray Eligibility Assessment Form in the Year 3 Clinic Visit Workbook must be completed. Participant may be eligible for knee MRI and X-ray.

† Interviewer Note: Year 3 Knee MRI and X-ray Eligibility Assessment Form in the Year 3 Clinic Visit Workbook must be completed. Participant may be eligible for knee MRI and X-ray as a "control."



50. Now, please think about the past 30 days. In the past 30 days, have you had any pain, aching or stiffness in either knee?

- Yes
 No †
 Don't know
 Refused

CMAJK30

Go to Question #51

a. In the past 30 days, have you had pain, aching or stiffness in either knee on most days?

- Yes *
 No †
 Don't know
 CMAJKMS

b. In the past 30 days, how much pain have you had in your knees for each activity I will describe. How much pain have you had while...? (*Interviewer Note: Read each activity separately. Read response options.*)

| | None † | Mild † | Moderate * | Severe * | Extreme * | Don't know |
|---------------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------------|
| a) Walking on a flat surface | <input type="radio"/> † | <input type="radio"/> † | <input type="radio"/> * | <input type="radio"/> * | <input type="radio"/> * | <input type="radio"/> CMAJKFS |
| b) Going up or down stairs | <input type="radio"/> † | <input type="radio"/> † | <input type="radio"/> * | <input type="radio"/> * | <input type="radio"/> * | <input type="radio"/> CMAJKST |
| c) At night while in bed | <input type="radio"/> † | <input type="radio"/> † | <input type="radio"/> * | <input type="radio"/> * | <input type="radio"/> * | <input type="radio"/> CMAJKBD |
| d) Standing upright | <input type="radio"/> † | <input type="radio"/> † | <input type="radio"/> * | <input type="radio"/> * | <input type="radio"/> * | <input type="radio"/> CMAJKUP |
| e) Getting in or out of a chair | <input type="radio"/> † | <input type="radio"/> † | <input type="radio"/> * | <input type="radio"/> * | <input type="radio"/> * | <input type="radio"/> CMAJKCH |
| f) Getting in or out of a car | <input type="radio"/> † | <input type="radio"/> † | <input type="radio"/> * | <input type="radio"/> * | <input type="radio"/> * | <input type="radio"/> CMAJKIN |

c. Have you had this pain in your right knee, left knee, or both knees?

(*Interviewer Note: Check only one response.*) **CMAJLRB2**

- Right knee only
 Left knee only
 Both right and left knee
 Don't know

* *Interviewer Note: Year 3 Knee MRI and X-ray Eligibility Assessment Form in the Year 3 Clinic Visit Workbook must be completed. Participant may be eligible for knee MRI and X-ray.*

† *Interviewer Note: Year 3 Knee MRI and X-ray Eligibility Assessment Form in the Year 3 Clinic Visit Workbook must be completed. Participant may be eligible for knee MRI and X-ray as a "control."*

In the past 30 days, have you limited your activities because of pain, aching or stiffness in your knees?

51.
 Yes
 No
 Don't know
 Refused
 CMAJLACT

On how many days did you limit your activities because of pain, aching or stiffness?

|
|

days

CMAJLDAY

52. Have you changed, cut back, or avoided any activities in order to avoid knee pain or reduce the amount of knee pain?

CMAJCUT

- Yes
 No
 Don't know
 Refused



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

a. A cataract in one eye? **CMESCAT1**
 1 Yes 0 No 8 Don't know 7 Refused

b. Cataracts in both eyes, at the same time? **CMESCAT2**
 1 Yes 0 No 8 Don't know 7 Refused

c. Glaucoma? **CMESGLAU**
 1 Yes 0 No 8 Don't know 7 Refused

d. Problems with your retina, retinopathy, or retinal disease or changes? **CMESRET**
 1 Yes 0 No 8 Don't know 7 Refused

e. Macular degeneration? **CMESMACD**
 1 Yes 0 No 8 Don't know 7 Refused

- 54.** 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 #7.)

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

CMESQUAL

- 55.** How much of the time do you worry about your eyesight?
(Interviewer Note: Read categories. OPTIONAL - Show card #8.)

- 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

CMESWORY



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.

- 56.** 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 #9.)

- 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

CMESREAD

- 57.** 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 you have . . . ?
(Interviewer Note: Read categories as needed. OPTIONAL - Show card #9.)

- 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

CMESSWUC

- 58.** 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 #10.)

- ① No difficulty at all
- ② A little difficulty
- ③ Moderate difficulty
- ④ Extreme difficulty
- ⑧ Don't know
- ⑦ Refused

CMESRECG

59. Because of your eyesight, how much difficulty do you have going down steps, stairs, or curbs in dim light or at night? (*Interviewer Note: Read categories as needed. OPTIONAL - Show card #11.*)

- 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

CMESSTEP

60. Because of your eyesight, how much difficulty do you have noticing objects off to the side while you are walking along? (*Interviewer Note: Read categories as needed. OPTIONAL - Show card #11.*)

- 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

CMESSIDE

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

61. Are you limited in the kinds or amount of work or other activities you can do? (*Interviewer Note: Read categories as needed. OPTIONAL - Show card #12.*)

- 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

CMESACT



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

- ① Yes ① No, I never drove ② No, I am no longer driving ⑧ Don't know ⑦ Refused

a. When did you stop driving? **CMESSTOP**

- ① Less than 6 months ago
② 6-12 months ago
③ More than 12 months ago
⑧ Don't know

b. Did you stop driving because of your eyesight?

- ① Yes ① No ⑧ Don't know

CMESSITE



63. In general, 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
- ⑤ Very poor
- ⑧ Don't know
- ⑦ Refused

CMAPPET

64. How much do you currently weigh?
(Interviewer Note: If necessary, probe - "If you are unsure, please make your best guess.")

pounds

CMWTLBS

⑧ Don't know/don't remember

⑦ Refused

CMLBS2

65. Since we last spoke to you about 6 months ago, has your weight changed by 5 or more pounds?

- ① Yes
- ⑦ Refused
- ⑧ Don't know
- ② No

CMCHN5LB

a. Did you gain or lose weight?
(Interviewer Note: We are interested in net gain or loss during the past 6 months.)

CMGNLS

- ① Gain
- ② Lose
- ⑧ Don't know/don't remember

b. Were you trying to gain/lose weight?

- ① Yes
- ② No
- ⑧ Don't know

CMTRGNLS

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

CMTRYLOS

- ① Yes
- ⑦ Refused
- ⑧ Don't know
- ② No

67. Do you currently smoke cigarettes?

CMSMOKE

- ① Yes
- ⑦ Refused
- ⑧ Don't know
- ② No

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

cigarettes per day

CMSMOKAV

b. Do you smoke to keep from gaining weight or to lose weight?

- ① Yes
- ② No
- ⑧ Don't know

CMSMOKWT



68. 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.)

CMSHNAPS

naps

⑧ Don't know ⑦ Refused

CMSHNPS2

69. 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 (Once per month or less) | Sometimes (2 to 4 times per month) | Often (5 to 15 times per month) | Almost Always (16 to 30 times per month) | Don't know | Refused |
|---|----------------------|------------------------------------|---------------------------------------|------------------------------------|---|------------|---------|
| a) Have trouble falling asleep. | ① CMSHTFS | ① | ② | ③ | ④ | ⑧ | ⑦ |
| b) Wake up during the night and have difficulty getting back to sleep. | ① CMSHWUDN | ① | ② | ③ | ④ | ⑧ | ⑦ |
| c) Wake up too early in the morning and be unable to get back to sleep. | ① CMSHWUTE | ① | ② | ③ | ④ | ⑧ | ⑦ |
| d) Feel excessively (overly) sleepy during the day. | ① CMSHFESD | ① | ② | ③ | ④ | ⑧ | ⑦ |
| e) Take sleeping pills or other medication to help you sleep. | ① CMSHMED | ① | ② | ③ | ④ | ⑧ | ⑦ |



FEELINGS IN THE PAST WEEK

70. 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 #14.)*

| | 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. CMBOTHER | ① | ② | ③ | ④ | ⑤ | ⑥ |
| b. I had trouble keeping my mind on what I was doing. CMMIND | ① | ② | ③ | ④ | ⑤ | ⑥ |
| c. I was depressed. CMDEPRES | ① | ② | ③ | ④ | ⑤ | ⑥ |
| d. I felt that everything I did was an effort. CMEFFORT | ① | ② | ③ | ④ | ⑤ | ⑥ |
| e. I felt hopeful about the future. CMFUTURE | ① | ② | ③ | ④ | ⑤ | ⑥ |
| f. I felt fearful. CMFEAR | ① | ② | ③ | ④ | ⑤ | ⑥ |
| g. My sleep was restless. CMREST | ① | ② | ③ | ④ | ⑤ | ⑥ |
| h. I was happy. CMHAPPY | ① | ② | ③ | ④ | ⑤ | ⑥ |
| i. I felt lonely. CMLONELY | ① | ② | ③ | ④ | ⑤ | ⑥ |
| j. I could not get going. CMGETGO | ① | ② | ③ | ④ | ⑤ | ⑥ |

71. Beside yourself, how many other people live in your household?

other people in household

CMSSOPIH

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

- ① Yes ② No ③ Don't know ④ Refused **CMLEACC**

73. Did a child, grandchild, close friend, or relative die in the past 12 months?
(Interviewer Note: The death of a spouse or partner should be recorded in the next question, Question #74.)

- ① Yes ② No ③ Don't know ④ Refused **CMLERDIE**

74. Did your spouse or partner die in the past 12 months? **CMLESDIE** **CMACROS2**

- ① Yes ② No ③ Don't know ④ Refused

Go to Question #81

75. Please tell me which best describes how you feel right now.
(Interviewer Note: **REQUIRED - Show card #15**)

| | Never | Rarely | Sometimes | Often | Always | Refused |
|--|-------|--------|-----------|-------|--------|---------|
| a. I think about this person so much that it's hard for me to do the things I normally do. | ① | ② | ③ | ④ | ⑤ | ⑥ |
| CMLETHNK | | | | | | |
| b. Memories of the person who died upset me. | ① | ② | ③ | ④ | ⑤ | ⑥ |
| CMLEMEM | | | | | | |
| c. I feel I cannot accept the death of the person who died. | ① | ② | ③ | ④ | ⑤ | ⑥ |
| CMLEACPT | | | | | | |
| d. I feel myself longing for the person who died. | ① | ② | ③ | ④ | ⑤ | ⑥ |
| CMLELONG | | | | | | |
| e. I feel drawn to places and things associated with the person who died | ① | ② | ③ | ④ | ⑤ | ⑥ |
| CMLEDRWN | | | | | | |
| f. I can't help feeling angry about his/her death. | ① | ② | ③ | ④ | ⑤ | ⑥ |
| CMLEANGR | | | | | | |
| g. I feel disbelief over what happened. | ① | ② | ③ | ④ | ⑤ | ⑥ |
| CMLEDISB | | | | | | |
| h. I feel stunned or dazed over what happened. | ① | ② | ③ | ④ | ⑤ | ⑥ |
| CMLEDAZE | | | | | | |
| i. Ever since s/he died it is hard for me to trust people. | ① | ② | ③ | ④ | ⑤ | ⑥ |
| CMLETRST | | | | | | |
| j. Ever since s/he died I feel like I have lost the ability to care about other people or I feel distant from people I care about. | ① | ② | ③ | ④ | ⑤ | ⑥ |
| CMLEDIST | | | | | | |
| k. I have pain in the same area of my body or have some of the same symptoms as the person who died. | ① | ② | ③ | ④ | ⑤ | ⑥ |
| CMLEPAIN | | | | | | |
| l. I go out of my way to avoid reminders of the person who died. | ① | ② | ③ | ④ | ⑤ | ⑥ |
| CMLEAVD | | | | | | |
| m. I feel that life is empty without the person who died. | ① | ② | ③ | ④ | ⑤ | ⑥ |
| CMLEEMPT | | | | | | |
| n. I hear the voice of the person who died speak to me. | ① | ② | ③ | ④ | ⑤ | ⑥ |
| CMLESPK | | | | | | |
| o. I see the person who died stand before me. | ① | ② | ③ | ④ | ⑤ | ⑥ |
| CMLESTND | | | | | | |
| p. I feel that it is unfair that I should live when this person died. | ① | ② | ③ | ④ | ⑤ | ⑥ |
| CMLELIVE | | | | | | |
| q. I feel bitter over this person's death. | ① | ② | ③ | ④ | ⑤ | ⑥ |
| CMLEBITR | | | | | | |
| r. I feel envious of others who have not lost someone close. | ① | ② | ③ | ④ | ⑤ | ⑥ |
| CMLEENV | | | | | | |
| s. I feel lonely a great deal of the time ever since s/he died. | ① | ② | ③ | ④ | ⑤ | ⑥ |
| CMLELONE | | | | | | |

Draft



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

- ① Yes ② No ③ Don't know ④ Refused **CMSSSEPY**

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

- ① A lot more ② Some more ③ A little more ④ Don't know

77. 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 #16.*)

CMSSFFST ④ Don't know ⑤ Refused **CMSSFFDR**

78. 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 #16.*)

CMSSFFH ④ Don't know ⑤ Refused **CMSSFHDR**

79. 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 #16.*)

CMSSMEAN ④ Don't know ⑤ Refused **CMSFMDR**

80. 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 #17.*)

CMSSHAPY ④ Don't know ⑤ Refused **CMSSHADR**

81. 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?

- CMSSCAN** ① Agree ② Disagree ④ Don't know ⑤ Refused

Would you say you agree strongly or agree somewhat?

- ① Agree strongly
② Agree somewhat
④ Don't know

CMSSCANANA

Would you say you disagree strongly or disagree somewhat?

- ① Disagree strongly
② Disagree somewhat
④ Don't know

CMSSCAND

82. 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 ④ Don't know ⑤ Refused **CMSSOFH**

Would you say you agree strongly or agree somewhat?

- ① Agree strongly
② Agree somewhat
④ Don't know

CMSSDFHA

Would you say you disagree strongly or disagree somewhat?

- ① Disagree strongly
② Disagree somewhat
④ Don't know

CMSSDFHD



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

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

CMSSNRVS

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

CMSSNDEG

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

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

CMSSTENS

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

CMSSTDEG

85. Do you have any pets that live with you?

CMPETS

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

What kind of pet do you have? *(Interviewer Note: Please mark all that apply.)*

- Dog
 Cat
 Bird
 Fish
 Other
- CMDOG**
 CMCAT
 CMBIRD
 CMFISH
 CMOTHPET

How many times a week do you walk your dog(s)?

CMDOGWLK
 per week



86. Have you changed your doctor or place that you usually go for health care or advice about your health care in the past 12 months? **CMHCADV**

- ① Yes
↓
- ② No
↓
- ③ Don't know
↓
- ④ Refused
↓
- ⑤ I don't have a doctor or place that I usually go for health care
↓
Go to Question #87

a. Where do you usually go 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)
CMHCSRC
- ② Public clinic such as a neighborhood health center
- ③ Health Maintenance Organization (HMO) *(Please specify: _____)*
(Examples: Security Blue, US Healthcare, Health America, The Apple Plan, Omnicare, Prucare)
- 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.

| | | |
|-----------------|---------------------------------------|-----------------|
| CMDFNAME | | |
| | First Name | |
| CMDLNAME | | |
| | Last Name | |
| CMDSTRT | | |
| | Street Address | |
| CMDCITY | | |
| | City | State |
| CMDZIP | - | CMDSTATE |
| | Zip Code | |
| Telephone: | () - | CMDPHONE |
| | Area Code Number | |



87. We would like to update all of your contact information this year. The address that we currently have listed for you is (**Examiner Note: Please read address from the Data from Prior Visits Report**):

Please tell me if the information I have is still correct.

Examiner Note: Clearly record correct address FOR ALL PARTICIPANTS below.

CMFNAME
First Name

CMLNAME
Last Name

CMSTREET
Street Address

CMAPT
Apt/Room

CMCITY
City State

CMZIP -
Zip Code

CMSTATE

The telephone number(s) that we currently have for you is (are): (**Examiner Note: Please read telephone number(s) from the Data from Prior Visits Report**)

Please tell me if this telephone number is correct.

Examiner Note: Clearly record correct telephone number(s) FOR ALL PARTICIPANTS below.

Home Telephone #: () -
Area Code Number **CMPHONE**

Work Telephone #: () -
Area Code Number **CMWKPHON**

CONTACT INFORMATION

91. Has the participant previously identified their next of kin in Question #89, #90 or #90a?

① Yes ② No

CMKNOK



Who is your next of kin?

CMKFNAME

First Name

CMKLNNAME

Last Name

CMKSTRT

Street Address

CMKAPT

Apt/Room

CMKCITY

City

State

CMKZIP -

Zip Code

CMKSTATE

Telephone:

() -

Area Code

Number

CMKPHONE

How is this person related to you?

- ① My husband or wife
- ② My son or daughter
- ③ My niece or nephew
- ④ My grandchild
- ⑤ My brother or sister
- ⑥ My mother or father
- ⑦ Friend/neighbor
- ⑧ Someone else *(Please say how related:)*

CMKREL



92. Has the participant previously identified their power of attorney in Question #89, #90 or #90a?

① Yes

② No

CMPPOA

Have you given anyone power of attorney?

① Yes

② No

CMPAYN

CMPAFNAM

First Name

CMPALNAM

Last Name

CMPASTRT

Street Address

CMPAAPT

Apt/Room

CMPACITY

City

State

CMPAZIP -

Zip Code

CMPASTAT

Telephone: **CMPAPHON**

() -

Area Code

Number

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

① My husband or wife

⑤ My brother or sister

② My son or daughter

⑥ My mother or father

③ My niece or nephew

⑦ Friend/neighbor

④ My grandchild

⑧ Someone else *(Please say how related:)*



93. *Interviewer Note: Please answer the following question based on your judgement of the participant's responses to this questionnaire.*

On the whole, how reliable do you think the participant's responses to this questionnaire are?

- ① Very reliable
- ② Fairly reliable
- ③ Not very reliable
- ④ Don't know

CMRELY





HABC Enrollment ID #

Acrostic

Date Form Completed

Staff ID #

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C4ID

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C4ACROS

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Month Day Year

C4DATE

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C4STFID

YEAR 3 CLINIC VISIT WORKBOOK

Arrival Time:

C4TIME1

Hours Minutes

Departure Time:

C4TIME2

Hours Minutes

YEAR 3 CLINIC VISIT PROCEDURE CHECKLIST

| Test | Page Numbers | Please check if done | | | Comments |
|--|--------------|----------------------|-------------------------|------------------|----------|
| | | Yes | No, participant refused | No, other reason | |
| 1. Was the Year 3 questionnaire administered? | | ① | ② | ③ | C4Y3ADM |
| 2. Medication inventory update | 2 | ① | ② | ③ | C4MI |
| 3. Weight | 7 | ① | ② | ③ | C4WT |
| 4. Radial pulse | 7 | ① | ② | ③ | C4RP |
| 5. Blood pressure | 8 | ① | ② | ③ | C4BP |
| 6. Bone density (DXA) scan | 9 | ① | ② | ③ | C4DXA |
| 7. Isokinetic muscle fatigue (Kin-Com) | 11 | ① | ② | ③ | C4ISO |
| 8. Isometric strength (Isometric chair) | 17 | ① | ② | ③ | C4ISOCH |
| 9. 20-meter walk | 19 | ① | ② | ③ | C420M |
| 10. Rapid Estimate of Adult Literacy in Medicine (REALM) | 20 | ① | ② | ③ | C4REALM |
| 11. Teng Mini-Mental | 22 | ① | ② | ③ | C4TMM |
| 12. Clox 1 | 28 | ① | ② | ③ | C4CLOX1 |
| 13. Exit 15 | 29 | ① | ② | ③ | C4EXIT15 |
| 14. Bailey-Lovie distance visual acuity | 33 | ① | ② | ③ | C4BLDVA |
| 15. Pelli-Robson contrast sensitivity | 35 | ① | ② | ③ | C4PRCS |
| 16. Frisby stereo test | 36 | ① | ② | ③ | C4FRISBY |
| 17. Olfaction (smell test) | 38 | ① | ② | ③ | C4SMELL |
| 18. MRI and X-ray Eligibility Assessment | 41 | ① | ② | ③ | C4MRI |
| 19. Phlebotomy | 42 | ① | ② | ③ | C4PHL |
| 20. Blood gas results/Laboratory processing | 45 | ① | ② | ③ | C4BLGAS |
| 21. Did participant agree to schedule a knee X-ray? | ① Yes | ② No | ⑤ Not applicable | ⑨ Not eligible | C4KNXR |
| 22. Did participant agree to schedule a knee MRI? | ① Yes | ② No | ⑤ Not applicable | ⑨ Not eligible | C4KNMRI |
| 23. Was the Year 3 Dental and Periodontal Exam Workbook completed? | ① Yes | ② No | ⑤ Not applicable | ⑨ Not eligible | C4DENTAL |
| 24. Was the energy expenditure visit 1 exam administered? | ① Yes | ② No | ⑤ Not applicable | ⑨ Not eligible | C4EEV1 |
| 25. Were the cognitive vitality exams administered? | ① Yes | ② No | ⑤ Not applicable | ⑨ Not eligible | C4CV |

Memphis Only:

Would you like us to send a copy of your test results to your doctor?

C4DOC

① Yes ② No

Draft

Page Link #

| |
|--|
| |
|--|

C4LINK



Health ABC MEDICATION INVENTORY FORM--page b

SectionB 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 | MIFUNIT | 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 Date Started: Month Year | MIFFORM Formulation Code: | <input checked="" type="checkbox"/> Rx 1 <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: | | | | Date Started: Month Year | Formulation Code: | <input checked="" 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: | | | | Date Started: Month Year | Formulation Code: | <input checked="" 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: | | | | Date Started: Month Year | Formulation Code: | <input checked="" 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: | | | | Date Started: Month Year | Formulation Code: | <input checked="" 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: | | | | Date Started: Month Year | Formulation Code: | <input checked="" 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: | | | | Date Started: Month Year | Formulation Code: | <input checked="" 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"/> <input type="text" value="D"/> <input type="text" value="W"/> <input type="text" value="M"/> | <input type="text" value="1"/> Y <input type="text" value="0"/> N MIFPRN | <input checked="" type="text" value="1"/> Y <input type="text" value="0"/> N MIFSEEN |
| Reason for use: <input type="text" value="MIFREAS"/> | | Date Started: Month <input type="text" value="MUS 1"/> Year <input type="text" value="MUS 2"/> <input type="text" value="MUS 3"/> | | Formulation Code: <input type="text" value="MIFFORM"/> | <input checked="" type="text" value="X"/> Rx <input type="text" value="1"/> <input type="text" value="0"/> Non Rx <input checked="" type="text" value="X"/> MIFRX |
| 2. <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> D W M | <input type="text"/> Y <input type="text"/> N | <input type="text"/> Y <input type="text"/> N |
| Reason for use: <input type="text"/> | | Date Started: Month <input type="text"/> Year <input type="text"/> | | Formulation Code: <input type="text"/> | <input type="text"/> Rx <input checked="" type="text" value="X"/> Non Rx |
| 3. <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> D W M | <input type="text"/> Y <input type="text"/> N | <input type="text"/> Y <input type="text"/> N |
| Reason for use: <input type="text"/> | | Date Started: Month <input type="text"/> Year <input type="text"/> | | Formulation Code: <input type="text"/> | <input type="text"/> Rx <input checked="" type="text" value="X"/> Non Rx |
| 4. <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> D W M | <input type="text"/> Y <input type="text"/> N | <input type="text"/> Y <input type="text"/> N |
| Reason for use: <input type="text"/> | | Date Started: Month <input type="text"/> Year <input type="text"/> | | Formulation Code: <input type="text"/> | <input type="text"/> Rx <input checked="" type="text" value="X"/> Non Rx |
| 5. <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> D W M | <input type="text"/> Y <input type="text"/> N | <input type="text"/> Y <input type="text"/> N |
| Reason for use: <input type="text"/> | | Date Started: Month <input type="text"/> Year <input type="text"/> | | Formulation Code: <input type="text"/> | <input type="text"/> Rx <input checked="" type="text" value="X"/> Non Rx |
| 6. <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> D W M | <input type="text"/> Y <input type="text"/> N | <input type="text"/> Y <input type="text"/> N |
| Reason for use: <input type="text"/> | | Date Started: Month <input type="text"/> Year <input type="text"/> | | Formulation Code: <input type="text"/> | <input type="text"/> Rx <input checked="" type="text" value="X"/> Non Rx |
| 7. <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> D W M | <input type="text"/> Y <input type="text"/> N | <input type="text"/> Y <input type="text"/> N |
| Reason for use: <input type="text"/> | | Date Started: Month <input type="text"/> Year <input type="text"/> | | Formulation Code: <input type="text"/> | <input type="text"/> Rx <input checked="" type="text" value="X"/> 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. | MIFNAME | MIF STREN | MIFUNIT | MIFDWM ___ D W M | <input checked="" type="checkbox"/> Y <input type="checkbox"/> N | MIFSEEN <input checked="" type="checkbox"/> Y <input type="checkbox"/> N |
| Reason for use: | MIFREAS | | MIFNMUS 1 2 3 MIFMONTH MIFYEAR | Date Started: Month Year | MIFPRN Formulation Code: MIFFORM | <input checked="" type="checkbox"/> Rx <input checked="" type="checkbox"/> Non Rx |
| 9. | | | | ___ D W M | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Reason for use: | | | | Date Started: Month Year | Formulation Code: _____ | <input type="checkbox"/> Rx <input checked="" type="checkbox"/> Non Rx |
| 10. | | | | ___ D W M | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Reason for use: | | | | Date Started: Month Year | Formulation Code: _____ | <input type="checkbox"/> Rx <input checked="" type="checkbox"/> Non Rx |
| 11. | | | | ___ D W M | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Reason for use: | | | | Date Started: Month Year | Formulation Code: _____ | <input type="checkbox"/> Rx <input checked="" type="checkbox"/> Non Rx |
| 12. | | | | ___ D W M | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Reason for use: | | | | Date Started: Month Year | Formulation Code: _____ | <input type="checkbox"/> Rx <input checked="" type="checkbox"/> Non Rx |
| 13. | | | | ___ D W M | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Reason for use: | | | | Date Started: Month Year | Formulation Code: _____ | <input type="checkbox"/> Rx <input checked="" type="checkbox"/> Non Rx |
| 14. | | | | ___ D W M | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Reason for use: | | | | Date Started: Month Year | Formulation Code: _____ | <input type="checkbox"/> Rx <input checked="" 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

| | |
|--|--|
| HABC Enrollment ID # | Acrostic |
| 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"/> |
| C1ID | C1ACROS |

WEIGHT AND RADIAL PULSE

WEIGHT

kg

C1WTK

C1STFID2

Staff ID#

RADIAL PULSE

Staff ID#

C1STFID3

Measurement 1 beats per 30 seconds

C1PLSSM1

x 2 = beats per minute

C1PULSE

Measurement 2 beats per 30 seconds

C1PLSMS2

x 2 = **C1PULSE2**
beats per minute

Total (Measurement 1 + Measurement 2)

C1PLSTOT

÷ 2

= Average
beats per minute

C1PLSAV

C1LINK



| HABC Enrollment ID # | Acrostic | Staff ID # |
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C1STFID4

BLOOD PRESSURE

① Cuff Size ④ Small ① Regular ② Large ③ Thigh **C1OCUF**

② **C1ARMRL**
 Arm Used ① Right ② Left → *Please explain why right arm was not used:*
(Examiner Note: Refer to Data from Prior Visits Report. If possible use same arm as Baseline-Year 1.)

Pulse Obliteration Level

③ Palpated Systolic mmHg * *Add +30 to Palpated Systolic to obtain Maximal Inflation Level.*
C1POPS **Add 30***

④ Maximal Inflation Level (MIL) † mmHg † *If MIL is ≥ 300 mmHg, repeat the MIL. If MIL is still ≥ 300 mmHg, terminate blood pressure measurements.*
C1POMX

⑤ Was blood pressure measurement terminated because MIL ≥ 300 mmHg after second reading?
C1BPYN ① Yes ② No

Sitting Blood Pressure Measurement

⑥ Systolic **C1SYS** mmHg *Comments (required for missing or unusual values):*

⑦ Diastolic **C1DIA** mmHg _____

| HABC Enrollment ID # | Acrostic | 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"/> |

C1STFID5

BONE DENSITY (DXA) SCAN

1 Do you have breast implants? **C1BI**

Yes
 No
 Don't know
 Refused

- ◆ Flag scan for review by DXA Reading Center.
- ◆ Indicate in the table in Question #4 whether breast implant is in "Left ribs" or "Right ribs" region.

2 Have you ever had a hip replacement surgery where all or part of your joint was replaced?

Yes
 No
 Don't know
 Refused
 C1HIPRP

On which side did you have hip replacement surgery? **C1HIPRP2**

Right
 Left
 Both

Do NOT scan right hip.

Do NOT scan left hip.

Do NOT scan either hip.

3 Which hip was scanned at the Baseline (Year 1) Clinic Visit?
 (Examiner Note: Refer to Data from Prior Visits Report to see which hip was scanned at Baseline-Year 1.)

Right
 Left
 Neither
 C1HIPY1

Scan right hip unless contraindicated.

Scan left hip unless contraindicated.

Scan right hip unless contraindicated.



/ /

Month Day Year

C1STFID6

ISOKINETIC MUSCLE FATIGUE ELIGIBILITY ASSESSMENT

Radial Pulse *(Examiner Note: Refer to Weight and Radial Pulse form, page 7.)*

1 a. Radial pulse: bpm **C1PULSE3**

b. Is radial pulse > 110 or < 40bpm?

Yes

No

C1PULSE4

Do NOT test. Go to Question #14.

2 Blood Pressure *(Examiner Note: Refer to Blood Pressure form, page 8.)*

a. Systolic blood pressure: mmHg **C1SYS1**

b. Is systolic > 199 mmHg?

Yes

No

C1SYS2

Do NOT test. Go to Question #14.

c. Diastolic blood pressure mmHg **C1DIA1**

d. Is diastolic > 109 mmHg?

Yes

No

C1DIA2

Do NOT test. Go to Question #14.

3 Are there abnormal Marquette ECG hardcopy references from Baseline (Year 1) that would preclude testing?
(Examiner Note: Refer to Data from Prior Visits Report.)

Yes

No

C1ABECG

Do NOT test. Go to Question #14.

4 Script: "First I need to ask you a few questions to see if you should try the test."

Has a doctor ever told you that you had an aneurysm in the brain?

Yes

No

C1ANEU

Do NOT test. Go to Question #14.

ISOKINETIC MUSCLE FATIGUE ELIGIBILITY ASSESSMENT

5 Has a doctor told you that you had a cerebral hemorrhage (bleeding in the brain) in the last six months?"

① Yes ② No **C1CERHEM**

Do NOT test. Go to Question #14.

6 Within the past 3 months, have you had...

C1HA a. a heart attack? ① Yes → Do NOT test. Go to Question #14. ② No

C1ANG b. angioplasty? ① Yes → Do NOT test. Go to Question #14. ② No

C1HS c. heart surgery? ① Yes → Do NOT test. Go to Question #14. ② No

7 Within the past 3 months, have you seen a health professional or thought about seeing a health professional for new or worsening symptoms of...?

C1CP a. chest pain ① Yes → Do NOT test. Go to Question #14. ② No

C1SB b. shortness of breath ① Yes → Do NOT test. Go to Question #14. ② No

C1FA c. fainting ① Yes → Do NOT test. Go to Question #14. ② No

C1ANGI d. angina ① Yes → Do NOT test. Go to Question #14. ② No



Determine Which Knee Can Be Tested

(Examiner Note: If the Isometric Strength test has already been administered mark the same answers in Questions #8 and #9 below as in Question #1 and #2 on the Isometric Strength form, page 17.)

8 Have you ever had knee surgery on either leg where all or part of the joint was replaced? **C1KNRP**
 ① Yes ② No ③ Don't know ④ Refused

Which leg? **C1KRLB1**

① Right leg ② Left leg ③ Both legs

Do not test right leg. Do not test left leg. Do NOT test either leg. Go to Question #14.

9 During the Kin-Com exam, which leg was tested at the Year 2 clinic visit?
(Examiner Note: Refer to the Health ABC Data from Prior Visits Report to see which leg was tested at Year 2.)

C1KCY2 ① Right leg ② Left leg ③ Test not performed at Year 2 Clinic Visit

Test right leg unless contraindicated. Test left leg unless contraindicated.

Which leg was tested at the Baseline (Year 1) clinic visit?
(Examiner Note: Refer to the Health ABC Data from Prior Visits Report.) **C1KCY1**

① Right leg ② Left leg ③ Neither

Test right leg unless contraindicated. Test left leg unless contraindicated.

Which hip was scanned during Baseline (Year 1)?
(Examiner Note: Refer to Data from Prior Visits Report.) **C1KCY1HP**

① Right leg ② Left leg ③ Neither

Test right leg unless contraindicated. Test left leg unless contraindicated. Test right leg unless contraindicated.

10 Have you ever had an injury that has made one leg weaker than the other? **C1INYN**
(Examiner Note: Do not change leg tested based on this question.)

① Yes ② No ③ Don't know ④ Refused

Which leg is stronger? **C1WKR**

① Right leg ② Left leg

11 Is it difficult for you to either bend or straighten either of your knees fully due to pain, arthritis, injury or some other condition? *(Examiner Note: Do not change leg tested based on this question. First try the Manual Test to determine if Kin-Com Test can be performed.)* **C1KNEE**

① Yes ② No ③ Don't know ④ Refused

Which knee? **C1KRLB2**

① Right knee ② Left knee ③ Both knees



Manual Test

- 12** Which leg was tested? **C1RL2**
- ① Right leg
 ② Left leg
 ③ Manual test not performed

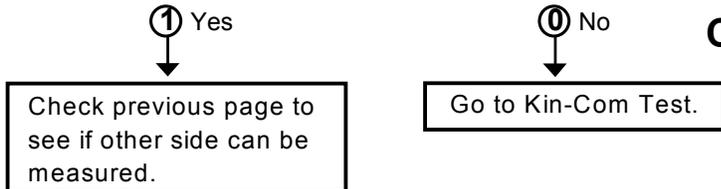
↓

Please explain why:

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:

- 13** Did you have pain in your knee that stopped you from pushing hard?
- ① Yes
 ② No
 C1KNPN



a. Can other side be measured? C1CANMS

① Yes → Do Manual Test on other side.

② No → Do NOT test. Go to Question #14.

After having tried the movement, the participant should be asked:

b. Did you have pain in your knee that stopped you from pushing hard? C1KNPN2

① Yes → Do NOT test. Go to Question #14.

② No → Test this leg.



14 Was participant eligible for the isokinetic muscle fatigue test?

Yes

No

C1ELIGKC

Why wasn't the test done?

(Examiner Note: Check all that apply.)

C1BP3

Systolic blood pressure > 199 mmHg or Diastolic > 109 mmHg

C1RP2

Radial pulse > 110 or < 40 bpm

C1ABECG2

Abnormal ECG from Baseline (Year 1)

C1BAS

Brain aneurysm

C1CERHEM2

Cerebral hemorrhage in past 6 months

C1CARDIA

Cardiac history exclusions

C1KR

Knee replacement

C1KP

Knee pain

C1KPRF

Participant refused

C1OTEX

Other *(Please specify:)*

Manual Positioning Settings

15 *(Examiner Note: Refer to the Health ABC Data from Prior Visits Report for dynamometer settings during the Year 2 Clinic Visit [or Year 1 Clinic Visit if the participant did not have the Kin-Com test during the Year 2 Visit.] Position dynamometer exactly as before, unless a change in leg tested requires a change in settings. Record the settings used during this Year 3 Clinic Visit below.)*

a. Dynamometer tilt

°

e. Seat rotation

°

C1DTLT

C1STROT

b. Dynamometer rotation

°

f. Seat back angle

°

C1DROT

C1STBK

c. Lever arm green C stop

g. Seat bottom depth

cm

C1LEVGR

C1STBOT

d. Lever arm red D stop

h. Seat bottom angle

°

C1LEVRD

C1STBOTA

i. Lever arm length

cm

C1LENGTH

Kin Com Test

16 Which leg was tested?

C1RL3

Right leg

Left leg



| | | | |
|----------------------|----------------------|--|----------------------|
| HABC Enrollment ID # | Acrostic | Date Form Completed | Staff ID # |
| <input type="text"/> | <input type="text"/> | <input type="text"/> / <input type="text"/> / <input type="text"/> Month Day Year | <input type="text"/> |

C1STFID7

ISOMETRIC STRENGTH (ISOMETRIC CHAIR)

Determine which knee can be tested

Examiner Note: If the Isokinetic Muscle Fatigue test has already been administered mark the same answers in Questions #1 & #2 below as in Questions #8 & #9 on the Isokinetic Muscle Fatigue (Kin-Com) form (page 13).

1 Have you ever had knee surgery on either leg where all or part of the joint was replaced?
 ① Yes ② No ③ Don't know ④ Refused **C1KNRP2**

Which leg? **C1KRLB3**

① Right leg ② Left leg ③ Both legs

Do NOT test right leg. Do NOT test left leg. Do NOT test either leg. Go to Question #8.

2 During the Kin-Com exam which leg was tested at the Year 2 clinic visit?
 (Examiner Note: Refer to the Health ABC Data from Prior Visits Report to see which leg was tested at Year 2.)

① Right leg ② Left leg ③ Test not performed at Year 2 Visit **C1KCY2B**

Test right leg unless contraindicated. Test left leg unless contraindicated.

Which leg was tested at the Baseline (Year 1) clinic visit?
 (Examiner Note: Refer to the Health ABC Data from Prior Visits Report. **C1KCY1B**)

① Right leg ② Left leg ③ Neither

Test right leg unless contraindicated. Test left leg unless contraindicated.

Which hip was scanned during Baseline (Year 1)?
 (Examiner Note: Refer to Data from Prior Visits Report.)

① Right leg ② Left leg ③ Neither **C1KCY1HB**

Test right leg unless contraindicated. Test left leg unless contraindicated. Test right leg unless contraindicated.

3 What is the length of the lower leg to be tested? . meters **C1LEG1**

4 Which leg was tested?
 ① Right leg ② Left leg ③ Test not performed **C1RL4**

Go to Question #8.

| Trial | Maximum Torque (Nm) | Max Rate Torque (Nm/sec) | Reaction Time (msec) | Time to 50% MVTD (msec) | Did participant have knee pain? |
|-------|------------------------------------|-------------------------------------|------------------------------------|--------------------------------------|--|
| 1. | <input type="text"/> C1MT1A | <input type="text"/> C1MRT1A | <input type="text"/> C1RT1A | <input type="text"/> C1MVTD1A | ① Yes ② No C1KP1A Test other leg. Go to Question #5. |
| 2. | <input type="text"/> C1MT2A | <input type="text"/> C1MRT2A | <input type="text"/> C1RT2A | <input type="text"/> C1MVTD2A | ① Yes ② No C1KP2A Test other leg. Go to Question #5. |
| 3. | <input type="text"/> C1MT3A | <input type="text"/> C1MRT3A | <input type="text"/> C1RT3A | <input type="text"/> C1MVTD3A | Test complete. Go to Question #7. |

Draft



| | | |
|--|--|--|
| HABC Enrollment ID # | Acrostic | 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"/> |
| C2ID | C2ACROS | C2STFID |

20-METER WALK

1 Describe the 20-meter walk.

Script: "This is a two part walking test. The first part tests your usual walking speed. When you go past the orange cone, I want you to stop."

[Demonstrate how to walk past the cone.]

"Now, wait until I say 'Go'. For the first part of this test, I want you to walk at your usual walking pace. Any questions?"

2 To start the test, say,

Script: "Ready, Go."

3 Begin timing and counting participant's steps until their first footfall over the finishing line at 20 meters. You will need to walk a few steps behind the participant. 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 right-hand STA/STP button on the stop watch, and record the number of steps taken on the form. You will need to carry the form on a clipboard.

Usual pace 20 meters: steps **C220STP1**

Record the time it took to do the first 20-meter walk:

Time on stop watch: : . **C220TIM1**
 Min Second Hundredths/Sec

Reset the stop watch and have the participant repeat the 20-meter walk by walking back to the starting line. Instruct the participant to walk as quickly as they can for the second portion of the test.

Script: "OK, fine. Now turn around and when I say go, walk back the other way as fast as you can. Ready, Go."

When the participant reaches the starting line, push the right-hand STA/STP button on the stop watch, and record the number of steps taken on the form below.

Fast pace 20 meters: steps **C220STP2**

Record the time it took to do the second 20-meter walk:

Time on stop watch: : . **C220TIM2**
 Min Second Hundredths/Sec

4 Was the participant using a walking aid, such as a cane?

Yes No

C2WLKAID

Page Link # **C2LINK**

| | | |
|----------------------|----------------------|----------------------|
| HABC Enrollment ID # | Acrostic | Staff ID # |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

RAPIDESTIMATEOFADULTLITERACY INMEDICINE(REALM)

C2STFID2

1 Determine if participant wears glasses for reading.

Script: "Do you usually wear glasses to read?"

1 Yes 0 No **C2READ**



Ask the participant to put on their reading glasses.

2 Place a laminated copy of the REALM before the participant and say:
(Examiner Note: REQUIRED - Show Card A)

"This sheet contains words commonly used by doctors and their patients. Please read aloud as many words as you can from these three lists. Begin with the first word on List 1 and read aloud. When you come to a word you cannot read, do the best you can or say 'skip' and go on to the next word."

If the participant takes more than five seconds on a word, say "skip" and point to the next word, if necessary, to move the participant along. If the participant misses three words in a row, have them pronounce only known words.

Record whether the participant correctly pronounces the word, mispronounces the word, or doesn't attempt to say the word by filling in the appropriate bubble. Count as correct any self-corrected word.

Count the number of correct words and record the number.

| LIST 1 | Correct | Incorrect | No attempt | LIST 2 | Correct | Incorrect | No attempt | LIST 3 | Correct | Incorrect | No attempt |
|------------------------|---------|-----------|------------|----------------------------|---------|-----------|------------|----------------------------|---------|-----------|------------|
| 1. fat C2RE01 | ① | ② | ③ | 23. fatigue C2RE23 | ① | ② | ③ | 45. allergic C2RE45 | ① | ② | ③ |
| 2. flu C2RE02 | ① | ② | ③ | 24. pelvic C2RE24 | ① | ② | ③ | 46. menstrual C2RE46 | ① | ② | ③ |
| 3. pill C2RE03 | ① | ② | ③ | 25. jaundice C2RE25 | ① | ② | ③ | 47. testicle C2RE47 | ① | ② | ③ |
| 4. dose C2RE04 | ① | ② | ③ | 26. infection C2RE26 | ① | ② | ③ | 48. colitis C2RE48 | ① | ② | ③ |
| 5. eye C2RE05 | ① | ② | ③ | 27. exercise C2RE27 | ① | ② | ③ | 49. emergency C2RE49 | ① | ② | ③ |
| 6. stress C2RE06 | ① | ② | ③ | 28. behavior C2RE28 | ① | ② | ③ | 50. medication C2RE50 | ① | ② | ③ |
| 7. smear C2RE07 | ① | ② | ③ | 29. prescription C2RE29 | ① | ② | ③ | 51. occupation C2RE51 | ① | ② | ③ |
| 8. nerves C2RE08 | ① | ② | ③ | 30. notify C2RE30 | ① | ② | ③ | 52. sexually C2RE52 | ① | ② | ③ |
| 9. germs C2RE09 | ① | ② | ③ | 31. gallbladder C2RE31 | ① | ② | ③ | 53. alcoholism C2RE53 | ① | ② | ③ |
| 10. meals C2RE10 | ① | ② | ③ | 32. calories C2RE32 | ① | ② | ③ | 54. irritation C2RE54 | ① | ② | ③ |
| 11. disease C2RE11 | ① | ② | ③ | 33. depression C2RE33 | ① | ② | ③ | 55. constipation C2RE55 | ① | ② | ③ |
| 12. cancer C2RE12 | ① | ② | ③ | 34. miscarriage C2RE34 | ① | ② | ③ | 56. gonorrhea C2RE56 | ① | ② | ③ |
| 13. caffeine C2RE13 | ① | ② | ③ | 35. pregnancy C2RE35 | ① | ② | ③ | 57. inflammatory C2RE57 | ① | ② | ③ |
| 14. attack C2RE14 | ① | ② | ③ | 36. arthritis C2RE36 | ① | ② | ③ | 58. diabetes C2RE58 | ① | ② | ③ |
| 15. kidney C2RE15 | ① | ② | ③ | 37. nutrition C2RE37 | ① | ② | ③ | 59. hepatitis C2RE59 | ① | ② | ③ |
| 16. hormones C2RE16 | ① | ② | ③ | 38. menopause C2RE38 | ① | ② | ③ | 60. antibiotics C2RE60 | ① | ② | ③ |
| 17. herpes C2RE17 | ① | ② | ③ | 39. appendix C2RE39 | ① | ② | ③ | 61. diagnosis C2RE61 | ① | ② | ③ |
| 18. seizure C2RE18 | ① | ② | ③ | 40. abnormal C2RE40 | ① | ② | ③ | 62. potassium C2RE62 | ① | ② | ③ |
| 19. bowel C2RE19 | ① | ② | ③ | 41. syphilis C2RE41 | ① | ② | ③ | 63. anemia C2RE63 | ① | ② | ③ |
| 20. asthma C2RE20 | ① | ② | ③ | 42. hemorrhoids C2RE42 | ① | ② | ③ | 64. obesity C2RE64 | ① | ② | ③ |
| 21. rectal C2RE21 | ① | ② | ③ | 43. nausea C2RE43 | ① | ② | ③ | 65. osteoporosis C2RE65 | ① | ② | ③ |
| 22. incest C2RE22 | ① | ② | ③ | 44. directed C2RE44 | ① | ② | ③ | 66. impetigo C2RE66 | ① | ② | ③ |

5 Total number of words correct: words

C2RETOT

6 Was the REALM administered? 1 Yes **C2REALM**
 0 No, participant had poor vision
 7 No, participant refused



| | | | |
|----------------------|----------------------|--|----------------------|
| HABC Enrollment ID # | Acrostic | Date Form Completed | Staff ID # |
| <input type="text"/> | <input type="text"/> | <input type="text"/> / <input type="text"/> / <input type="text"/> Month Day Year | <input type="text"/> |

C2STFD3

COGNITIVE FUNCTION

TengMini-MentalStateExam

Are you comfortable?

I would like to ask you a few questions that require concentration and memory. Some are a little bit more difficult than others. Some questions will be asked more than once.

(Examiner Note: Record responses. If the participant does not answer, mark the "No response" option.)

① When were you born?

C2BORND

a. / / ① No response
 Month Day Year

C2BORNM

Where were you born?

Place of Birth? **C2BORNRY** Not attempted/ disabled

| | | | |
|------------------|--------------|-------------------|-------------------------|
| | Answer given | Can't do/ Refused | Not attempted/ disabled |
| C2CITY | ① | ⑦ | ③ |
| d. City/town | | | |
| C2STE | ① | ⑦ | ③ |
| e. State/Country | | | |

Examiner Note:
Ask again in Question #18.

③ I would like you to count from 1 to 5.

C2CNT

- | | |
|-------------------------|--|
| ① Able to count forward | ② Unable to count forward Say 1-2-3-4-5 |
|-------------------------|--|

Now I would like to you count backwards from 5 to 1. Record the responses in the order given:

(Examiner Note: Enter "99999" if no response)

C2CNTBK

④ Spell "world."

C2SPL

- | | |
|-----------------|--|
| ① Able to spell | ② Unable to spell "It's spelled W-O-R-L-D." |
|-----------------|--|

a. Now spell "world" backwards

(Examiner Note: Record letter in order given: Enter "xxxxx" if no response.)

C2SPWLD

② I am going to say three words for you to remember. Repeat them after I have said all three words:

Shirt, Blue, Honesty

(Examiner Note: Do not repeat the words for the participant until after the first trial. The participant may give the words in any order. If there are errors on the first trial, repeat the items up to six times until they are learned.)

| | | | | |
|------------|---------------|---------|----------------|-------------------------|
| | | Correct | Error/ Refused | Not attempted/ disabled |
| a. Shirt | C2SHRT | ① | ⑦ | ③ |
| b. Blue | C2BLU | ① | ⑦ | ③ |
| c. Honesty | C2HON | ① | ⑦ | ③ |

d. Numbers of presentations necessary for the participant to repeat the sequence: presentations

C2NUM



5 What three words did I ask you to remember earlier?

(Examiner Note: 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 C2SHRM

- 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 C2BLRM

- 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 C2HNRM

- 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

6 a. What is today's date?
(Examiner Note: If the participant does not answer, mark the "No response" option.)

| | | | | | | | | | |
|--------|--|--|-----|--|------|--|--|--|-----------------|
| | | | | | | | | | |
| C22DAY | | | / | | | | | | ① No response |
| Month | | | Day | | Year | | | | C22DAYRF |

b. What is the day of the week?
(Examiner Note: Record answer in error. Enter 'X' if no response.)

① Correct **C2DAYWK**

⑦ Error/refused _____
Day of the week

③ Not attempted/disabled

c. What season of the year is it?
(Examiner Note: Record answer in error. Enter 'X' if no response.)

① Correct **C2SEAS**

⑦ Error/refused _____
Season

③ Not attempted/disabled

7 a. What state are we in?
(Examiner Note: Record answer in error. Enter 'X' if no response.)

① Correct **C2STAT**

⑦ Error/refused _____
State

③ Not attempted/disabled

b. What county are we in?
(Examiner Note: Record answer in error. Enter 'X' if no response.)

① Correct **C2CNTY**

⑦ Error/refused _____
County

③ Not attempted/disabled

c. What (city/town) are we in?
(Examiner Note: Record answer in error. Enter 'X' if no response.)

① Correct **C2CITN**

⑦ Error/refused _____
City/town

③ Not attempted/disabled

d. Are we in a clinic, store, or home?
(Examiner Note: 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 **C2WHRE**

⑦ Error/refused

③ Not attempted/disabled



8 (Examiner Note: 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? C2PENC | ① | ⑦ | ③ |
| b. Watch: What is this? C2WTCH | ① | ⑦ | ③ |
| c. Forehead: What do you call this part of the face? C2FRHD | ① | ⑦ | ③ |
| d. Chin: And this part? C2CHIN | ① | ⑦ | ③ |
| e. Shoulder: And this part of the body? C2SHLD | ① | ⑦ | ③ |
| f. Elbow: And this part? C2ELB | ① | ⑦ | ③ |
| g. Knuckle: And this part? C2KNK | ① | ⑦ | ③ |

9 What animals have four legs?
Tell me as many as you can.

(Examiner Note: 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.

C2SCR

Score (total correct responses):

| | |
|--|--|
| | |
|--|--|

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

(Examiner Note: Write any additional correct answers on a separate sheet of paper.)

10 (Examiner Note: 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.) **C2ARLG**

a. In what way are an arm and a leg alike?

- ① Limbs, extremities, appendages
- ② Lesser correct answer (e.g., body parts, both bend, have joints)
- ⑦ Error/refused (e.g. states differences, gives unrelated answer)
- ③ Not attempted/disabled

b. In what way are laughing and crying alike?

- ① Expressions of feelings, emotions
- C2LCRY**
- ② Lesser correct answer (e.g., sounds, expressions, other similar responses)
 - ⑦ Error/refused (e.g. states differences, gives unrelated answer)
 - ③ Not attempted/disabled

c. In what way are eating and sleeping alike?

C2ETSL

- ① Necessary bodily functions, essential for life
- 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 Not attempted/disabled

11 Repeat what I say: I would like to go out.

(Examiner Note: Pronounce the individual words distinctly but with normal tempo of a spoken sentence.)

- ① Correct **C2RPT**
- ② 1 or 2 words missed
- ⑦ 3 or more words missed/refused
- ③ Not attempted/disabled

| |
|--|
| |
|--|



12 Now repeat: **No ifs, ands or buts.**

(Examiner Note: 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 C2IF | ① | ⑦ | ③ |
| b. ands C2AND | ① | ⑦ | ③ |
| c. or buts C2BUT | ① | ⑦ | ③ |

13 *Examiner Note: Hold up Card B 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." **C2CRD1***

- ① Closes eyes without prompting
- ② Closes eyes after prompting
- ③ Reads aloud, but does not close eyes
- ⑦ Does not read aloud or close eyes/refused
- ⑤ Not attempted/disabled

14 Please write the following sentence:

I would like to go out.

(Examiner Note: 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 C2WLD | ① | ⑦ | ③ |
| b. like C2LKE | ① | ⑦ | ③ |
| c. to C2TO | ① | ⑦ | ③ |
| d. go C2GO | ① | ⑦ | ③ |
| e. out C2OUT | ① | ⑦ | ③ |

(Examiner Note: 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])

- C2HAND**
- ① Right
 - ② Left
 - ⑧ Unknown



15 Here is a drawing. Please copy the drawing onto this piece of paper.

(Examiner Note: Hand participant Card C. 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 C2PENT1

- 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 not attempted/disabled

b. Pentagon 2 C2PENT2

- 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 not attempted/disabled

c. Intersection C2INT

- ① 4-cornered enclosure
- ② not a 4-cornered enclosure
- ⑦ no enclosure/refused
- ④ not attempted/disabled

16 *(Examiner Note: 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."

(Examiner Note: 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 C2PCOR | ① | ⑦ | ③ |
| b. Folds paper in half C2PFLD | ① | ⑦ | ③ |
| c. Hands paper back C2PHND | ① | ⑦ | ③ |



17 What three words did I ask you to remember earlier?

(Examiner Note: 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.)

C2SH2

- a. **Shirt**
- 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**

- C2BLU2**
- 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

C2HON2

- c. **Honesty**
- 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?

(Examiner Note: 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. C2CITY2 City/town | ① | ⑦ | ③ |
| b. C2STE2 State/Country | ① | ⑦ | ③ |

19 *(Examiner Note: If physical/functional disabilities or other problems exist which cause the participant difficulty in completing any of the tasks, record the nature of the problem listed below. Check all that apply.)*

- ⓪ Vision **C2VIS**
- ⓪ Hearing **C2HEAR**
- ⓪ Writing problems due to injury or illness **C2WRITE**
- ⓪ Illiteracy or lack of education **C2ILLIT**
- ⓪ Language **C2LANG**
- ⓪ Other *(Please record the specific problem in the space provided.)*
C2OTH



Examiner Note: Place a plain white sheet of paper in front of the participant and say:

Script: "Draw me a clock that says 1:45. Set the hands and numbers on the face so that a child could read them."

| | | |
|---|--|-----------------|
| 1. Does figure resemble a clock? | <input type="radio"/> Yes <input type="radio"/> No | C2CLX01 |
| 2. Is a circular face present? | <input type="radio"/> Yes <input type="radio"/> No | C2CLX02 |
| 3. Are the dimensions >1 inch? | <input type="radio"/> Yes <input type="radio"/> No | C2CLX03 |
| 4. Are all numbers inside the perimeter? | <input type="radio"/> Yes <input type="radio"/> No | C2CLX04 |
| 5. Is there sectoring or are there tic marks? | <input type="radio"/> Yes <input type="radio"/> No | C2CLX05 |
| 6. Were 12, 6, 3, & 9 placed first? | <input type="radio"/> Yes <input type="radio"/> No | C2CLX06 |
| 7. Is the spacing intact? (Symmetry on either side of 12 o'clock and 6 o'clock?) | <input type="radio"/> Yes <input type="radio"/> No | C2CLX07 |
| 8. Were only Arabic numerals used? | <input type="radio"/> Yes <input type="radio"/> No | C2CLX08 |
| 9. Are only the numbers 1 through 12 among the numerals present? | <input type="radio"/> Yes <input type="radio"/> No | C2CLX09 |
| 10. Is the sequence 1 through 12 intact? (No omissions or intrusions.) | <input type="radio"/> Yes <input type="radio"/> No | C2CLX10 |
| 11. Are there exactly 2 hands present? (Ignore sectoring/tic marks) | <input type="radio"/> Yes <input type="radio"/> No | C2CLX11 |
| 12. Are all hands represented as arrows? | <input type="radio"/> Yes <input type="radio"/> No | C2CLX12 |
| 13. Is the hour hand between 1 o'clock and 2 o'clock? | <input type="radio"/> Yes <input type="radio"/> No | C2CLX13 |
| 14. Is the minute hand obviously longer than the hour hand? | <input type="radio"/> Yes <input type="radio"/> No | C2CLX14 |
| 15. Are there any of the following...? | | |
| a) Hand pointing to 4 or 5 o'clock? | <input type="radio"/> Yes <input type="radio"/> No | C2CLX15A |
| b) "1:45" present? | <input type="radio"/> Yes <input type="radio"/> No | C2CLX15B |
| c) Any other notation (e.g. "9:00")? | <input type="radio"/> Yes <input type="radio"/> No | C2CLX15C |
| d) Any arrows point inward? | <input type="radio"/> Yes <input type="radio"/> No | C2CLX15D |
| e) Intrusions from "hand" or "face" present? | <input type="radio"/> Yes <input type="radio"/> No | C2CLX15E |
| f) Any letters, words or pictures? | <input type="radio"/> Yes <input type="radio"/> No | C2CLX15F |

| | | |
|----------------------|----------|------------|
| HABC Enrollment ID # | Acrostic | Staff ID # |
| | | |

C2STFID5

Script: I will be asking you to do some routine exercises that measure how well you pay attention. Are you ready? Any questions?

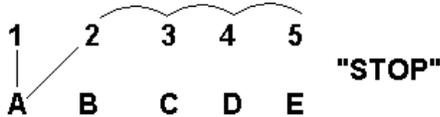
1 Number-Letter Task

"I'd like you to say some numbers and letters for me like this."

"1-A, 2-B, 3-what would come next?"

"C"

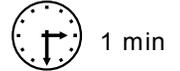
"Now you try it starting with the number 1." Keep going until I say "stop."



Score:

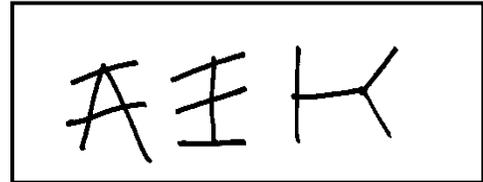
- ① No errors **C2EX01**
- ② Completes task with prompting (or repeat instruction)
- ③ Doesn't complete task

3 Design Fluency



"Look at these pictures. Each is made with only four (4) lines. I am going to give you one minute to draw as many DIFFERENT designs as you can. The only rule is that they must each be different and be drawn with four lines."

(Examiner Note: Model this task by drawing the figures below.)



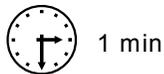
"Now go!"

C2EX03

Score:

- ① 10 or more unique drawings (no copies of examples)
- ② 5-9 unique drawings
- ③ Less than 5 unique drawings

2 Word Fluency



"I am going to give you a letter. You will have one minute to name as many words as you can think of which begin with that letter."

"For example, with the letter 'P' you could say 'people, pot, plant'...and so on."

"Do you have any questions?" Are you ready?"

"The letter is 'A'. Go!"

- | | |
|-----------|-----------|
| 1. _____ | 11. _____ |
| 2. _____ | 12. _____ |
| 3. _____ | 13. _____ |
| 4. _____ | 14. _____ |
| 5. _____ | 15. _____ |
| 6. _____ | 16. _____ |
| 7. _____ | 17. _____ |
| 8. _____ | 18. _____ |
| 9. _____ | 19. _____ |
| 10. _____ | 20. _____ |

Score:

- ① 10 or more words
- ② 5-9 words **C2EX02**
- ③ Less than 5 words

4 Anomalous Sentence Repetitions

"Listen very carefully and repeat these sentences exactly..."

(Examiner Note: Read the sentence in its original tone of voice.)

1. "I pledge allegiance to those flags."
2. "Mary fed a little lamb."
3. "Throw, throw, throw your boat."
4. "Tinkle, tinkle little star."
5. "ABCDUFG"

Score:

- ① No errors **C2EX04**
- ② Fails to make one or more changes
- ③ Continues with one or more expressions (e.g. "Mary had a little lamb whose fleece was white as snow")



5 Thematic Perception



(Examiner Note: REQUIRED - Show Card D. The picture should be left in front of the participant until this task is completed.)

"Tell me what is happening in this picture."

Score: **C2EX05**

- ① Tells spontaneous story (story=setting, 3 characters, action)
- ② Tells story with prompting once ("anything else?")
- ③ Fails to tell story despite prompt

7 Interference Task

br own

"What color are these letters?"

(Examiner Note: REQUIRED - Show Card E. Sweep hand back and forth over all letters.)

Score:

- ① black **C2EX07**
- ② brown (prompt "Are you sure?") then black
- ③ brown (prompt "Are you sure?") then brown (intrusion)

6 Memory/Distraction Task

"Remember these three words."

APPLE, TABLE, PENNY

(Participant repeats words until all three are registered.)

"Remember them - I'll ask you to repeat them for me later."

"Now spell CAT for me..."

"Good. Now spell it backwards..."

"OK. Tell me the three words I asked you to remember."

1) _____ 2) _____ 3) _____

Score: **C2EX06**

- ① Participant names some or all of the three words correctly without naming CAT
- ② Other responses (Examiner may prompt: "Anything else?")
- ③ Participant names CAT as one of the three words (intrusion)

8 Motor Impersistence

"Stick out your tongue and say 'aah.' Keep going until I say stop..."

(Examiner should model a short "ah sound, but expect a long "ahhh.")

"Go!"

(Count to three silently. Participant must sustain a constant tone, not "ah...ah...ah...")

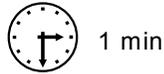
Score:

C2EX08

- ① Completes task spontaneously
- ② Completes task with examiner modeling task
- ③ Fails task despite modeling by examiner



9 Go/No-Go Task



"Now... When I touch my nose, you raise your finger like this." (*Examiner Note: Raises index finger.*)

"When I raise my finger, you touch your nose like this."

(Examiner Note: Touch nose with index finger. Have participant repeat instructions if possible. Begin task. Leave finger in place while awaiting participant's response. Put your finger back in your lap between trials to reduce the potential for confusion.)

| Examiner | Participant |
|----------|-------------|
| F | N F |
| N | F N |
| F | N F |
| F | N F |
| N | F N |

Score:

- ① Performs **bold** sequence correctly
- ② Correct, requires prompting/repeat instructions
- ③ Fails sequence despite prompting/repeat instructions

C2EX09

10 Echopraxia

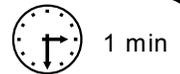
"Now listen carefully. I want you to do exactly what I say. Ready?"

"Touch your ear." (*Examiner Note: Touch your nose and keep finger there.*)

Score: **C2EX10**

- ① Participant touches their ear
- ② Other response
(look for "mid-position" stance)
- ③ Participant touches their nose

11 Luria Hand Sequence I: Palm/Fist



"Can you do this?"

(Examiner Note: Model: a. palm, b. fist)

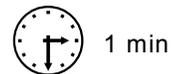
"Now, follow me."

(Examiner Note: Begin to repeat sequence. Once the participant appears to have mastered the task, have them demonstrate it. Tell the participant to "keep going" after you stop. Count the number of successive palm/fist cycles. Prompting is allowed at 30 seconds: "Are you sure you've got it?" Stop after one minute.)

Score: **C2EX11**

- ① 5 cycles without error after examiner stops
- ② 5 correct cycles with additional verbal prompt
- ③ Unsuccessful despite prompting
(watch for "mid-position" stances)

12 Luria Hand Sequence II: 3 Hands



"Can you do this?"

(Examiner Note: Model: a) slap, b) fist, c) cut - while participant imitates each step)

"Now follow me."

(Examiner Note: Begin to repeat sequence. Once the participant appears to have mastered the task, have them demonstrate it. Tell the participant to "keep going" after you stop. Count the number of successive cycles. Prompting is allowed at 30 seconds: "Are you sure you've got it?" Stop after one minute.)

Score: **C2EX12**

- ① 4 cycles without error after examiner stops
- ② 4 correct cycles with additional verbal prompt
- ③ Unsuccessful



13 Complex Command Task

"Put your left hand on top of your head and close your eyes..."

That was good..."

(Examiner Note: Remain aloof. Quickly go onto next task.)

Score: **C2EX13**

- ① Participant stops when next task began
- ② Equivocal - holds posture during part of next task
- ③ Participant maintains posture (eyes/hands or both) through completion of next task - has to be told to cease

14 Serial Order Reversal Task

(Examiner Note: Have participant recite the months of the year.)

"Next, I would like you to recite all the months of the year."

"Now start with January and say them all backwards..."

Score: **C2EX14**

- ① No errors, at least past September
- ② Gets past September but requires repeat instructions ("Just start with January and say them all backwards.")
- ③ Can't succeed despite prompting

15 Imitation Behavior

(Examiner Note: Flex wrist up and down and point to it asking: "What is this called?")

Score:

- ① Wrist **C2EX15**
- ② Other response
(Describe _____)
- ③ Participant flexes wrist up and down (echopraxia)



| | | |
|---|---|--|
| HABC Enrollment ID # | Acrostic | 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"/> |
| C3ID | C3ACROS | C3STFID6 |

FUNCTIONAL VISION

1 Is the letter literacy test required? (*Examiner Note: Refer to page #21 "Total number of words correct." If less than 5 words are correct the letter literacy test is required.*)

1 Yes **0** No **C3LITREQ**

Examiner Note: Administer the letter literacy test. Show participant letter literacy card. (REQUIRED - Show Card F) Be sure they are wearing their reading glasses, if needed.
Script: "Can you see these letters (point to card). Read me the letters one by one across the line."

A B O S E R T H U P I V Z J Q

Letter literacy test score: **C3LIT** **C3LITRF**

a. Number of correct letters: **1** Participant refused

b. Were 10 or more letters read correctly?

1 Yes **0** No **C3LIT10**

Administer all functional vision tests.

- ◆ Do not administer the Bailey-Lovie or Pelli-Robson exam.
- ◆ Do administer the Frisby stereo test (page 36).

Bailey-Lovie Distance Visual Acuity

2 Does the participant usually wear glasses or contact lenses for distance tasks?

1 Yes **0** No **C3BLGL1**

Is the participant wearing glasses or contact lenses for the Bailey-Lovie test?

1 Yes **0** No **C3BLGL2**

Note: "Both glasses and contacts" choice added to C3BLGL3, C3PRGL2, C3FSGL2

What is the participant wearing - glasses or contact lenses? **C3BLGL3**

1 Glasses **2** Contact lenses **4** Both glasses and contacts

What type of glasses?

- 1** Distance
- 2** Bifocal
- 3** No-line bifocal

C3BLGL4

What type of contact lenses?

- 1** Distance
- 2** Bifocal
- 3** Monovision (one eye corrected for near, one for distance)

C3BLGL5



3 Which chart was used?

- ① Chart #1 ② Chart #2

C3BLCHRT

4 Which distance was used?

- ① 10 feet ② 5 feet ③ Participant unable to read chart at 5 feet

C3BLDIST

5 **Examiner Note: Make an "X" through each letter incorrectly identified. If the participant misses 3 or more letters on one row, stop administering the test and go to Question #6.**

| Chart 1 | Chart 2 | Letter Count | SNELLEN equivalent | |
|-----------|-----------|--------------|--------------------|----------|
| | | | (10 feet) | (5 feet) |
| D V N Z R | H E F P U | 5 | 20/250 | 20/500 |
| H N F D V | E P U R Z | 10 | 20/200 | 20/400 |
| F U P V E | H N R Z D | 15 | 20/160 | 20/320 |
| P E R Z U | F N H V D | 20 | 20/125 | 20/250 |
| F H P V E | N D Z R U | 25 | 20/100 | 20/200 |
| Z R F N U | V D E H P | 30 | 20/80 | 20/160 |
| P R Z E U | N F V H D | 35 | 20/63 | 20/125 |
| F V P Z D | N R E H U | 40 | 20/50 | 20/100 |
| U P N F H | R Z V D E | 45 | 20/40 | 20/80 |
| R Z U F N | D H E V P | 50 | 20/32 | 20/63 |
| F H U V D | E P N R Z | 55 | 20/25 | 20/50 |
| N E F Z R | H P V D U | 60 | 20/20 | 20/40 |
| Z D R V E | N U P F H | 65 | 20/16 | 20/32 |
| U D F V N | Z P E H R | 70 | 20/12 | 20/25 |

6 Number of letters read correctly:

letters

C3BLLET

(Examiner Note: Starting with the Letter Count for the last line read without errors, add one for each additional letter correctly read on lines below it.)

7 Was the Bailey-Lovie test administered?

- ① Yes ② No

C3BLTEST

Why not?
(Examiner Note: Check main reason test was not administered.)

- ① Did not pass letter literacy exam
② Participant fatigued
③ Unable to see chart
④ Did not understand
⑦ Refused

C3BLNON



1 Is the participant wearing glasses or contact lenses for the Pelli-Robson test?

- ① Yes ② No

C3PRGL1

Note: "Both glasses and contacts" choice added to C3BLGL3, C3PRGL2, C3FSGL2

What is the participant wearing - glasses or contact lenses?

C3PRGL2

- ① Glasses ② Contact lenses ④ Both glasses and contacts

What type of glasses?

- ① Distance
② Bifocal
③ No-line bifocal

C3PRGL3

What type of contact lenses?

- ① Distance
② Bifocal
③ Monovision
(one eye corrected for near, one for distance)

C3PRGL4

2 Which chart was used?

- ① Chart #1 ② Chart #2

C3PRCHRT

3 Which distance was used? *(Examiner Note: Use the same distance as for the Bailey-Lovie chart or if the participant cannot identify the darkest triplet correctly at 10 feet, move to 5 feet.)*

- ① 10 feet ② 5 feet

C3PRDIST

4 *Examiner Note: Make an "X" through each letter incorrectly identified. When the participant misses all 3 letters in a triplet, stop administering the test and go to Question #5.*

| <u>Chart 1</u> | | <u>Letter Count</u> | <u>Chart 2</u> | |
|----------------|-------|---------------------|----------------|-------|
| H S Z | D S N | 06 | V R S | K D R |
| C K R | Z V R | 12 | N H C | S O K |
| N D C | O S K | 18 | S C N | O Z V |
| O Z K | V H Z | 24 | C N H | Z O K |
| N H O | N R D | 30 | N O D | V H R |
| V R C | O V H | 36 | C D N | Z S V |
| C D S | N D C | 42 | K C H | O D K |
| K V Z | O H R | 48 | R S Z | H V R |

5 Number of letters read correctly:

| | |
|--|--|
| | |
|--|--|

letters

C3PRLET

(Examiner Note: Starting with the Letter Count for the last line read without errors, add one for each additional letter correctly read on lines below it.)

6 Was the Pelli-Robson test administered?

- ① Yes ② No

C3PRTEST

Why not?

(Examiner Note: Check main reason test was not administered.)

- ① Did not pass letter literacy exam
② Participant fatigued
③ Unable to see chart
④ Did not understand
⑦ Refused

C3PRNON



1 Does the participant usually wear glasses or contact lenses for reading?

- ① Yes ② No

C3FSGL1

Note: "Both glasses and contacts" choice added to C3BLGL3, C3PRGL2, C3FSGL2

Is the participant wearing glasses or contact lenses for the Frisby Stereo test? **C3FSGL2**

① Glasses ② Contact lenses ③ Not wearing glasses or contact lenses ④ Both glasses and contacts

What type of glasses?

① Distance
② Bifocal
③ No-line bifocal
④ Reading
C3FSGL3

What type of contact lenses?

① Distance
② Bifocal
③ Monovision (one eye corrected for near, one for distance)
C3FSGL4

Examiner Note: Show the participant the thickest plate.

Script: "This is a test of depth perception. One of the squares has a circular area of pattern standing out in front of it. Can you see which one it is?"

2 Was the participant able to point out the depth cue without hesitation (either before or after a demonstration using monocular clues)?

- ① Yes **C3FSCUE**

- ② No

| Start here Plate 2 (medium thickness) | Plate 3 (thinnest) | Start here Plate 1 (thickest) |
|--|---|--|
| <p>Trial C3FS1PL2</p> <p>1. ① Correct ② Incorrect C3FS2PL2</p> <p>2. ① Correct ② Incorrect C3FS3PL2</p> <p>3. ① Correct ② Incorrect</p> <p style="border: 1px solid black; padding: 2px;">If 3 correct, record as "Pass" & go to Plate #3.</p> <p>4. ① Correct ② Incorrect C3FS4PL2</p> <p>5. ① Correct ② Incorrect C3FS5PL2</p> <p>6. ① Correct ② Incorrect C3FS6PL2</p> <p style="border: 1px solid black; padding: 2px;">Pass if 3/3 or at least 5/6 correct</p> <p>Plate 2 C3FSPL2</p> <p>① Pass ② Fail ③ Did not test</p> <div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; padding: 2px;">Go to Plate 3</div> <div style="border: 1px solid black; padding: 2px;">Go to Plate 1</div> </div> | <p>Trial C3FS1PL3</p> <p>1. ① Correct ② Incorrect C3FS2PL3</p> <p>2. ① Correct ② Incorrect C3FS3PL3</p> <p>3. ① Correct ② Incorrect</p> <p style="border: 1px solid black; padding: 2px;">If 3 correct, record as "Pass" & go to Question #3 on next page.</p> <p>4. ① Correct ② Incorrect C3FS4PL3</p> <p>5. ① Correct ② Incorrect C3FS5PL3</p> <p>6. ① Correct ② Incorrect C3FS6PL3</p> <p style="border: 1px solid black; padding: 2px;">Pass if 3/3 or at least 5/6 correct</p> <p>Plate 3 C3FSPL3</p> <p>① Pass ② Fail ③ Did not test</p> <div style="border: 1px solid black; padding: 2px;">Go to Question #3 on next page.</div> | <p>Trial C3FS1PL1</p> <p>1. ① Correct ② Incorrect C3FS2PL1</p> <p>2. ① Correct ② Incorrect C3FS3PL1</p> <p>3. ① Correct ② Incorrect</p> <p style="border: 1px solid black; padding: 2px;">If 3 correct, record as "Pass" & go to Plate #2.</p> <p>4. ① Correct ② Incorrect C3FS4PL1</p> <p>5. ① Correct ② Incorrect C3FS5PL1</p> <p>6. ① Correct ② Incorrect C3FS6PL1</p> <p style="border: 1px solid black; padding: 2px;">Pass if 3/3 or at least 5/6 correct</p> <p>Plate 1 C3FSPL1</p> <p>① Pass ② Fail ③ Did not test</p> <div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; padding: 2px;">Go to Plate 2</div> <div style="border: 1px solid black; padding: 2px;">STOP. Go to Question #3 on next page.</div> </div> |

3 Was a non-standard distance (other than 40 cm) used?

1 Yes

0 No

C3FSDIST1

Specify distance used: cm

C3FSDIST2

4 Was the Frisby Stereo test administered?

1 Yes

0 No

C3FSTEST

Why not? (*Examiner Note: Check main reason test was not administered.*)

1 Participant fatigued

2 Unable to see chart

3 Did not understand

4 Other (*Please specify:* C3FSNON)

7 Refused



| HABC Enrollment ID # | Acrostic | Staff ID # |
|---|---|--|
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OLFACTION

C3STFID5

Script: "As people get older, they sometimes say their taste for food has changed. This may be due to a change in the sense of smell, so we have included a short test of smell in the examination this year.

This is a simple test. On these cards (**show example**), there are very small capsules of odors which people find familiar. I will show you another card with four choices for each odor of the 12 odors we will test. I will read you these four choices and leave the card on the table in front of you, like this. I will then scratch the odor card with a paper clip and immediately hold it under your nose for you to sniff. I will then ask you to tell me which of the four choices you feel this smell is most like. If you are not sure, you can ask for a second sniff. After that, we would like you to make the best guess as to what odor you are smelling."

a. Have you had a cold in the past week? ① Yes ② No **C3OLCOLD**

b. Have you ever been hit in the head hard enough to make you faint? ① Yes ② No **C3OLHEAD**

c. Do you suffer from smell and/or taste problems? ① Yes ② No **C3OLSMEL**

↓

Please describe: _____

d. Do you currently smoke? ① Yes ② No **C3OLSMOK**

Odorants:

① This odor smells most like... ① Fruit
 (REQUIRED - Show Card G) ② Cinnamon **C3OLG01**
 ③ Woody
 ④ Coconut
 ⑧ Don't know
 ⑦ Refused

② This odor smells most like... ① Turpentine
 (REQUIRED - Show Card H) ② Soap **C3OLH02**
 ③ Dog
 ④ Black pepper
 ⑧ Don't know
 ⑦ Refused

③ This odor smells most like... ① Motor oil
 (REQUIRED - Show Card I) ② Garlic **C3OLI03**
 ③ Rose
 ④ Lemon
 ⑧ Don't know
 ⑦ Refused



OLFACTION

4 This odor smells most like...
(REQUIRED - Show Card J)

- ① Apple
- ② Grass
- ③ Smoke
- ④ Grape
- ⑧ Don't know
- ⑦ Refused

C3OLJ04

5 This odor smells most like...
(REQUIRED - Show Card K)

- ① Lemon
- ② Chocolate
- ③ Strawberry
- ④ Black pepper
- ⑧ Don't know
- ⑦ Refused

C3OLK05

6 This odor smells most like...
(REQUIRED - Show Card L)

- ① Mint
- ② Rose
- ③ Lime
- ④ Fruit
- ⑧ Don't know
- ⑦ Refused

C3OLL06

7 This odor smells most like...
(REQUIRED - Show Card M)

- ① Watermelon
- ② Peanut
- ③ Rose
- ④ Paint thinner
- ⑧ Don't know
- ⑦ Refused

C3OLM07

8 This odor smells most like...
(REQUIRED - Show Card N)

- ① Banana
- ② Garlic
- ③ Cherry
- ④ Motor oil
- ⑧ Don't know
- ⑦ Refused

C3OLN08



OLFACTION

9 This odor smells most like...
(REQUIRED - Show Card O)

- ① Smoke
- ② Whiskey
- ③ Pineapple
- ④ Onion
- ⑧ Don't know
- ⑦ Refused

C3OLO09

10 This odor smells most like...
(REQUIRED - Show Card P)

- ① Rose
- ② Lemon
- ③ Apple
- ④ Gasoline
- ⑧ Don't know
- ⑦ Refused

C3OLP10

11 This odor smells most like...
(REQUIRED - Show Card Q)

- ① Soap
- ② Black pepper
- ③ Chocolate
- ④ Peanut
- ⑧ Don't know
- ⑦ Refused

C3OLQ11

12 This odor smells most like...
(REQUIRED - Show Card R)

- ① Chocolate
- ② Banana
- ③ Onion
- ④ Fruit
- ⑧ Don't know
- ⑦ Refused

C3OLR12



1 Did the participant have knee symptoms in Year 2?
(Examiner Note: Refer to Data from Prior Visits Report.)

1 Yes **C3KSY2A**

a. Does the participant have knee symptoms at this Year 3 clinic visit?

(Examiner Note: Review Questions #49a, #50a and #50b on Year 3 Questionnaire -- participant must have at least one asterisked "" answer.)* **C3KSY3A**

1 Yes **0** No
 STOP.

b. Did the participant have a knee x-ray in Year 2?
(Examiner Note: Refer to Data from Prior Visits Report.) **C3KXY2**

1 Yes **0** No
 Do NOT schedule x-ray. Schedule knee x-ray.

c. Did the participant have an MRI in Year 2?
(Examiner Note: Refer to Data from Prior Visits Report.) **C3KY2MA**

1 Yes **0** No
 Do NOT schedule MRI. Schedule knee MRI.

0 No

a. Does the participant have knee symptoms at this Year 3 clinic visit?

(Examiner Note: Review Questions #49a, #50a and #50b on Year 3 Questionnaire -- participant must have all answers with "+".)

C3KSY3B

1 Yes **0** No
 STOP.

b. Did the participant have an MRI in Year 2? *(Examiner Note: Refer to Data from Prior Visits Report.)*

C3KY2MB

1 Yes **0** No
 STOP.

c. Check MRI/Xray scheduling roster for final determination of whether to recruit participant as a control.

Is the participant eligible as a control?

C3KELIG

1 Yes **0** No
 STOP.

- ◆ Schedule an MRI
- ◆ Schedule an x-ray only if an MRI is scheduled.



| | | | |
|---|---|--|---|
| HABC Enrollment ID # H <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | Acrostic <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | Date Form Completed C3DATE <input type="text"/> / <input type="text"/> / <input type="text"/> Month Day Year | Staff ID # <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| C3ID2 | C3ACROS2 | | C3STFID |

PHLEBOTOMY

Bar Code Label

C3BRCD

1 Did the participant have cells collected during Visit 2?
(Examiner Note: Refer to Data from Prior Visits Report.)

1 Yes

0 No

C3V2CELL

Do not fill CPT tubes.

Did participant refuse cell collection during Visit 2?
(Examiner Note: Refer to Data from Prior Visit Report.)

1 Yes

0 No

C3CELLRF

Do not fill CPT tubes.

2 Do you bleed or bruise easily?
1 Yes **0** No **8** Don't know **7** Refused **C3BLBR**

3 Have you ever experienced fainting spells while having blood drawn?
1 Yes **0** No **8** Don't know **7** Refused **C3FNT**

4 Have you ever had a radical mastectomy? (Female Participants Only)
1 Yes **0** No **8** Don't know **7** Refused **C3RADMAS**

Which side?

1 Right

2 Left

3 Both

C3RMSIDE

Draw blood on left side.

Draw blood on right side.

Do not draw blood.

5 Have you ever had a graft for kidney dialysis?
1 Yes **0** No **8** Don't know **7** Refused **C3KIDNEY**

Which side?

1 Right

2 Left

3 Both

C3KDSIDE

Draw blood on left side.

Draw blood on right side.

Do not draw blood.

LCBR Use only: Received Date: _____ Time: _____

Frozen? Yes No



6 Is participant currently receiving supplemental oxygen?

- Yes
 No
 Don't know
 Refused
 C3OXY

How much?

| | | |
|--|--|------------|
| | | liters/min |
|--|--|------------|

C3OXYAMT

7 Participant's temperature:

| | | | | | | |
|--|--|--|--|--|--|-----|
| | | | | | | ° F |
|--|--|--|--|--|--|-----|

C3TEMP

8 Time at start of venipuncture?

| | | | | | |
|-------|--|---|---------|--|--|
| | | | | | |
| Hours | | : | Minutes | | |

- am
 pm

C3VTM

C3AMPM4

a. Was any blood drawn?

- Yes
 No
 C3BLDR

Please describe why not?

9 Time blood draw completed:

| | | | | | |
|-------|--|---|---------|--|--|
| | | | | | |
| Hours | | : | Minutes | | |

- am
 pm

C3BLDRTM

C3AMPM5

10 Total tourniquet time:

| | | |
|--|--|---------|
| | | minutes |
|--|--|---------|

C3TOUR

Comments on phlebotomy:

11 What is the date and time you last ate anything?

a. Date of last food:

| | | | | | | | | | | |
|-------|--|---|-----|--|---|------|--|--|--|--|
| | | | | | | | | | | |
| Month | | / | Day | | / | Year | | | | |

C3LMD

b. Time of last food:

| | | | | | |
|-------|--|---|---------|--|--|
| | | | | | |
| Hours | | : | Minutes | | |

- am
 pm

C3MHM

C3LMAPM

c. How many hours have passed since the participant last ate any food?

| | | |
|--|--|-------|
| | | hours |
|--|--|-------|

(Question 9 minus Question 11b. Round to nearest hour)

C3FAST



12 Quality of venipuncture:

① Clean ② Traumatic **C3QVEN**

| | |
|--------------------|----------------------------------|
| ① Vein collapse | ⑤ Excessive duration of draw |
| ② Hematoma | ⑥ Leakage at venipuncture site |
| ③ Vein hard to get | ⑦ Other <i>(Please specify:)</i> |
| ④ Multiple sticks | C3TRM |

13 Was arterialized venous blood sample obtained?

① Yes ② No **C3AVBLDR**

14 Was a standard blood draw done?

① Yes ② No **C3STBLDR**

15 Were tubes filled to specified capacity? If not, comment why.

| | Blood Volume/Tube | Filled to Capacity? | | Comment |
|----|-------------------|---------------------|-----|--------------|
| | | Yes | No | |
| 1. | CBC 3 ml | ① | ② → | C3BV1 |
| 2. | CPT 8 ml | ① | ② → | C3BV2 |
| 3. | CPT 8 ml | ① | ② → | C3BV3 |
| 4. | Serum 10 ml | ① | ② → | C3BV4 |

| | | |
|---|---|---|
| HABC Enrollment ID # | Acrostic | Date Form Completed |
| 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"/> |
| C3ID3 | C3ACROS3 | Month Day Year |

BLOOD GAS RESULTS

C3DATE2

1 Controls (yellow)

a. pH **C3YAPH**

C3YAGO2
pCO₂ mmHg

C3YAO2
pO₂ mmHg

b. pH **C3YBPH**

C3YBCO2
pCO₂ mmHg

C3YBO2
pO₂ mmHg

2 Participant's blood gas:

a. pH **C3BGAPH**

C3BGACO2
pCO₂ mmHg

C3BGAO2
pO₂ mmHg

C3BGAO3
HCO₃ mmol/L

b. pH **C3BGBPH**

C3BGBCO2
pCO₂ mmHg

C3BGBO2
pO₂ mmHg

C3BGBO3
HCO₃ mmol/L

c. pH **C3BGCPH**

C3BGCCO2
pCO₂ mmHg

C3BGCO2
pO₂ mmHg

C3BGCO3
HCO₃ mmol/L

3 Controls (red)

a. pH **C3RAPH**

C3RACO2
pCO₂ mmHg

C3RAO2
pO₂ mmHg

b. pH **C3RBPH**

C3RBCO2
pCO₂ mmHg

C3RBO2
pO₂ mmHg

4 Were controls in range?

1 Yes

0 No

Complete Blood Gas Results Supplement form.

C3RANGE

Staff ID #

5 Room temperature where vials are stored:

C3RMTEMP

°C

C3STFID2

LABORATORY PROCESSING

Time at start of serum processing: **C3TIMESP** **1** am **2** pm

Staff ID #: **C3AMPMS P**

C3STFID3

Time at start of cell processing: **C3TIMECP** **1** am **2** pm

Staff ID #: **C3AMPMCP**

C3STFID4

| Collection Tubes | Cryo # | Vol. | Type | To | Fill in bubble | Problems |
|------------------|--------|------|-------|----|-----------------------|-------------------------------------|
| #4 Serum | 01 | 1.0 | R/1.5 | M | 1 C301X | 1 H 2 P C301HP |
| | 02 | 1.0 | R/1.5 | M | 1 C302X | 1 H 2 P C302HP |
| | 03 | 1.0 | R/1.5 | M | 1 C303X | 1 H 2 P C303HP |
| | 04 | 1.0 | R/1.5 | M | 1 C304X | 1 H 2 P C304HP |

| Collection Tubes | Cryo # | Vol. | Type | To | Fill in bubble | Problems |
|------------------|--------|------|-------|----|-----------------------|-------------------------------------|
| #2, 3 Citrate | 05 | 1.0 | B/1.5 | L | 1 C305X | 1 H 2 P C305HP |
| | 06 | 1.0 | B/1.5 | L | 1 C306X | 1 H 2 P C306HP |
| | 07 | 1.0 | B/1.5 | L | 1 C307X | 1 H 2 P C307HP |
| | 08 | 1.0 | B/1.5 | L | 1 C308X | 1 H 2 P C308HP |

Bar Code Label

C3BRCD2

| | | | | | | |
|------------------------------------|----|-----|-------|----|-----------------------|-------------------------------------|
| #2, 3 Buffy Refused DNA collection | 13 | var | C/2.0 | M* | 1 C313X | 1 H 2 P C313HP |
| | 14 | var | C/2.0 | M* | 1 C314X | 1 H 2 P C314HP |
| #2, 3 Platelets | 15 | var | O/2.0 | M | 1 C315X | 1 H 2 P C315HP |
| | 16 | var | O/2.0 | M | 1 C316X | 1 H 2 P C316HP |

M=McKesson; H=Hemolyzed; P=Partial; R=Red; C=clear; B=blue; O=Orange

*Place in a styrofoam box at -20°C for 2 hours. Transfer to -80°C to hold for shipping.

Draft



| | | | |
|--|--|--|--|
| HABC Enrollment ID # H <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | Acrostic <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | Date Form Completed <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | Staff ID # <input type="text"/> <input type="text"/> <input type="text"/> |
| C7ID | C7ACROS | Month C7DATE Day Year | C7STFID |

ISOMETRIC CHAIR SUPPLEMENTAL FORM

- 1** What is the seat height?
(Examiner Note: Record the seat height by measuring the distance between point "A" and "B" as noted below. Use a ruler marked in millimeters.)

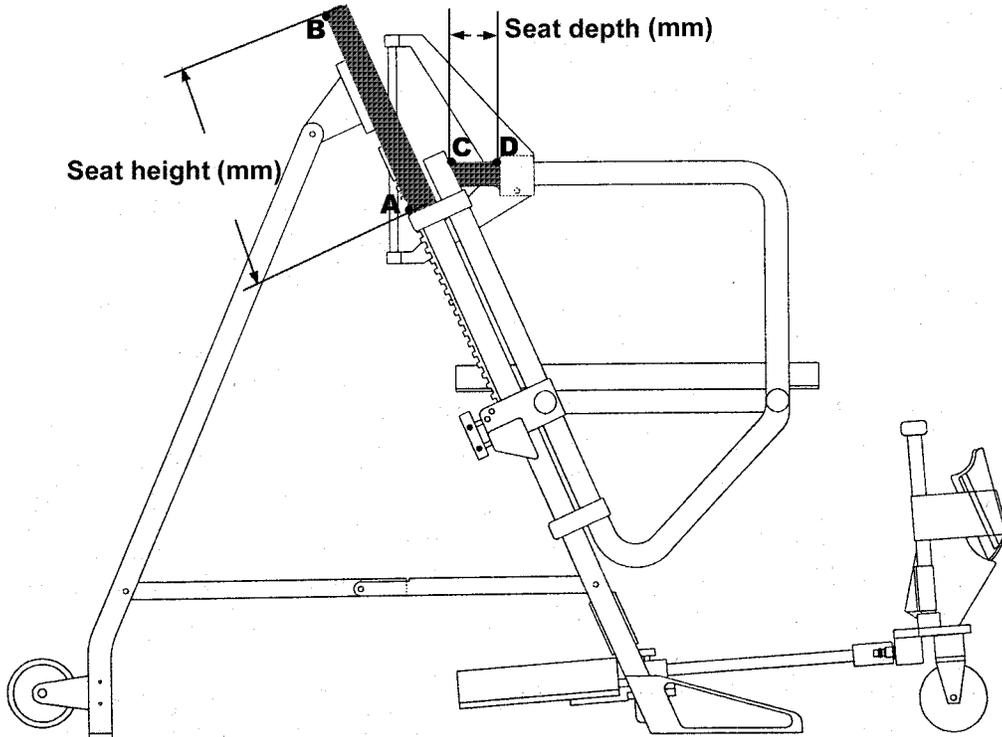
| | | | |
|----------------------|----------------------|----------------------|----|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | mm |
|----------------------|----------------------|----------------------|----|

C7SEATHT

- 2** What is the seat depth?
(Examiner Note: Record the seat depth by measuring the distance between point "C" and "D" as noted below. Use a ruler marked in millimeters. Be sure that the depth is exactly the same measurement on both sides of the chair.)

| | | | |
|----------------------|----------------------|----------------------|----|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | mm |
|----------------------|----------------------|----------------------|----|

C7SEATDP



| | | | |
|--|---|--|--|
| 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"/> |
| CHID | CHACROS | CHDATE | CHSTFID |

YEAR 3 CBC RESULTS

Examiner Note: Please record the following results listed on the Complete Blood Count results report sent by the local laboratory.

| | | | |
|-------------------------|---|--------------------|----------------|
| White blood count | <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> | thousands/ μ L | CHWBC |
| Hemoglobin | <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> | g/dL | CHHGB |
| Hematocrit | <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> | percent | CHHCT |
| Mean corpuscular volume | <input type="text"/> <input type="text"/> <input type="text"/> | fL | CHMCV |
| Platelets | <input type="text"/> <input type="text"/> <input type="text"/> | thousands/ μ L | CHPLATE |

| | | | |
|---|---|--|---|
| HABC Enrollment ID # H <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | Acroscopic <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | Date Form Completed <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | Staff ID # <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| C5ID | C5ACROS | C5DATE | C5STFID |

YEAR 3 RETURN VISIT PHLEBOTOMY

| |
|---------------------------------|
| Bar Code Label C5BRCD |
|---------------------------------|

1 Why did the participant return for phlebotomy?
(Examiner Note: Please mark all that apply.)

For standard phlebotomy (cells and/or serum) only **C5STAND**

For arterialized venous blood sample only **C5ART**

For both (either combined or separately) **C5BOTH**

2 Did the participant have cells collected during Visit 2?
(Examiner Note: Refer to Data from Prior Visits Report.)

Yes **C5V2CELL**

No

Do not fill CPT tubes.

Did participant refuse cell collection during Visit 2?
(Examiner Note: Refer to Data from Prior Visit Report.)

Yes **C5CELLRF**

No

Do not fill CPT tubes.

•

•

3 Do you bleed or bruise easily?

Yes No Don't know Refused **C5BLBR**

4 Have you ever experienced fainting spells while having blood drawn?

Yes No Don't know Refused **C5FNT**

5 Have you ever had a radical mastectomy? **(Female Participants Only)**

Yes No Don't know Refused **C5RADMAS**

Which side?

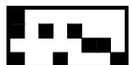
Right Left Both **C5RMSIDE**

Draw blood on left side. Draw blood on right side. Do not draw blood.

LCBR Use only: Received Date: _____ Time: _____

Frozen? Yes No

Draft



6 Have you ever had a graft for kidney dialysis? **C5KIDNEY**

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

Which side?

| | | |
|--|--|---|
| <input type="radio"/> 1 Right ↓ Draw blood on left side. | <input type="radio"/> 2 Left ↓ Draw blood on right side. | <input type="radio"/> 3 Both ↓ Do not draw blood. |
|--|--|---|

C5KDSIDE

7 Is participant currently receiving supplemental oxygen?

- 1 Yes
 0 No
 8 Don't know
 7 Refused
 C5OXY

How much?

| | |
|--|--|
| | |
|--|--|

liters/min **C5OXYAMT**

8 Participant's temperature:

| | | | | | |
|--|--|--|--|--|--|
| | | | | | |
|--|--|--|--|--|--|

° F **C5TEMP**

9 Time at start of venipuncture?

C5VTM **C5AMPM4**

| | | | |
|--|--|--|--|
| | | | |
|--|--|--|--|

Hours Minutes

1 am 2 pm

a. Was any blood drawn?

- 1 Yes
 0 No
 C5BLDR

Please describe why not?

10 Time blood draw completed:

C5BLDRTM **C5AMPM5**

| | | | |
|--|--|--|--|
| | | | |
|--|--|--|--|

Hours Minutes

1 am 2 pm

11 Total tourniquet time:
(Examiner Note: If tourniquet was reapplied, enter total time tourniquet was on. Note that 2 minutes is optimum.)

| | |
|--|--|
| | |
|--|--|

minutes

C5TOUR

Comments on phlebotomy:

| |
|--|
| |
|--|



12 What is the date and time you last ate anything?

a. Date of last food: / / **C5LMD**
Month Day Year

b. Time of last food: : am pm **C5LMAPM**
C5MHM Hours Minutes

c. How many hours have passed since the participant last ate any food? hours (Question 10 minus Question 12b. Round to nearest hour)

C5FAST

13 Quality of venipuncture:

Clean Traumatic **C5QVEN**

- | | |
|--|--|
| <input type="radio"/> Vein collapse | <input type="radio"/> Excessive duration of draw |
| <input type="radio"/> Hematoma | <input type="radio"/> Leakage at venipuncture site |
| <input type="radio"/> Vein hard to get | <input type="radio"/> Other (Please specify:) |
| <input type="radio"/> Multiple sticks | C5TRM |

14 Was arterialized venous blood sample obtained?

Yes No **C5AVBLDR**

15 Was a standard blood draw done?

Yes No **C5STBLDR**

16 Were tubes filled to specified capacity? If not, comment why.

| Blood Volume/Tube | Filled to Capacity? | Filled to Capacity? | | Comment |
|-------------------|--|----------------------------------|-------------------------|--------------|
| | | Yes | No | |
| 1. CBC 3 ml | <input type="radio"/> Yes <input type="radio"/> No | <input checked="" type="radio"/> | <input type="radio"/> → | C5BV1 |
| 2. CPT 8 ml | <input type="radio"/> Yes <input type="radio"/> No | <input checked="" type="radio"/> | <input type="radio"/> → | C5BV2 |
| 3. CPT 8 ml | <input type="radio"/> Yes <input type="radio"/> No | <input checked="" type="radio"/> | <input type="radio"/> → | C5BV3 |
| 4. Serum 10 ml | <input type="radio"/> Yes <input type="radio"/> No | <input checked="" type="radio"/> | <input type="radio"/> → | C5BV4 |



| | | |
|---|---|---|
| HABC Enrollment ID # | Acrostic | Date Form Completed |
| <input type="text" value="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"/> |
| C6ID | C6ACROS | Month Day Year |

YEAR 3 RETURN VISIT BLOODGAS

1 Controls (yellow)

| | | | | | | | |
|-------|-------------------------------------|------------------|--------------------------------------|------|-----------------|-------------------------------------|------|
| a. pH | <input type="text" value="C6YAPH"/> | pCO ₂ | <input type="text" value="C6YACO2"/> | mmHg | pO ₂ | <input type="text" value="C6YAO2"/> | mmHg |
| b. pH | <input type="text" value="C6YBPH"/> | pCO ₂ | <input type="text" value="C6YBCO2"/> | mmHg | pO ₂ | <input type="text" value="C6YBO2"/> | mmHg |

2 Participant's blood gas:

| | | | | | | | | | | |
|-------|---------------------------------------|------------------|---------------------------------------|------|-----------------|--------------------------------------|------|------------------|--------------------------------------|--------|
| a. pH | <input type="text" value="C6BGAPH"/> | pCO ₂ | <input type="text" value="C6BGACO2"/> | mmHg | pO ₂ | <input type="text" value="C6BGAO2"/> | mmHg | HCO ₃ | <input type="text" value="C6BGAO3"/> | mmol/L |
| b. pH | <input type="text" value="C6BGBPH"/> | pCO ₂ | <input type="text" value="C6BGBCO2"/> | mmHg | pO ₂ | <input type="text" value="C6BGBO2"/> | mmHg | HCO ₃ | <input type="text" value="C6BGBO3"/> | mmol/L |
| c. pH | <input type="text" value="C6BGC PH"/> | pCO ₂ | <input type="text" value="C6BGCCO2"/> | mmHg | pO ₂ | <input type="text" value="C6BGCO2"/> | mmHg | HCO ₃ | <input type="text" value="C6BGCO3"/> | mmol/L |

3 Controls (red)

| | | | | | | | |
|-------|-------------------------------------|------------------|--------------------------------------|------|-----------------|-------------------------------------|------|
| a. pH | <input type="text" value="C6RAPH"/> | pCO ₂ | <input type="text" value="C6RACO2"/> | mmHg | pO ₂ | <input type="text" value="C6RAO2"/> | mmHg |
| b. pH | <input type="text" value="C6RBPH"/> | pCO ₂ | <input type="text" value="C6RBCO2"/> | mmHg | pO ₂ | <input type="text" value="C6RBO2"/> | mmHg |

4 Were controls in range?

Yes **C6RANGE**
 No → Complete Blood Gas Results Supplement form.
 Staff ID #

Room temperature where vials are stored: °C
 C6STFID

5 Room temperature where vials are stored:

YEAR 3 RETURN VISIT LABORATORY C6AMPMCP

| | | | |
|------------------------------------|---------------------------------------|--------------------------|--------------------------|
| Time at start of serum processing: | <input type="text" value="C6TIMESP"/> | <input type="radio"/> am | <input type="radio"/> pm |
| Staff ID #: | <input type="text"/> | C6AMPMS | C6STFID2 |

| | | | |
|-----------------------------------|---------------------------------------|--------------------------|--------------------------|
| Time at start of cell processing: | <input type="text" value="C6TIMECP"/> | <input type="radio"/> am | <input type="radio"/> pm |
| Staff ID #: | <input type="text"/> | C6STFID3 | |

| Collection Tubes | Cryo # | Vol. | Type | To | Fill in bubble | Problems |
|------------------------------------|--------|------|-------|----|-----------------------------|---|
| #4 Serum | 01 | 1.0 | R/1.5 | M | <input type="radio"/> C601X | <input type="radio"/> H <input type="radio"/> P C601HP |
| | 02 | 1.0 | R/1.5 | M | <input type="radio"/> C602X | <input type="radio"/> H <input type="radio"/> P C602HP |
| | 03 | 1.0 | R/1.5 | M | <input type="radio"/> C603X | <input type="radio"/> H <input type="radio"/> P C603HP |
| | 04 | 1.0 | R/1.5 | M | <input type="radio"/> C604X | <input type="radio"/> H <input type="radio"/> P C604HP |
| Bar Code Label | | | | | | |
| C6BRCD | | | | | | |
| Collection Tubes | Cryo # | Vol. | Type | To | Fill in bubble | Problems |
| #2, 3 Citrate | 05 | 1.0 | B/1.5 | L | <input type="radio"/> C605X | <input type="radio"/> H <input type="radio"/> P C605HP |
| | 06 | 1.0 | B/1.5 | L | <input type="radio"/> C606X | <input type="radio"/> H <input type="radio"/> P C606HP |
| | 07 | 1.0 | B/1.5 | L | <input type="radio"/> C607X | <input type="radio"/> H <input type="radio"/> P C607HP |
| | 08 | 1.0 | B/1.5 | L | <input type="radio"/> C608X | <input type="radio"/> H <input type="radio"/> P C608HP |
| #2, 3 Buffy Refused DNA collection | 13 | var | C/2.0 | M* | <input type="radio"/> C613X | <input type="radio"/> H <input type="radio"/> P C613HP |
| | 14 | var | C/2.0 | M* | <input type="radio"/> C614X | <input type="radio"/> H <input type="radio"/> P C614HP |
| #2, 3 Platelets | 15 | var | O/2.0 | M | <input type="radio"/> C615X | <input type="radio"/> H <input type="radio"/> P C615HP |
| | 16 | var | O/2.0 | M | <input type="radio"/> C616X | <input type="radio"/> H <input type="radio"/> P C616HP |

M=McKesson; H=Hemolyzed; P=Partial; R=Red; C=clear; B=blue; O=Orange

*Place in a styrofoam box at -20°C for 2 hours. Transfer to -80°C to hold for shipping.

Draft



| | | | |
|--|---|---|---|
| HABC Enrollment ID # H [] [] [] [] [] [] ZBID | Acrostic [] [] [] [] [] [] ZBACROS | Date Form Completed [] [] / [] [] / [] [] [] [] Month Day Year ZBDATE | Staff ID # [] [] [] ZBSTFID |
|--|---|---|---|

CORE HOME VISIT WORKBOOK

Version 1.2, 1/12/00

Arrival Time: [] [] : [] [] **ZBTIME1**
Hours Minutes

Departure Time: [] [] : [] [] **ZBTIME2**
Hours Minutes

Year of annual contact:
 3 Year 03 6 Year 06 **ZBTYPE**
 4 Year 04 7 Year 07
 5 Year 05 8 Other (Please specify)

CORE HOME VISIT PROCEDURE CHECKLIST

| | Page Numbers | Please mark if done | Comments |
|---|--------------|--|---|
| 1. Home Visit Interview | 2 | 1 <input type="radio"/> Completed interview 2 <input type="radio"/> Partial interview: All priority questions completed 3 <input type="radio"/> Partial interview: Priority questions incomplete 4 <input type="radio"/> Not done | ZBHV |
| 2. Medication Inventory Update | 29 | <input type="radio"/> 1 Yes <input type="radio"/> 0 No | ZBMI |
| 3. Weight | 34 | <input type="radio"/> 1 Yes <input type="radio"/> 0 No | ZBWT |
| 4. Radial Pulse | 34 | <input type="radio"/> 1 Yes <input type="radio"/> 0 No | ZBRP |
| 5. Blood Pressure | 35 | <input type="radio"/> 1 Yes <input type="radio"/> 0 No | ZBBP |
| 6. Grip Strength | 36 | <input type="radio"/> 1 Yes <input type="radio"/> 0 No | ZBGRIP |
| 7. Standing Balance | 37 | <input type="radio"/> 1 Yes <input type="radio"/> 0 No | ZBSB |
| 8. Chair Stands | 38 | <input type="radio"/> 1 Yes <input type="radio"/> 0 No | ZBCS |
| 9. 4-meter Walk | 40 | <input type="radio"/> 1 Yes <input type="radio"/> 0 No | ZB4MW |
| 10. Knee Crepitus | 41 | <input type="radio"/> 1 Yes <input type="radio"/> 0 No | ZBKNEE |
| 11. Isometric Strength (Isometric Chair) | 42 | <input type="radio"/> 1 Yes <input type="radio"/> 0 No | ZBISO |
| 12. Ultrasound | 45 | <input type="radio"/> 1 Yes <input type="radio"/> 0 No | ZBULTRA |
| 13. DXA: Did participant agree to come into clinic for DXA? | 47 | <input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 5 Not applicable | ZBDXA |
| 14. Was blood collected? | | <input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 5 Not applicable | ZBBLOOD |
| 15. Was urine collected? | | <input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 5 Not applicable | ZBURINE |
| 16. Was the Visit-specific Home Visit Workbook filled out (either in part or completely)? | | <input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 5 Not applicable | ZBHVWK |
| 17. Was the Substudy Workbook filled out (either in part or completely)? | | <input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 5 Not applicable | ZBSUB |
| 18. Did participant agree to schedule an x-ray? | | <input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 5 Not applicable | ZBXR <input type="radio"/> 9 Not eligible |

Draft



| | | | |
|---|---|---|--|
| 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"/> |
| ZCID | ZCACROS | Month ZCDATE Year | ZCSTFID |

CORE HOME VISIT WORKBOOK

Year of annual contact: **ZCTYPE**

Year 03 Year 06
 Year 04 Year 07
 Year 05 Other (Please specify) _____

Type of contact: **ZCCONTAC**

Home (face-to-face interview)
 Telephone interview
 Other (Please specify) _____

Date of last regularly scheduled contact: **ZCDATES**

/ /

Month Day Year ★ = Priority questions

★ 1. In general, how would you say your health is? Would you say it is. . .
(Interviewer Note: Read response options.)

- ZCHSTAT**
- Excellent Poor
 Very good Don't know
 Good Refused
 Fair

★ 2. Since we last spoke to you 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. **ZCBED12**

- Yes No Don't know Refused

★ 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.
(Interviewer Note: If necessary, probe - "If you are unsure, please make your best guess.")

days **ZCBEDDAY**

★ 3. Since we last spoke to you 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? Please include days in bed. **ZCCUT12**

- Yes No Don't know Refused

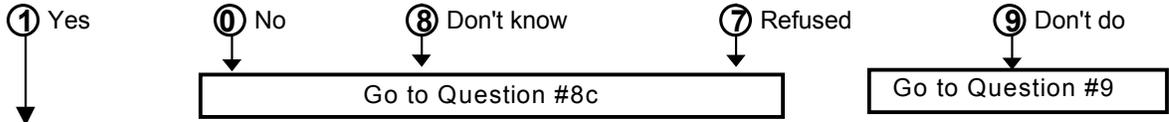
★ How many days did you cut down on the things you usually do because of illness or injury? Please include days in bed.
(Interviewer Note: If necessary, probe - "If you are unsure, please make your best guess.")

days **ZCCUTDAY**



- ★ **8.** 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? *(Interviewer Note: If the participant responds "Don't do," probe to determine whether this is because of a health or physical problem. If the participant doesn't walk because of a health or physical problem, mark "Yes." If the participant doesn't walk for other reasons, mark "Don't do.")*

ZCDWQMYN



- ★ **a.** How much difficulty do you have? *(Interviewer Note: Read response options.)*

- ① A little difficulty
- ② Some difficulty
- ③ A lot of difficulty
- ④ Or are you unable to do it?
- ⑧ Don't know

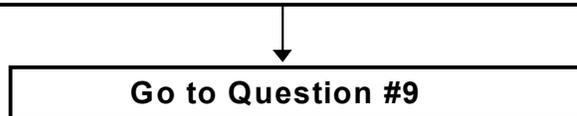
ZCDWQMDF

- ★ **b.** 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.)

ZCMNRS

- | | |
|--|--|
| ① Arthritis | ① Hip fracture |
| ② Back pain | ⑬ Injury (Please specify: _____) |
| ③ Balance problems/unsteadiness on feet | ⑭ Joint pain |
| ④ Cancer | ⑮ Lung disease (asthma, chronic bronchitis, emphysema, etc) |
| ⑤ Chest pain/discomfort | ⑯ Old age (no mention of a specific condition) |
| ⑥ Circulatory problems | ⑰ Osteoporosis |
| ⑦ Diabetes | ⑱ Shortness of breath |
| ⑧ Fatigue/tiredness (no specific disease) | ⑲ Stroke |
| ⑨ Fall | ⑳ Other symptom (Please specify: ZCMNRS4) |
| ⑩ Heart disease (including angina, congestive heart failure, etc) | ㉑ Multiple conditions/symptoms given; unable to determine MAIN reason |
| ⑪ High blood pressure/hypertension | ㉒ Don't know |



★ 8c. How easy is it for you to walk a quarter of a mile?
(Interviewer Note: Read response options.)

- ① Very easy
- ② Somewhat easy
- ③ Or not that easy
- ⑧ Don't know/Don't do

ZCDWQMEZ

★ 8d. Do you get tired when you walk a quarter of a mile?

- ① Yes
- ② No
- ⑧ Don't know/Don't do

ZCDWQMT2

★ 8e. 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
- ② No
- ⑧ Don't know/Don't do

ZCDW1MYN

→ Go to Question #9

→ Go to Question #8f

→ Go to Question #8f

★ 8f. How easy is it for you to walk one mile?
(Interviewer Note: Read response options.)

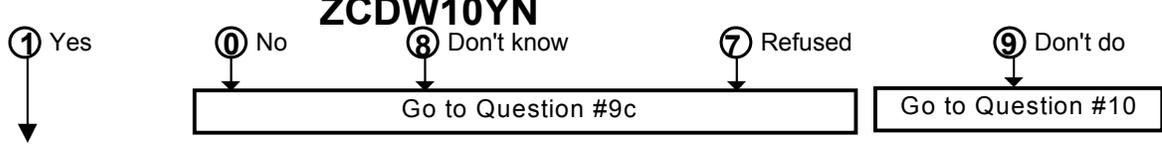
- ① Very easy
- ② Somewhat easy
- ③ Or not that easy
- ⑧ Don't know/Don't do

ZCDW1MEZ



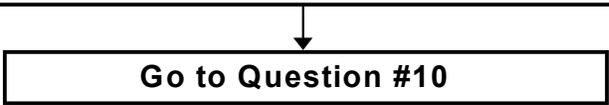
**CORE HOME VISIT WORKBOOK
PHYSICAL FUNCTION**

- ★ **9.** Because of a health or physical problem, do you have any difficulty walking up 10 steps, that is about 1 flight, without resting?
(Interviewer Note: If the participant responds "Don't do", probe to determine whether this is because of a health or physical problem. If the participant doesn't walk up 10 steps because of a health or physical problem, mark "Yes". If the participant doesn't walk up steps for other reasons, such as there are simply no steps in the area, mark "Don't do".)



- ★ **a.** How much difficulty do you have?
(Interviewer Note: Read response options.)
- ZCDIF**
- 1 A little difficulty
 - 2 Some difficulty
 - 3 A lot of difficulty
 - 4 Or are you unable to do it?
 - 8 Don't know

- ★ **b.** 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.)
- ZCMNRS2**
- | | |
|--|--|
| <ul style="list-style-type: none"> <input type="radio"/> 1 Arthritis <input type="radio"/> 2 Back pain <input type="radio"/> 3 Balance problems/unsteadiness on feet <input type="radio"/> 4 Cancer <input type="radio"/> 5 Chest pain/discomfort <input type="radio"/> 6 Circulatory problems <input type="radio"/> 7 Diabetes <input type="radio"/> 8 Fatigue/tiredness (no specific disease) <input type="radio"/> 9 Fall <input type="radio"/> 10 Heart disease (including angina, congestive heart failure, etc) <input type="radio"/> 11 High blood pressure/hypertension | <ul style="list-style-type: none"> <input type="radio"/> 12 Hip fracture <input type="radio"/> 13 Injury (Please specify: _____) <input type="radio"/> 14 Joint pain <input type="radio"/> 15 Lung disease (asthma, chronic bronchitis, emphysema, etc) <input type="radio"/> 16 Old age (no mention of a specific condition) <input type="radio"/> 17 Osteoporosis <input type="radio"/> 18 Shortness of breath <input type="radio"/> 19 Stroke <input type="radio"/> 20 Other symptom ZCMNRS3 (Please specify: _____) <input type="radio"/> 21 Multiple conditions/symptoms given; unable to determine MAIN reason <input type="radio"/> 22 Don't know |
|--|--|



★ 9c. How easy is it for you to walk up 10 steps without resting?
(Interviewer Note: Read response options.)

- ① Very easy
- ② Somewhat easy
- ③ Or not that easy
- ⑧ Don't know/Don't do

ZCDW10EZ

★ 9d. Do you get tired when you walk up 10 steps without resting?

- ① Yes
- ② No
- ⑧ Don't know/Don't do

ZCDW10WX

★ 9e. 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
- ② No
- ⑧ Don't know/Don't do

→ Go to Question #10
→ Go to Question #9f
→ Go to Question #9f

ZCDW20YN

★ 9f. How easy is it for you to walk up 20 steps without resting?
(Interviewer Note: Read response options.)

- ① Very easy
- ② Somewhat easy
- ③ Or not that easy
- ⑧ Don't know/Don't do

ZCDW20EZ



★ **10.** Do you have to use a cane, walker, crutches, or other special equipment to help you get around?
 1 Yes 2 No 3 Don't know 4 Refused **ZCEQUIP**

★ **11.** Because of a health or physical problem, do you have any difficulty getting in and out of bed or chairs?
 1 Yes 2 No 3 Don't know 4 Refused **ZCDIOYN**

★ How much difficulty do you have?
*(Interviewer Note:
 Read response options.)*

ZCDIODIF

- 1 A little difficulty
- 2 Some difficulty
- 3 A lot of difficulty
- 4 Or are you unable to do it?
- 5 Don't know

★ Do you usually receive help from another person when you get in and out of bed or chairs?
 1 Yes 2 No 3 Don't know

ZCDIORHY

★ **12.** Do you have any difficulty bathing or showering? **ZCBATHYN**
 1 Yes 2 No 3 Don't know 4 Refused

★ How much difficulty do you have?
*(Interviewer Note:
 Read response options.)*

ZCBATHDF

- 1 A little difficulty
- 2 Some difficulty
- 3 A lot of difficulty
- 4 Or are you unable to do it?
- 5 Don't know

★ Do you usually receive help from another person in bathing or showering?
 1 Yes 2 No 3 Don't know

ZCBATHRH

★ **13.** Do you have any difficulty dressing? **ZCDDYN**
 1 Yes 2 No 3 Don't know 4 Refused

★ How much difficulty do you have?
*(Interviewer Note:
 Read response options.)*

ZCDDIF

- 1 A little difficulty
- 2 Some difficulty
- 3 A lot of difficulty
- 4 Or are you unable to do it?
- 5 Don't know

★ Do you usually receive help from another person in dressing?
 1 Yes 2 No 3 Don't know

ZCDDRHYN



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

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

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

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

16. 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.

In the past 12 months, did you walk up a flight of stairs (a flight is about 10 steps), at least 10 times?

- 1 Yes
 0 No
 8 Don't know
 7 Refused
 ZCFS12MO
-

a. In the past 7 days, did you walk up a flight of stairs? **ZCS7DAY**

- 1 Yes
 0 No
 8 Don't know

b. About how many flights did you walk up in the past 7 days?
If you are unsure, please make your best guess.

ZCFSNUM

flights

- 1 Don't know

ZCFSNUMD

c. About how many of these flights did you walk up carrying a small load like laundry, groceries, or an infant?

flights

- 1 Don't know

ZCFSLODK

ZCFSLOAD

17. In the past 12 months, did you walk for exercise, or walk to work, the store, church or walk the dog, at least 10 times? **ZCEW12MO**

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

Go to Question #18

In the past 7 days, did you go walking? **ZCEW7DAY**

- 1 Yes
 0 No

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

ZCEWTIME **ZCEWTMDK**
 times -1 Don't know

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.)

ZCEWHRS **ZCEWMINS**
 Hours Minutes -1 Don't know
ZCEWTDK

c. When you walk, 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
 3 stroll
 8 Don't know

ZCEWPACE

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

blocks -1 Number of blocks unknown
ZCEWBLUK

ZCEWBLOX

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

ZCEWKNOW

- 1 Yes
 0 No

a. What is the unit of measure?

ZCEWUNIT

b. How many do you walk, on average?

units -1 Don't know

ZCEWNUMU **ZCEWUNDK**

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

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

Go to Question #18



Now I'm going to ask you about any medical problems you might have had since we last spoke to you about 6 months ago, which was on

/ /
 Month / Day / Year

★ **23.** Since we last spoke to you about 6 months ago, has a doctor told you that you had a heart attack, angina, or chest pain due to heart disease? **ZCHCHAMI**

- Yes No Don't know Refused

★ Were you hospitalized overnight for this problem?
ZCHOSMI

Yes No

★ Complete a Health ABC Event Form(s), Section I, for each overnight hospitalization. Record reference #'s below:

ZCREF23A a.

ZCREF23B b.

ZCREF23C c.

Go to Question #24

★ **24.** Since we last spoke to you about 6 months ago, has a doctor told you that you had a stroke, mini-stroke, or TIA ?

- Yes No Don't know Refused

ZCHCCVA

★ Were you hospitalized overnight for this problem?
ZCHOSMI2

Yes No

★ Complete a Health ABC Event Form(s), Section I, for each overnight hospitalization. Record reference #'s below:

ZCREF24A a.

ZCREF24B b.

ZCREF24C c.

Go to Question #25

★ **25.** Since we last spoke to you about 6 months ago, has a doctor told you that you had congestive heart failure?

- Yes No Don't know Refused

★ Were you hospitalized overnight for this problem?
ZCHOSMI3

Yes No

★ Complete a Health ABC Event Form(s), Section I, for each overnight hospitalization. Record reference #'s below:

ZCREF25A a.

ZCREF25B b.

ZCREF25C c.

Go to Question #26



★ 26. Since we last spoke to you 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 we last spoke to you.

ZCCHMGMT

- Yes
 No
 Don't know
 Refused

★ Complete a Health ABC Event Form(s), Section II, for each event.
Record reference #'s below:

a.

| | | | | |
|--|--|--|--|--|
| | | | | |
|--|--|--|--|--|

b.

| | | | | |
|--|--|--|--|--|
| | | | | |
|--|--|--|--|--|

c.

| | | | | |
|--|--|--|--|--|
| | | | | |
|--|--|--|--|--|

**ZCREF26A
ZCREF26B
ZCREF26C**

★ 27. Since we last spoke to you about 6 months ago, has a doctor told you that you had pneumonia?

ZCLCPNEU

- Yes
 No
 Don't know
 Refused

★ Complete a Health ABC Event Form(s), Section II, for each event.
Record reference #'s below:

a.

| | | | | |
|--|--|--|--|--|
| | | | | |
|--|--|--|--|--|

b.

| | | | | |
|--|--|--|--|--|
| | | | | |
|--|--|--|--|--|

c.

| | | | | |
|--|--|--|--|--|
| | | | | |
|--|--|--|--|--|

**ZCREF27A
ZCREF27B
ZCREF27C**

★ 28. Since we last spoke to you about 6 months ago, have you been told by a doctor that you broke or fractured a bone(s)?

ZCOSBR45

- Yes
 No
 Don't know
 Refused

★ Complete a Health ABC Event Form(s), Section II, for each event.
Record reference #'s below:

a.

| | | | | |
|--|--|--|--|--|
| | | | | |
|--|--|--|--|--|

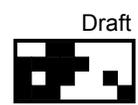
b.

| | | | | |
|--|--|--|--|--|
| | | | | |
|--|--|--|--|--|

c.

| | | | | |
|--|--|--|--|--|
| | | | | |
|--|--|--|--|--|

**ZCREF28A
ZCREF28B
ZCREF28C**



★ **29.** Were you hospitalized overnight for any other reasons since we last spoke to you about 6 months ago?
 1 Yes 0 No 8 Don't know 7 Refused **ZCHOSP12**

★ Complete a Health ABC Event Form(s), Section I, for each event.
Record reference #'s and reason for hospitalization below.

| | | |
|--|--|--|
| <p>a. <input type="text"/> Reason for hospitalization: ZCREF29A</p> | <p>b. <input type="text"/> Reason for hospitalization: ZCREF29B</p> | <p>c. <input type="text"/> Reason for hospitalization: ZCREF29C</p> |
| <p>d. <input type="text"/> Reason for hospitalization: ZCREF29D</p> | <p>e. <input type="text"/> Reason for hospitalization: ZCREF29E</p> | <p>f. <input type="text"/> Reason for hospitalization: ZCREF29F</p> |

★ **30.** Have you had any same day outpatient surgery since we last spoke to you about 6 months ago?
 1 Yes 0 No 8 Don't know 7 Refused **ZCOUTPA**

| | | |
|--|---|---|
| <p>★ a. Was it for...? A procedure to open a blocked artery ZCBLART</p> | <p><input type="radio"/> 1 Yes → Complete a Health ABC Event form, Section III. Record reference #: <input type="radio"/> 0 No <input type="radio"/> 8 Don't know</p> | <p>Reference #'s <input type="text"/> ZCREF30A</p> |
| <p>★ b. Gall bladder surgery ZCGALLBL</p> | <p><input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Don't know</p> | |
| <p>★ c. Cataract surgery ZCCATAR</p> | <p><input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Don't know</p> | |
| <p>★ d. Hernia repair (Inguinal abdominal hernia.) ZCHERN</p> | <p><input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Don't know</p> | |
| <p>★ e. TURP (MEN ONLY) (transurethral resection of prostate) ZCTURP</p> | <p><input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Don't know</p> | |
| <p>★ f. Other ZCOTH</p> | <p><input type="radio"/> 1 Yes → <input type="radio"/> 0 No <input type="radio"/> 8 Don't know</p> | <p>Please specify the type of outpatient surgery. i. _____ ii. _____ iii. _____</p> |



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

① Yes

② No

⑧ Don't know

⑦ Refused

Please go to Question #32

ZCOTILL

Please describe for what:

32. This next question refers to the past month. In the past month, on the average, have you been feeling unusually tired during the day?

ZCELTIRE

① Yes

② No

⑧ Don't know

⑦ Refused

Have you been feeling unusually tired...?
(Interviewer Note: Read response options.)

① All of the time

② Most of the time

③ Some of the time

⑧ Don't know

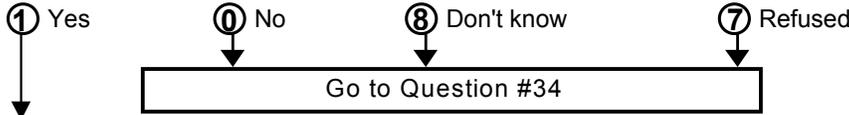
⑦ Refused

ZCELOFTN



Now I am going to ask you some questions about pain, aching or stiffness in, or around your knee. This includes the front, back and sides of the knee.

33. In the past 12 months, have you had any pain, aching or stiffness in either knee? **ZCAJK12**



In the past 12 months, have you had pain, aching or stiffness in either knee on most days for at least one month? **ZCAJKMD**

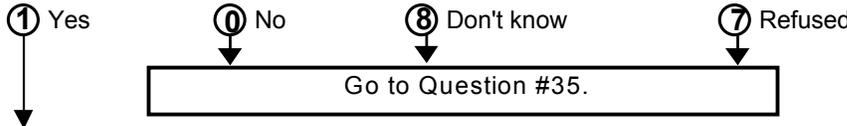
1 Yes * 0 No 8 Don't know

↓

Have you had this pain in your right knee, left knee, or both knees?
(Interviewer Note: Mark only one answer.)

1 Right knee only **ZCAJLRB1**
 2 Left knee only
 3 Both right and left knee
 8 Don't know

34. Now, please think about the past 30 days. In the past 30 days, have you had any pain, aching or stiffness in either knee? **ZCAJK30**



a. In the past 30 days, have you had pain, aching or stiffness in either knee on most days? **ZCAJKMS**

1 Yes * 0 No 8 Don't know

b. In the past 30 days, how much pain have you had in your knees for each activity I will describe. How much pain have you had while...? *(Interviewer Note: Read each activity separately. Read response options.)*

| | None | Mild | Moderate* | Severe* | Extreme* | Don't know |
|---------------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|--|
| a) Walking on a flat surface | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 8 ZCAJKFS |
| b) Going up or down stairs | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 8 ZCAJKST |
| c) At night while in bed | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 8 ZCAJKBD |
| d) Standing upright | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 8 ZCAJKUP |
| e) Getting in or out of a chair | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 8 ZCAJKCH |
| f) Getting in or out of a car | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 8 ZCAJKIN |

c. Have you had this pain in your right knee, left knee, or both knees?
(Interviewer Note: Mark only one answer.) **ZCAJLRB2**

1 Right knee only 2 Left knee only 3 Both right and left knee 8 Don't know

*** Interviewer Note: Participant may be eligible for knee x-ray. If knee x-rays are a part of this year's exam, go to Home Visit Knee X-ray Tracking Form.**



★ **35.** In general, would you say that your appetite or desire to eat has been . . . ?
(Interviewer Note: Read response options.) **ZCAPPET**

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

★ **36.** How much do you currently weigh?
(Interviewer Note: If necessary, probe - "If you are unsure, please make your best guess.")

ZCWTLBS pounds ⑧ Don't know/don't remember ⑦ Refused **ZCLBS2**

37. Since we last spoke to you about 6 months ago, has your weight changed by 5 or more pounds?

- ① Yes
 - ② No
 - ⑧ Don't know
 - ⑦ Refused
- ZCCHN5LB**

a. Did you gain or lose weight?

① Gain ② Lose ⑧ Don't know/don't remember **ZCGNLS**

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.")

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

ZCHOW6 **ZCHOW6DN**

c. Were you trying to gain/lose weight?

① Yes ② No ⑧ Don't know

ZCTRGNLS

★ **38.** At the present time, are you trying to lose weight? **ZCTRYLOS**

- ① Yes
- ② No
- ⑧ Don't know
- ⑦ Refused

**CORE HOME VISIT WORKBOOK
FEELINGS IN THE PAST WEEK**

39. 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; Most or All of the time. (*Interviewer Note: REQUIRED - Show card #1.*)

| | 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. ZCFBOTH | ① | ② | ③ | ④ | ⑧ | ⑦ |
| b. I did not feel like eating: my appetite was poor. ZCFEAT | ① | ② | ③ | ④ | ⑧ | ⑦ |
| c. I felt that I could not shake off the blues even with help from my family and friends. ZCFBLUES | ① | ② | ③ | ④ | ⑧ | ⑦ |
| d. I felt that I was just as good as other people. ZCFGOOD | ① | ② | ③ | ④ | ⑧ | ⑦ |
| e. I had trouble keeping my mind on what I was doing. ZCFMIND | ① | ② | ③ | ④ | ⑧ | ⑦ |
| f. I was depressed. ZCFDOWN | ① | ② | ③ | ④ | ⑧ | ⑦ |
| g. I felt that everything I did was an effort. ZCFEFFRT | ① | ② | ③ | ④ | ⑧ | ⑦ |
| h. I felt hopeful about the future. ZCFHOPE | ① | ② | ③ | ④ | ⑧ | ⑦ |
| i. I thought my life had been a failure. ZCFFAIL | ① | ② | ③ | ④ | ⑧ | ⑦ |
| j. I felt fearful. ZCFFEAR | ① | ② | ③ | ④ | ⑧ | ⑦ |
| k. My sleep was restless. ZCFSLEEP | ① | ② | ③ | ④ | ⑧ | ⑦ |
| l. I was happy. ZCFHAPPY | ① | ② | ③ | ④ | ⑧ | ⑦ |
| m. It seemed that I talked less than usual. ZCFTALK | ① | ② | ③ | ④ | ⑧ | ⑦ |
| n. I felt lonely. ZCFLONE | ① | ② | ③ | ④ | ⑧ | ⑦ |
| o. People were unfriendly. ZCFUNFR | ① | ② | ③ | ④ | ⑧ | ⑦ |
| p. I enjoyed life. ZCFENJOY | ① | ② | ③ | ④ | ⑧ | ⑦ |
| q. I had crying spells. ZCFCRY | ① | ② | ③ | ④ | ⑧ | ⑦ |
| r. I felt sad. ZCFSAD | ① | ② | ③ | ④ | ⑧ | ⑦ |
| s. I felt that people disliked me. ZCFDISME | ① | ② | ③ | ④ | ⑧ | ⑦ |
| t. I could not get going. ZCFNOGO | ① | ② | ③ | ④ | ⑧ | ⑦ |



| | | | |
|--|--|---|--|
| 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"/> |
| ZDID | ZDACROS | ZDDATE Month Day Year | ZDSTFID |

**CORE HOME VISIT WORKBOOK
LIFE EVENTS**

Year of annual contact:

ZDTYPE

Year 03 Year 06
 Year 04 Year 07
 Year 05 Other *(Please specify)*

40. Did your spouse or partner die in the past 12 months? **ZDLESDIE**

Yes No Don't know Refused

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

Yes No Don't know Refused

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

Yes No Don't know Refused

ZDLINK





43. Have you changed your doctor or place that you usually go for health care or advice about your health care in the past 12 months?

① Yes
 ④ No
 ② I don't have a doctor or place that I usually go for health care
 ⑧ Don't know
 ⑦ Refused

ZDHCADV

Interviewer Note:

- ◆ If Year 3, go to Questions #43a and #43b.
- ◆ If Year 4-7, go to Question #44.



a. Where do you usually go for health care or advice about health care?

(Interviewer Note: Read response options. Please mark only one.)

ZDHCSRC

- ① Private doctor's office (individual or group practice)
- ② Public clinic such as a neighborhood health center
- ③ Health Maintenance Organization (HMO) *(Please specify: _____)*
(Examples: Security Blue, US Healthcare, Health America, The Apple Plan, Omnicare, Prucare)
- 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.

ZDDFNAME

First Name

ZDDLNAME

Last Name

ZDDSTRT

Street Address

ZDDCITY

City

State

-

Zip Code

ZDDZIP

ZDDSTATE

Telephone:

() -

Area Code

Number

ZDDPHONE





46.

You previously told us the name of someone who could provide information and answer questions for you in the event that you were unable to answer for yourself. Please tell me if the information I have is still correct.

(Interviewer Note: Refer participant's chart. Ideally, this contact should be a relative who lives with the participant. If Year 3, clearly record contact information for all participants, even if contact information has not changed from previous years. If Year 4-Year 7, record contact information only if it needs to be corrected and/or updated.)

a.

ZDCIFNAM

First Name

ZDCILNAM

Last Name

ZDCISTR

Street Address

ZDCIAPT

Apt/Room

ZDCICITY

City

State

-

ZDCIZIP

Zip Code

ZDCISTAT

Telephone:

() -

Area Code

Number

ZDCITELE

b. How is this person related to you?

- ① My husband or wife
- ② My son or daughter
- ③ My niece or nephew
- ④ My grandchild
- ⑤ My brother or sister
- ⑥ My mother or father
- ⑦ Friend/neighbor
- ⑧ Someone else *(Please say how related:)*

ZDCIREL

c. Is this person your next of kin?

- ① Yes
- ② No
- ③ Don't know
- ④ Refused

ZDCINOK

d. Have you given this person power of attorney?

- ① Yes
- ② No
- ③ Don't know
- ④ Refused

ZDCIPOA



★ 47. You previously told us 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 did not have to be local people. Please tell me if the information I have is still correct.

(Interviewer Note: Refer to participant's chart. If Year 3, clearly record contact information for all participants, even if contact information has not changed from previous years. If Year 4- Year 7, record contact information only if it needs to be corrected and/or updated. Ideally, these contacts should not live with the participant.)

Contact #1

a.

ZDC1FNAM

First Name

ZDC1LNAM

Last Name

ZDC1STRT

Street Address

ZDC1APT

Apt/Room

ZDC1CITY

City

State

ZDC1ZIP -

Zip Code

ZDC1STAT

Telephone:

() -

Area Code

Number

ZDC1PHON

b. How is this person related to you?

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

ZDC1REL

c. Is this person your next of kin? **ZDC1NOK**

① Yes

② No

③ Don't know

④ Refused

d. Have you given this person power of attorney? **ZDC1POA**

① Yes

② No

③ Don't know

④ Refused



47a.

Contact #2

a. **ZDC2FNAM**

First Name

ZDC2LNAM

Last Name

ZDC2STRT

Street Address

ZDC2APT

Apt/Room

ZDC2CITY

City

State

ZDC2ZIP -

Zip Code

ZDC2STAT

Telephone:

() -

Area Code

Number

ZDC2PHON

b. How is this person related to you?

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

ZDC2REL

c. Is this person your next of kin? **ZDC2NOK**

① Yes

② No

③ Don't know

⑦ Refused

d. Have you given this person power of attorney? **ZDC2POA**

① Yes

② No

③ Don't know

⑦ Refused



48. Has the participant previously identified their next of kin in Question #46, #47 or #47a?

① Yes ② No **ZDKNOK**



Who is your next of kin?

ZDKFNAME

First Name

ZDKLNAME

Last Name

ZDKSTRT

Street Address

ZDKAPT

Apt/Room

ZDKSTATE

ZDKCITY

City

State

-

Zip Code

ZDKZIP

Telephone:

() -

Area Code

Number

ZDKPHONE

How is this person related to you?

- ① My husband or wife ⑤ My brother or sister
- ② My son or daughter ⑥ My mother or father
- ③ My niece or nephew ⑦ Friend/neighbor
- ④ My grandchild ⑧ Someone else *(Please say how related:)*

ZDKREL _____



50. *Interviewer Note: Please answer the following question based on your judgement of the participant's responses to the Home Visit Interview.*

On the whole, how reliable do you think the participant's responses to the Home Visit Interview are?

- ① Very reliable
- ② Fairly reliable
- ③ Not very reliable
- ④ Don't know

ZDRELY

51. What is the primary reason an alternate type of contact was done for the Annual Clinic Visit? Please mark only one reason.

- ① Illness/health problem(s)
- ② Hearing difficulties
- ③ Cognitive difficulties
- ④ In nursing home/long-term care facility
- ⑤ Too busy; time and/or work conflict
- ⑥ Caregiving responsibilities
- ⑦ Physician's advice
- ⑧ Family member's advice
- ⑨ Clinic too far/travel time
- 10 Moved out of area
- 11 Travelling/on vacation
- 12 Personal problem(s)
- 13 Refused to give reason
- 14 Other (Please specify: _____)

ZDREASON

Thank you very much for answering these questions. I enjoyed talking with you. Please remember to call us if you are admitted to a hospital or nursing home for any reason so that we can better understand changes in your health. We would also like to hear from you if you move or if your mailing address changes. We will be calling you in about 6 months from now to find out how you've been doing.

Interviewer Note:
If participant reported having a cold or flu in the past 6 months that was bad enough to keep them in bed for all or most of the day AND they had a temperature of 100° or higher, complete Substudy Workbook.





| | | | |
|---|--|--|--|
| HABC Enrollment ID # H [] [] [] [] [] MAID/MIFIF | Acrostic [] [] [] [] [] MAACROS | Date Form Completed [] / [] / [] Month Day Year MIFDATE/MADATE | Staff ID # [] [] [] [] MASTAFF |
|---|--|--|--|

HOME VISIT MEDICATION INVENTORY FORM -- page a

Section A Medication Reception

Refer to *Data From Prior Visits Report*. Ask the participant if they have used each prescription and over-the-counter medication listed on *Data From Prior Visits Report* within the past 2 weeks. Record on the *Home Visit Medication Inventory Form* all prescription and over-the-counter medications (including pills, dermal patches, eye drops, creams, salves, and injections) used in the previous two weeks, even if already listed on the *Data From Prior Visits Report*. If possible, record the complete drug name exactly as written on the container label. Confirm strength, units, number used, etc.

We are interested in all the prescription and over-the-counter medications that you took during the past 2 weeks. We are also interested in drugs not usually prescribed by a doctor, such as supplements, vitamins, pain medications, laxatives or bowel medicines, cold and cough medications, antacids or stomach medicines, and ointments or salves.

Did the participant take any prescription or non-prescription medications in the past 2 weeks?

MAMEDS Yes No Don't know Refused

Section B Prescription Medication.

Copy the name of the prescription, 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 8 Circle Day, Week or Month | PRN? Check "X": Yes or No | Container Seen? Check "X": Yes or No |
|---|----------|-------|---|---------------------------------|--|
|---|----------|-------|---|---------------------------------|--|

| | | | | | | | | | | | |
|----|------------------------------------|------------------------------|-----------------------------|--|---|--|-------------------------|---------------------|--------------------|---------------------------|---|
| 1. | MIFNAME [] [] [] [] [] [] | MIF STREN [] [] [] [] | MIF UNIT [] [] [] [] | MIFDWM [] [] [] [] [] [] D W M | MIFPRN 1 <input type="checkbox"/> 0 <input type="checkbox"/> N | MIFSEEN 1 <input type="checkbox"/> 0 <input type="checkbox"/> N | Reason for use: MIFREAS | MIFMONTH [] [] | MIFYEAR [] [] | Formulation Code: MIFFORM | <input checked="" type="checkbox"/> Rx 1 <input type="checkbox"/> Non Rx 0 |
| 2. | [] [] [] [] [] [] | [] [] [] [] | [] [] [] [] | [] [] [] [] [] [] D W M | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N | Reason for use: _____ | [] [] / [] [] | [] [] / [] [] | Formulation Code: _____ | <input checked="" type="checkbox"/> Rx <input type="checkbox"/> Non Rx |
| 3. | MIFNAME [] [] [] [] [] [] | [] [] [] [] | [] [] [] [] | [] [] [] [] [] [] D W M | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N | Reason for use: _____ | [] [] / [] [] | [] [] / [] [] | Formulation Code: _____ | <input checked="" type="checkbox"/> Rx <input type="checkbox"/> Non Rx |
| 4. | [] [] [] [] [] [] | [] [] [] [] | [] [] [] [] | [] [] [] [] [] [] D W M | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N | Reason for use: _____ | [] [] / [] [] | [] [] / [] [] | Formulation Code: _____ | <input checked="" type="checkbox"/> Rx <input type="checkbox"/> Non Rx |
| 5. | [] [] [] [] [] [] | [] [] [] [] | [] [] [] [] | [] [] [] [] [] [] D W M | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N | Reason for use: _____ | [] [] / [] [] | [] [] / [] [] | Formulation Code: _____ | <input checked="" type="checkbox"/> Rx <input type="checkbox"/> Non Rx |

Health ABC HOME VISIT MEDICATION INVENTORY FORM--page b

SectionB 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

| | | | | | | |
|-----|-------------------------|-----------|----------|--------------------------|---|--|
| 6. | MIFNAME | MIF STREN | MIF UNIT | MIFDWM ___ D W M | 1 Y 0 N MIFPRN | 1 Y 0 N MIFSEEN |
| | Reason for use: MIFREAS | | | Date Started: Month Year | Formulation Code: MIFFORM 0 | Rx 1 MIFRX |
| 7. | | | | ___ D W M | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| | Reason for use: _____ | | | Date Started: Month Year | Formulation Code: _____ | <input checked="" type="checkbox"/> Rx <input type="checkbox"/> Non Rx |
| 8. | | | | ___ D W M | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| | Reason for use: _____ | | | Date Started: Month Year | Formulation Code: _____ | <input checked="" type="checkbox"/> Rx <input type="checkbox"/> Non Rx |
| 9. | | | | ___ D W M | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| | Reason for use: _____ | | | Date Started: Month Year | Formulation Code: _____ | <input checked="" type="checkbox"/> Rx <input type="checkbox"/> Non Rx |
| 10. | | | | ___ D W M | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| | Reason for use: _____ | | | Date Started: Month Year | Formulation Code: _____ | <input checked="" type="checkbox"/> Rx <input type="checkbox"/> Non Rx |
| 11. | | | | ___ D W M | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| | Reason for use: _____ | | | Date Started: Month Year | Formulation Code: _____ | <input checked="" type="checkbox"/> Rx <input type="checkbox"/> Non Rx |
| 12. | | | | ___ D W M | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| | Reason for use: _____ | | | Date Started: Month Year | Formulation Code: _____ | <input checked="" 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

Health ABC HOME VISIT MEDICATION INVENTORY FORM--page c

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="MIF UNIT"/> | <input type="text" value="MIEDWM"/> <small>D W M</small> | <input type="text" value="1 Y 0 N"/> <small>MIFPRN</small> | <input type="text" value="1 Y 0 N"/> <small>MIFSEEN</small> |
| Reason for use: <input type="text" value="MIFREAS"/> | | | Date Started: <input type="text"/> / <input type="text"/> / <input type="text"/> | Formulation Code: <input type="text" value="MIFFORM"/> | <input checked="" type="checkbox"/> Rx <input checked="" type="checkbox"/> Non Rx |
| 2. <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> <small>D W M</small> | <input type="text"/> <small>Y N</small> | <input type="text"/> <small>Y N</small> |
| 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 checked="" type="checkbox"/> Non Rx |
| 3. <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> <small>D W M</small> | <input type="text"/> <small>Y N</small> | <input type="text"/> <small>Y N</small> |
| 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 checked="" type="checkbox"/> Non Rx |
| 4. <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> <small>D W M</small> | <input type="text"/> <small>Y N</small> | <input type="text"/> <small>Y N</small> |
| 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 checked="" type="checkbox"/> Non Rx |
| 5. <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> <small>D W M</small> | <input type="text"/> <small>Y N</small> | <input type="text"/> <small>Y N</small> |
| 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 checked="" type="checkbox"/> Non Rx |
| 6. <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> <small>D W M</small> | <input type="text"/> <small>Y N</small> | <input type="text"/> <small>Y N</small> |
| 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 checked="" type="checkbox"/> Non Rx |
| 7. <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> <small>D W M</small> | <input type="text"/> <small>Y N</small> | <input type="text"/> <small>Y N</small> |
| 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 checked="" type="checkbox"/> Non Rx |

Health ABC HOME VISIT MEDICATION INVENTORY FORM--page d

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. | MIFNAME | MIF STREN | MIF UNIT | MIFDWM D W M | 1 Y 0 N | 1 Y 0 N |
| Reason for use: | MIFREAS | | | MIFMONTH / MIFYEAR Date Started: Month Year | MIFPRN Code: MIFFORM | MIFSEEN Rx 1 Non Rx X |
| 9. | | | | D W M | Y N | Y N |
| Reason for use: | | | | Date Started: Month Year | Formulation Code: | Rx Non Rx X |
| 10. | | | | D W M | Y N | Y N |
| Reason for use: | | | | Date Started: Month Year | Formulation Code: | Rx Non Rx X |
| 11. | | | | D W M | Y N | Y N |
| Reason for use: | | | | Date Started: Month Year | Formulation Code: | Rx Non Rx X |
| 12. | | | | D W M | Y N | Y N |
| Reason for use: | | | | Date Started: Month Year | Formulation Code: | Rx Non Rx X |
| 13. | | | | D W M | Y N | Y N |
| Reason for use: | | | | Date Started: Month Year | Formulation Code: | Rx Non Rx X |
| 14. | | | | D W M | Y N | Y N |
| Reason for use: | | | | Date Started: Month Year | Formulation Code: | Rx Non Rx X |

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 # H | Acrostic | Date Form Completed / / | Staff ID # |
| MAID/MIFIF | MAACROS | MIFDATE/MADATE Month Day Year | MASTAFF |

HOME VISIT 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. MIFNAME | MIF STREN | MIF UNIT | MIFDWM D W M | 1 Y 0 N MIFPRN | 1 Y 0 N MIFSEEN Rx 1 MIFRX |
| Reason for use: MIFREAS Date Started: MIFMONTH / MIFYEAR Formulation Code: MIFFORM | | | | | |
| 2S. | | | D W M | Y N | Y N |
| Reason for use: Date Started: Month / Year Formulation Code: Rx Non Rx | | | | | |
| 3S. | | | D W M | Y N | Y N |
| Reason for use: Date Started: Month / Year Formulation Code: Rx Non Rx | | | | | |
| 4S. | | | D W M | Y N | Y N |
| Reason for use: Date Started: Month / Year Formulation Code: Rx Non Rx | | | | | |
| 5S. | | | D W M | Y N | Y N |
| Reason for use: Date Started: Month / Year Formulation Code: Rx Non Rx | | | | | |
| 6S. | | | D W M | Y N | Y N |
| Reason for use: Date Started: Month / Year Formulation Code: Rx Non Rx | | | | | |
| 7S. | | | D W M | Y N | Y N |
| Reason for use: Date Started: Month / Year Formulation Code: Rx Non Rx | | | | | |

| | |
|---|---|
| HABC Enrollment ID # | Acrostic |
| 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"/> |

Z4ID

Z4ACROS

CORE HOME VISIT WORKBOOK

Year of annual contact: **3** Year 03 **6** Year 06
4 Year 04 **7** Year 07
5 Year 05 **8** Other *(Please specify)* _____

Z4TYPE

WEIGHT AND RADIAL PULSE

WEIGHT

lbs **Z4WTLBS**

Staff ID#

Z4STFID1

RADIAL PULSE

Staff ID#

Z4STFID2

Measurement 1 beats per 30 seconds **x 2 =** beats per minute

Z4PLSSM1 **Z4PULSE**

Measurement 2 beats per 30 seconds **x 2 =** **Z4PULSE2** beats per minute

Z4PLSMS2

Total (Measurement 1 + Measurement 2) **Z4PLSTOT**

÷ 2

= Average beats per minute

Z4PLSAV



| | | |
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Z4STFID3

CORE HOME VISIT WORKBOOK

BLOOD PRESSURE

① Cuff Size ④ Small ① Regular ② Large ③ Thigh **Z4OCUF**

② Arm Used ① Right ② Left → *Please explain why right arm was not used:*
(Examiner Note: Refer to Health ABC Data from Prior Visits Report.) **Z4ARMRL**

Pulse Obliteration Level

③ Palpated Systolic **Z4POPS** * Add +30 to Palpated Systolic to obtain Maximal Inflation Level.
 mmHg

Add 30*

④ Maximal Inflation Level (MIL) **Z4POMX** † If MIL is ≥ 300 mmHg, repeat the MIL. If MIL is still ≥ 300 mmHg, terminate blood pressure measurements.
 mmHg

⑤ Was blood pressure measurement terminated because MIL ≥ 300 mmHg after second reading?
 ① Yes ② No **Z4BPYN**

Sitting Blood Pressure Measurement #1

⑥ Systolic mmHg *Comments (required for missing or unusual values):*
Z4SYS

⑦ Diastolic mmHg **Z4DIA**

Sitting Blood Pressure Measurement #2

⑧ Systolic mmHg *Comments (required for missing or unusual values):*
Z4SY2

⑨ Diastolic mmHg **Z4DIA2**



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CORE HOME VISIT WORKBOOK GRIPSTRENGTH (Hand-Held Dynamometry)

Z4STFID4

Exclusion Criteria:

1 Has any pain or arthritis in your hands gotten worse recently? ① Yes ② No **Z4ARWRS**

Which hand? **Z4HANDRL**

① Right
② Left
③ Both right and left

Do not test right.

Do not test left.

Do not test either hand.

2 Have you had any surgery on your hands or wrists in the past three months? ① Yes ② No **Z4WRST1**

Which hand? **Z4WRTRL**

① Right
② Left
③ Both right and left

Do not test right.

Do not test left.

Do not test either hand.

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! Now, STOP."

Right ① Unable to test/exclusion **Z4NOTST**

Z4RTR1 kg ① Refused **Z4RF1** *(Examiner Note: Wait 15-20 seconds before second trial.)*

"Now, one more time. Squeeze as hard as you can. Ready. Squeeze! Squeeze! Squeeze! Now, STOP."

Z4RTR2 kg ① Refused **Z4RF2**

Repeat the procedure on the left side.

Script: "Now we'll test your left side. When I say squeeze, squeeze as hard as you can. Ready. Squeeze! Squeeze! Squeeze! Now, STOP."

Left ① Unable to test/exclusion **Z4LNTST**

Z4LTR1 kg ① Refused **Z4LRF1** *(Examiner Note: Wait 15-20 seconds before second trial.)*

"Now, one more time. Squeeze as hard as you can. Ready. Squeeze! Squeeze! Squeeze! Now, STOP."

Z4LTR2 kg ① Refused **Z4LRF2**



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CORE HOME VISIT WORKBOOK STANDING BALANCE

Z4STFID5

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."*

Z4STS

⑦ Participant refused → Go to Chair Stands.

⑨ Not attempted, unable
(Please comment: _____) → Go to Chair Stands.

① Unable to attain position or cannot hold for at least one second → STOP Semi-Tandem Stand.
Go to Chair Stands.

② Holds position between 1 and 29 seconds → **Z4STSTM**
seconds. Go to Tandem Stand.

③ Holds position for 30 seconds → Go to Tandem Stand.

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:

Z4TS1

⑦ Participant refused → Go to One-Leg Stand.

⑨ Not attempted, unable
(Please comment: _____) → Go to One-Leg Stand.

① Unable to attain position or cannot hold for at least one second → Go to Trial 2.

② Holds position between 1 and 29 seconds → **Z4TSTM**
seconds. Go to Trial 2.

③ Holds position for 30 seconds → Go to One-Leg Stand.

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CORE HOME VISIT WORKBOOK CHAIR STANDS

Z4STFID6

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!"

| | |
|--|--|
| <p>⑦ Participant refused Z4SCS</p> <p>⑨ Not attempted, unable (Please comment: _____)</p> <p>⑩ Unable to stand</p> <p>① Rises using arms</p> <p>② Stands without using arms</p> <p>③ No suitable chair</p> | <p>→ <input type="text" value="Go to 4-meter walk."/></p> <p>→ <input type="text" value="Go to Repeated Chair Stands."/></p> <p>→ <input type="text" value="Go to 4-meter walk."/></p> |
|--|--|

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.

| | | |
|--|---|---|
| <p>⑦ Participant refused</p> <p>⑨ Not attempted, unable (Please comment: _____)</p> <p>① Attempted, unable to complete 5 stands</p> <p>② Completes 5 stands</p> | <p>Z4RCS</p> <p>Z4COMP Number completed</p> <p>Z4SEC Seconds to complete</p> | <p>→ <input type="text"/></p> <p>→ <input type="text"/></p> <p>→ <input type="text"/></p> |
|--|---|---|

| | | |
|--|----------------------|--------------------|
| Unusual values? | <p>① Yes ⑩ No</p> | <p>Z4UN</p> |
| <p>Comments: <input style="width: 100%; height: 40px;" type="text"/></p> | | |



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CORE HOME VISIT WORKBOOK 4-METERWALK

Z4STFID7

Examiner Note: Measure out 4 meters for the walk. If a 4-meter space is not available, measure 3 meters.

1 Which walk was set up? **Z44MW**

- 1 4-meter
 2 3-meter
 0 None:
 No 3-meter space was available → Go to Ultrasound.

USUAL PACE WALK

2 Describe the 4-meter walk and demonstrate how to walk past the tape.

Script: "This is a three part walking test. The first and second parts test your usual walking speed. Please walk past the tape, then stop. Now, wait until I say 'Go'. For the first part of this test, I want you to walk at your usual walking pace. Any questions?"

3 To start the test, say,

Script: "Ready, Go."

4 Start timing with the first footfall over the start line (participant's foot touches the floor). Stop timing with the participant's first footfall over the finish line at 4-meters (or 3-meters). You will need to walk a few steps behind the participant. Start timing with the first footfall over the starting line (participant's foot touches the floor.)

Z44MWTM1

Time on stopwatch: .
Second Hundredths/Sec

Examiner Note: If greater than 30 seconds mark as "Attempted, but unable to complete." Do not record time. Explain in comment section.

- 7 Participant refused → Go to Ultrasound.
- 9 Not attempted, unable → Go to Ultrasound.

 (Please comment: _____)
- 1 Attempted, but unable to complete → Go to Ultrasound.

 (Please comment: _____)

Z44MW1

5 Reset the stopwatch and have the participant repeat the usual-pace walk.

Script: "For the next part of the test, I want you to walk again at your usual walking pace. When you walk past the tape please stop. Ready, Go."

Time on stopwatch: . **Z44MWTM2**
Second Hundredths/Sec

6 RAPID WALK

Reset the stopwatch and instruct the participant to walk as quickly as they can for the third portion of the test.

Script: "When I say go, I want you to walk as fast as you can. Ready, Go."

Time on stopwatch: . **Z44MWTM3**
Second Hundredths/Sec

Z44MW3

- 7 Participant refused → Go to Ultrasound.
- 9 Not attempted, unable → Go to Ultrasound.

 (Please comment: _____)
- 1 Attempted, but unable to complete → Go to Ultrasound.

 (Please comment: _____)

7 Was the participant using a walking aid, such as a cane or walker?

- 1 Yes
 0 No

Z4WLKAID

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KNEE CREPITUS

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Z4STFID8

Examiner Note: If participant has an artificial leg or total knee replacement, do not test for knee crepitus on that side. Crepitus is defined as palpable continuous noise or grinding sensation (series of small clicks, pops, or grinding similar to sandpaper scratching sensation). Place your palm over the participant's patella. Ask the participant to actively move their leg to a full extended position (zero degrees) twice, then rest a moment, then twice more.

1 Have you had a knee replacement in your right knee?

- Yes
 No
 Don't know

Refused **Z4KNREP**

Do not examine right knee.
Go to Question #3. Do not schedule for MRI exam.

2 Is there crepitus in the right knee?

- Absent on all trials **Z4AJCRPR**
 Present on just one trial
 Present on two or three trials
 Present all four trials
 Uncertain
 Unable to examine due to knee pain
 Unable to examine for other reason
 (e.g. artificial leg)

Consensus with 2nd examiner

- Absent on all trials **Z4RN2EX**
 Present on just one trial
 Present on two or three trials
 Present all four trials
 Uncertain
 Unable to examine due to knee pain
 Unable to examine for other reason

Z42EXID1
2nd examiner Staff ID#:

3 Have you had a knee replacement in your left knee?

- Yes
 No
 Don't know

Refused **Z4KNREPL**

Do not examine left knee. Do not schedule for MRI exam.

4 Is there crepitus in the left knee?

- Absent on all trials **Z4AJCRPL**
 Present on just one trial
 Present on two or three trials
 Present all four trials
 Uncertain
 Unable to examine due to knee pain
 Unable to examine for other reason
 (e.g. artificial leg)

Consensus with 2nd examiner

- Absent on all trials **Z4LN2EX**
 Present on just one trial
 Present on two or three trials
 Present all four trials
 Uncertain
 Unable to examine due to knee pain
 Unable to examine for other reason

Z42EXID2
2nd examiner Staff ID#:

Examiner Note: If the participant cannot fully extend their leg, assist them by holding the leg at the ankle and pumping through a full range of motion.

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ISOMETRIC STRENGTH (ISOMETRIC CHAIR) Z4STFD9

1 Have you ever had knee surgery on either leg where all or part of the joint was replaced? **Z4KNRP2**
 ① Yes ② No ③ Don't know ④ Refused

Which leg?

① Right leg ② Left leg ③ Both legs **Z4KRLB3**

Do NOT test right leg. Do NOT test left leg. Do NOT test either leg. Go to Question #10.

2 Has the participant ever had the isometric chair measurement? **Z4ISO**
 (Examiner Note: Refer to the Health ABC Data from Prior Visits Report.)
 ① Yes ② No

Which leg was tested during the most recent isometric chair measurement?
 (Examiner Note: Refer to the Health ABC Data from Prior Visits Report.) **Z4ISOLEG**

① Right leg ② Left leg

Test right leg unless contraindicated. Test left leg unless contraindicated.

Has the participant ever had the Kin-Com exam? **Z4KC**

① Yes ② No

Test right leg unless contraindicated.

Which leg was tested during the most recent Kin-Com exam? (Examiner Note: Refer to the Health ABC Data from Prior Visits Report.)

① Right leg ② Left leg

Test right leg unless contraindicated. Test left leg unless contraindicated.

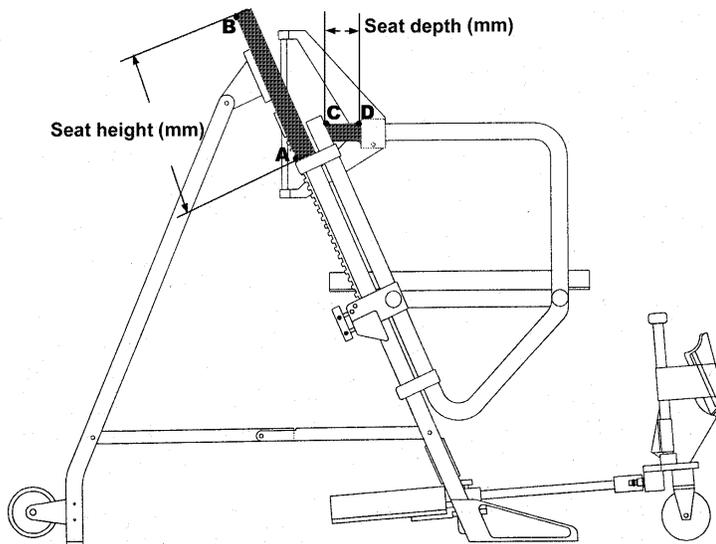
Z4KCLEG

3 What is the seat height?
 (Examiner Note: Record the seat height by measuring the distance between point "A" and "B" as noted below. Use a ruler marked in millimeters.)

mm **Z4SEATHT**

4 What is the seat depth?
 (Examiner Note: Record the seat depth by measuring the distance between point "C" and "D" as noted below. Use a ruler marked in millimeters. Be sure that the depth is exactly the same measurement on both sides of the chair.)

mm **Z4SEATDP**

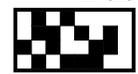


5 What is the length of the lower leg to be tested? meters **Z4LEG1**

6 Which leg was tested?
 ① Right leg ② Left leg ③ Test not performed **Z4RL4**
 ↓ ↓ ↓
 ↓ ↓ **Go to Question #10.**

| Trial | Maximum Torque (Nm) | Max Rate Torque (Nm/sec) | Reaction Time (msec) | Time to 50% MVTD (msec) | Did participant have knee pain? |
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| 1. | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Z4MT1A | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Z4MRT1A | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Z4RT1A | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Z4MVTD1A | ① Yes ② No Z4KP1A Test other leg. Go to Question #7. |
| 2. | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Z4MT2A | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Z4MRT2A | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Z4RT2A | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Z4MVTD2A | ① Yes ② No Z4KP2A Test other leg. Go to Question #7. |
| 3. | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Z4MT3A | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Z4MRT3A | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Z4RT3A | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Z4MVTD3A | Test complete. Go to Question #9. |

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Health ABC ISOMETRIC STRENGTH (ISOMETRIC CHAIR)

7 What is the length of the lower leg?
 (Examiner Note: Only test the other leg if three trials were not possible on the first leg.
 This should be the length of the other leg to be tested.)

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meters **Z4LEG2**

8 Which other leg is being tested?
 ① Right leg ② Left leg ③ Test not performed **Z4RL5**

Go to Question #10.

| Trial | Maximum Torque (Nm) | Max Rate Torque (Nm/sec) | Reaction Time (msec) | Time to 50% MVTD (msec) | Did participant have knee pain? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|-------|---|--------------------------|----------------------|-------------------------|---------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|
| 1. | <table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 20px;"></td><td style="width: 20px;"></td> </tr> </table> <p>Z4MT1B</p> | | | | | | | | | | | <table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 20px;"></td><td style="width: 20px;"></td> </tr> </table> <p>Z4MRT1B</p> | | | | | | | | | | | <table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td> </tr> </table> <p>Z4RT1B</p> | | | | | <table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td> </tr> </table> <p>Z4MVTD1B</p> | | | | | ① Yes ② No ↓ Z4KP1B STOP. Go to Question #9. |
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9 What size connecting rod was used?
 ① Small ② Medium ③ Large **Z4ROD**

10 Was the participant able to complete the isometric strength test?
 ① Yes ② No **Z4ISOTST**

Why not?
 (Examiner Note: Check all that apply.)

Not eligible: bilateral knee replacement **Z4KCBKR3**
 Knee pain **Z4KCPN3**
 Equipment problems **Z4KCEQ3**
 Participant refused **Z4KCREF3**
 Participant fatigue **Z4KCFAT3**
 Other (Please specify: **Z4KCOH3** _____)

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Z4STID10

**CORE HOME VISIT WORKBOOK
ULTRASOUND**

1 Have you broken any bone in your right leg, ankle, or foot in the past year?
(Examiner Note: Do not include isolated toe fractures.)

Z4BKFOOT

- Yes
 No
 Don't know
 Refused

Have you broken any bone in your left leg, ankle, or foot in the past year?
(Examiner Note: Do not include isolated toe fractures)

Z4BKLEFT

Yes
 No
 Don't know

Which side was most recently broken? **Z4BKSIDE**

Right
 Left
 Don't know

Scan left foot.
 Scan right foot.
 Go to question #2.

2 Have you ever broken your right heel bone? **Z4BKRHL**

- Yes
 No
 Don't know
 Refused

Scan left foot.

3 Do you have any permanent weakness in your legs, ankles or feet from an old injury or stroke? **Z4WKLEGS**

- Yes
 No
 Don't know
 Refused

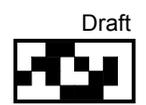
Which side is weaker? **Z4SIDEWK**

Right
 Left
 Right and left are equally weak

Scan left foot; unless contraindicated in question #1 and #2 above.
 Scan right foot; unless contraindicated in question #1 and #2 above.
 Scan right foot.

4 Sahara serial #:

Z4SERIAL



5 Which foot was scanned? **Z4BUSCAN**

① Right

② Left

③ Scan not attempted

④ Scan not completed

2
3

Why was the left foot scanned?

- Z4BULEFT**
- ① Fracture
 - ② Permanent weakness on right side
 - ③ Hardware
 - ④ Other
(Please specify: _____)

Why wasn't the scan attempted?

- Z4BUCOMP**
- ① Participant refused
 - ② Equipment problem
 - ③ Foot too big/edema/deformity
 - ④ Other
(Please specify: _____)

Why wasn't the scan completed?

- Z4BUNOSC**
- ① Out of range reading
 - ② Invalid measurement
 - ③ Other
(Please specify: _____)

6 Measurement #1:

QUI units **Z4BUQUI1**

BUA **Z4BUBUA1** units

SOS **Z4BUSOS1** m/s

Did BUA result have an asterisk?

- ① Yes ② No

Z4BUAST1

Measurement #2:

QUI units **Z4BUQUI2**

BUA **Z4BUBUA2** units

SOS **Z4BUSOS2** m/s

Did BUA result have an asterisk?

- ① Yes ② No

Z4BUAST2

7 What is the difference between BUA measurement #1 and BUA measurement #2?

units **Z4BUDIF1**

a. Was the difference between BUA measurement #1 and BUA measurement #2 \geq 10 units?

- ① Yes ② No **Z4BUDIF2**

Repeat scan and record results in section #8 below.

b. Did both BUA measurement #1 and BUA measurement #2 have an asterisk?

- ① Yes ② No **Z4BU2AST**

Repeat scan and record results in section #8 below.

8 QUI units **Z4BUQUI3**

BUA **Z4BUBUA3** units

SOS **Z4BUSOS3** m/s

Did BUA result have an asterisk?

- ① Yes ② No

Z4BUAST3

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CORE HOME VISIT WORKBOOK BONE DENSITY (DXA) SCAN

Z4STID11

1 Do you have breast implants?

① Yes ② No **Z4BI**

- ◆ Flag scan for review by DXA Reading Center.
- ◆ Indicate in the table below whether breast implant is in "Left ribs" or "Right ribs"

2 Do you have any metal objects in your body, such as a pacemaker, staples, screws, plates, etc.?

① Yes ② No **Z4MO**

- a. Flag scan for review by DXA Reading Center.
- b. Indicate in the table the location of joint replacement, hardware or other artifacts (sub regions are those defined by the whole body scan analysis.)

| Sub | Hardware | Other Artifacts | |
|----------------|----------|-----------------|---------------|
| Head | ① | ② | Z4HEAD |
| Left arm | ① | ② | Z4LA |
| Right arm | ① | ② | Z4RA |
| Left ribs | ① | ② | Z4LR |
| Right ribs | ① | ② | Z4RR |
| Thoracic spine | ① | ② | Z4TS |
| Lumbar spine | ① | ② | Z4LS |
| Pelvis | ① | ② | Z4PEL |
| Left leg | ① | ② | Z4LL |
| Right leg | ① | ② | Z4RL |

3 Have you had any of the following tests within the past ten days?

- | | Yes | No | |
|---|---------------------------|-------------------------|---------------|
| a. Barium enema | <input type="radio"/> 1 * | <input type="radio"/> 0 | Z4BE |
| b. Upper GI X-ray series | <input type="radio"/> 1 * | <input type="radio"/> 0 | Z4UGI |
| c. Lower GI X-ray series | <input type="radio"/> 1 * | <input type="radio"/> 0 | Z4LGI |
| d. Nuclear medicine scan | <input type="radio"/> 1 * | <input type="radio"/> 0 | Z4NUKE |
| e. Other tests using contrast ("dye") or radioactive materials | <input type="radio"/> 1 * | <input type="radio"/> 0 | Z4OTH2 |

(*Examiner Note: If yes to any, reschedule bone density measurement so that at least 10 days will have passed since the tests were performed.)

4 Was a bone density measurement obtained for...?

a. Whole Body **Z4WB**
 1 Yes 0 No

Last 2 characters of scan ID #: **Z4SCAN1**

Date of scan: / /

Month Day Year

Z4SCDTE1

b. Hip **Z4HIP**
 1 Yes 0 No

Last 2 characters of scan ID #: **Z4SCAN2**

Date of scan: / /

Month Day Year

Z4SCDTE2

| | | | |
|-----------------------|---------------------|--------------------------|-----------------|
| HABC Enrollment ID # | Acrostic | Date Form Completed | Staff ID # |
| H [] [] [] [] [] | [] [] [] [] [] | [] [] / [] [] / 2000 | [] [] [] [] |
| YAID | YAACROS | Month Day Year | YASTFID |

PROXY INTERVIEW

Month or Year of Contact:

- YAVISIT
- 3 Year 3 annual contact
 - 30 30-month semi-annual contact
 - 4 Year 4 annual contact
 - 42 42-month semi-annual contact
 - 5 Year 5 annual contact
 - 54 54-month semi-annual contact
 - 6 Year 6 annual contact
 - 66 66-month semi-annual contact
 - 7 Year 7 annual contact
 - 78 78-month semi-annual contact
 - 8 Other (Please specify) _____

Type of Contact:

- YACONTAC
- 1 Home (face-to-face interview)
 - 4 Clinic (face-to-face interview)
 - 5 Nursing home (face-to-face interview)
 - 2 Telephone interview
 - 3 Other (Please specify) _____
- YADATES

Date of last regularly scheduled contact:

[] [] / [] [] / [] [] [] []

Month Day Year



= Semi-annual telephone contact questions

Interviewer Note: Ask all questions for annual contact. Ask only questions during semi-annual telephone contact.



- 1.** What is your relationship to (name of Health ABC participant)?
- 1 Spouse or partner
 - 2 Child
 - 3 Family member (other than spouse or child) (Please specify: _____)
 - YAREL 4 Close friend
 - 5 Health care provider YARELOTH
 - 6 Other (Please specify: _____)
 - 7 Refused



- 2.** How often do you have contact with (him/her)?
(Interviewer Note: Please mark only one answer.)
- 1 Live together → Go to Question #4
 - 2 Daily (but does not live together)
 - YACONFRQ 3 3 or more times a week
 - 4 Less than 3 times a week
 - 8 Don't know
 - 7 Refused

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[] [] [] [] []

PROXY INTERVIEW

★ **3.** What is the most frequent type of contact?

- ① Mostly in person
- ② Mostly by phone
- ③ Both in person and by phone
- ④ Other *(Please specify: _____)*
- ⑧ Don't know
- ⑦ Refused

YACONTYP

★ **4.** Since we last spoke to *(name of Health ABC participant)* about 6 months ago, did *(he/she)* stay in bed all or most of the day because of an illness or injury? Please include days that *(he/she)* was a patient in a hospital.

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

★ About how many days did *(he/she)* stay in bed all or most of the day because of an illness or injury? Please include days that *(he/she)* was a patient in a hospital.
(Interviewer Note: If necessary, probe - "If you are unsure, please make your best guess.")

YABEDDAY days

★ **5.** Since we last spoke to *(name of Health ABC participant)* about 6 months ago, did *(he/she)* cut down on the things *(he/she)* usually did, such as going to work or working around the house, because of an illness or injury? Please include days in bed.

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

★ How many days did *(he/she)* cut down on the things *(he/she)* usually did because of illness or injury? Please include days in bed.
(Interviewer Note: If necessary, probe - "If you are unsure, please make your best guess.")

YACUTDAY days

★ **6.** Since we last spoke to *(name of Health ABC participant)* about 6 months ago, did *(he/she)* stay overnight as a patient in a nursing home or rehabilitation center?

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

★ **7.** Since we last spoke to *(name of Health ABC participant)* about 6 months ago, did *(he/she)* receive care at home from a visiting nurse, home health aide, or nurse's aide?

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



Now I'm going to ask you about some medical problems that (name of Health ABC participant) might have had in the past 12 months.

In the past 12 months, was (name of Health ABC participant) told by a doctor that (he/she) had...?

8. Hypertension or high blood pressure? We are specifically interested in hearing about hypertension or high blood pressure that was diagnosed for the first time in the past 12 months.

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

9. Diabetes or sugar diabetes? Again, we are specifically interested in hearing about diabetes that was diagnosed for the first time in the past 12 months.

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

10. In the past 12 months, has (name of Health ABC participant) fallen and landed on the floor or ground?

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

Please go to Question #11

How many times has (he/she) fallen in the past 12 months?
If you are unsure, please make your best guess.

- 1 One
- 2 Two or three
- YAAJFNUM 4 Four or five
- 6 Six or more
- 8 Don't know



Empty box for page link number

Now I'm going to ask about some medical problems (*name of Health ABC participant*) might have had since we last spoke to (*him/her*) about 6 months ago, which was on / /

Month / Day / Year

- ★ **11.** Since we last spoke to (*name of Health ABC participant*) about 6 months ago, was (*he/she*) told by a doctor that (*he/she*) had a heart attack, angina, or chest pain due to heart disease?
YAHCHAMI Yes No Don't know Refused

★ Was (*he/she*) hospitalized overnight for this problem?

YAHOSMI Yes

No

★ Complete a Health ABC Event Form, Section I, for each overnight hospitalization. Record reference #'s below:

- a. **YAREF11A**
 b. **YAREF11B**
 c. **YAREF11C**

Go to Question #12

- ★ **12.** Since we last spoke to (*name of Health ABC participant*) about 6 months ago, was (*he/she*) told by a doctor that (*he/she*) had a stroke, mini-stroke, or TIA?
YAHCCVA Yes No Don't know Refused

★ Was (*he/she*) hospitalized overnight for this problem?

YAHOSMI2 Yes

No

★ Complete a Health ABC Event Form, Section I, for each overnight hospitalization. Record reference #'s below:

- a. **YAREF12A**
 b. **YAREF12B**
 c. **YAREF12C**

Go to Question #13

- ★ **13.** Since we last spoke to (*name of Health ABC participant*) about 6 months ago, was (*he/she*) told by a doctor that (*he/she*) had congestive heart failure?

YACHF Yes

No

Don't know

Refused

★ Was (*he/she*) hospitalized overnight for this problem?

YAHOSMI3 Yes

No

★ Complete a Health ABC Event Form, Section I, for each overnight hospitalization. Record reference #'s below:

- a. **YAREF13A**
 b. **YAREF13B**
 c. **YAREF13C**

Go to Question #14



★ **14.** Since we last spoke to *(name of Health ABC participant)* about 6 months ago, was *(he/she)* told by a doctor that *(he/she)* had cancer? We are specifically interested in hearing about a cancer that was diagnosed for the first time since we last spoke to *(him/her)*.

YACHMGMT ① Yes ② No ③ Don't know ④ Refused

★ Complete a Health ABC Event Form, Section II, for each event.
Record reference #'s below:

a. YAREF14A

b. YAREF14B

c. YAREF14C

★ **15.** Since we last spoke to *(name of Health ABC participant)* about 6 months ago, was *(he/she)* told by a doctor that *(he/she)* had pneumonia?

YALCPNEU ① Yes ② No ③ Don't know ④ Refused

★ Complete a Health ABC Event Form, Section II, for each event.
Record reference #'s below:

a. YAREF15A

b. YAREF15B

c. YAREF15C

★ **16.** Since we last spoke to *(name of Health ABC participant)* about 6 months ago, was *(he/she)* told by a doctor that *(he/she)* broke or fractured a bone(s)?

YAOSBR45 ① Yes ② No ③ Don't know ④ Refused

★ Complete a Health ABC Event Form, Section II, for each event.
Record reference #'s below:

a. YAREF16A

b. YAREF16B

c. YAREF16C



★ **17.** Was (name of Health ABC participant) hospitalized overnight for any other reasons since we last spoke to (him/her) about 6 months ago?
YAHOSP ① Yes ② No ③ Don't know ④ Refused

★ **Complete a Health ABC Event Form, Section I, for each event. Record reference #'s and reason for hospitalization below.**

| | | |
|--|--|--|
| a. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YAREF17A | b. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YAREF17B | c. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YAREF17C |
| Reason for hospitalization: _____ | Reason for hospitalization: _____ | Reason for hospitalization: _____ |
| d. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YAREF17D | e. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YAREF17E | f. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YAREF17F |
| Reason for hospitalization: _____ | Reason for hospitalization: _____ | Reason for hospitalization: _____ |

★ **18.** Has (name of Health ABC participant) had any same day outpatient surgery since we last spoke to (him/her) about 6 months ago?
YAOUTPA ① Yes ② No ③ Don't know ④ Refused

Was it for...?

| | | | |
|--|--------------|---|--|
| ★ a. A procedure to open a blocked artery | ① Yes | → Complete a Health ABC Event Form, Section III. Record reference #: | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| | ② No | | YAREF18A |
| | ③ Don't know | | |
| ★ b. Gall bladder surgery | ① Yes | | |
| | ② No | | |
| | ③ Don't know | | |
| ★ c. Cataract surgery | ① Yes | | |
| | ② No | | |
| | ③ Don't know | | |
| ★ d. Hernia repair (Inguinal abdominal hernia.) | ① Yes | | |
| | ② No | | |
| | ③ Don't know | | |
| ★ e. TURP (MEN ONLY) (transurethral resection of prostate) | ① Yes | | |
| | ② No | | |
| | ③ Don't know | | |
| ★ f. Other | ① Yes | → | <div style="border: 1px solid black; padding: 5px;"> Please specify the type of outpatient surgery. i. _____ ii. _____ iii. _____ </div> |
| | ② No | | |
| | ③ Don't know | | |



19. Is there any other illness or condition for which (*name of Health ABC participant*) sees a doctor or other health care professional?

YAOTILL Yes No Don't know Refused

Please go to Question #20

Please describe for what:

20. Does (*name of Health ABC participant*) have any problems with (*his/her*) memory?

YAMEM Yes No Don't know Refused

Please go to Question #21

a. Did (*his/her*) trouble with memory begin suddenly or slowly?

Suddenly

YAMEMBEG Slowly

Don't know

b. Has the course of memory problems been a steady downhill progression, an abrupt decline, stayed the same, or gotten better?

Steady downhill progression

Abrupt decline

YAMEMPRG Stayed the same (no decline)

Gotten better

Don't know

c. Is a doctor aware of (*his/her*) memory problems?

YAMEMDR Yes No Don't know

What does the doctor believe is causing (*his/her*) memory problems?
(Interviewer Note: Please mark only one answer.)

Alzheimer's disease

Parkinson's disease

Confusion

Stroke

Delirium

Nothing wrong

YAMEMPRB

Dementia

Other (*Please specify*)

Depression

Don't know

Multiinfarct



★ **21.** Because of a health or physical problem, does (*name of Health ABC participant*) have any difficulty walking a quarter of a mile, that is about 2 or 3 blocks?
(Interviewer Note: If the proxy responds "Doesn't do," probe to determine whether this was because of a health or physical problem. If the participant doesn't walk because of a health or physical problem, mark "Yes." If the participant doesn't walk for other reasons, mark "Does not do.")

YADWQMYN ① Yes ② No ⑧ Don't know ⑦ Refused ⑨ Does not do

↓ ↓ ↓ ↓ ↓

Go to Question #22

★ How much difficulty does (*he/she*) have?
(Interviewer Note: Read response options.)

① A little difficulty
 ② Some difficulty
 YADWQMDF ③ A lot of difficulty
 ④ Or are they unable to do it?
 ⑧ Don't know

★ **22.** Because of a health or physical problem, does (*name of Health ABC participant*) have any difficulty walking up 10 steps, that is about 1 flight, without resting?
(Interviewer Note: If the proxy responds "Doesn't do," probe to determine whether this is because of a health or physical problem. If the participant doesn't walk up 10 steps because of a health or physical problem, mark "Yes." If the participant doesn't walk up steps for other reasons, such as there are simply no steps in the area, mark "Does not do.")

YADW10YN ① Yes ② No ⑧ Don't know ⑦ Refused ⑨ Does not do

↓ ↓ ↓ ↓ ↓

Go to Question #23

★ How much difficulty does (*he/she*) have?
(Interviewer Note: Read response options.)

① A little difficulty
 ② Some difficulty
 YADIF ③ A lot of difficulty
 ④ Or are they unable to do it?
 ⑧ Don't know



23. Does (name of Health ABC participant) have to use a cane, walker, crutches, or other special equipment to help (him/her) get around?

YAEQUIP ① Yes ① No ⑧ Don't know ⑦ Refused

24. Because of a health or physical problem, does (name of Health ABC participant) have any difficulty getting in and out of bed or chairs?

YADIOYN ① Yes ① No ⑧ Don't know ⑦ Refused

a. How much difficulty does (he/she) have?
(Interviewer Note: Read response options.)

① A little difficulty

② Some difficulty

YADIODIF ③ A lot of difficulty

④ Or are they unable to do it?

⑧ Don't know

b. Does (he/she) usually receive help from another person when (he/she) gets in and out of bed or chairs?

YADIORHY ① Yes ① No ⑧ Don't know

25. Does (name of Health ABC participant) have any difficulty bathing or showering?

YABATHYN ① Yes ① No ⑧ Don't know ⑦ Refused

a. How much difficulty does (he/she) have?
(Interviewer Note: Read response options.)

① A little difficulty

② Some difficulty

YABATHDF ③ A lot of difficulty

④ Or are they unable to do it?

⑧ Don't know

b. Does (he/she) usually receive help from another person in bathing or showering?

YABATHRH ① Yes ① No ⑧ Don't know

26. Does (name of Health ABC participant) have any difficulty dressing?

YADDYN ① Yes ① No ⑧ Don't know ⑦ Refused

a. How much difficulty does (he/she) have?
(Interviewer Note: Read response options.)

① A little difficulty
 ② Some difficulty
 YADDIF ③ A lot of difficulty
 ④ Or are they unable to do it?
 ⑧ Don't know

b. Does (he/she) usually receive help from another person in dressing?

YADDRHYN ① Yes ① No ⑧ Don't know

★ **27.** In general, would you say that (name of Health ABC participant's) appetite or desire to eat has been. . . ?

(Interviewer Note: Read response options.)

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

★ **28.** Since we last spoke to (name of Health ABC participant) about 6 months ago, has (his/her) weight changed by 5 or more pounds?

(Interviewer Note: We are interested in net gain or loss during the past 6 months. In other words, is the participant either 5 or more pounds heavier or lighter than they were 6 months ago?)

YACHN5LB ① Yes ① No ⑧ Don't know ⑦ Refused

★ a. Did (he/she) gain or lose weight?
(Interviewer Note: We are interested in net gain or loss during the past 6 months.)

YAGNLS ① Gain ② Lose ⑧ Don't know

★ b. How many pounds did (he/she) gain/lose in the past 6 months?
(Interviewer Note: If necessary, probe - "If you are unsure, please make your best guess.")

YAHOW6 pounds ⑧ Don't know YAHOW6DN



32. *Interviewer Note: Please answer the following question based on your judgment of the proxy's responses to the Proxy Interview.*

On the whole, how reliable do you think the proxy's responses to the Proxy Interview are?

- ① Very reliable
 - ② Fairly reliable
 - ③ Not very reliable
 - ④ Don't know
- YARELY**

33. What is the primary reason a proxy was contacted for the Semi-Annual Telephone Interview or Annual Contact? Please mark only one reason.

- ① Illness/health problem(s)
- ② Hearing difficulties
- ③ Cognitive difficulties
- ④ In nursing home/long-term care facility
- ⑤ Refused to give reason
- ⑥ Other (Please specify:)

YAPROXY

YAPROXOT

Thank you very much for answering these questions. Please remember to call us if (name of Health ABC participant) is admitted to a hospital or nursing home for any reason so that we can better understand changes in (his/her) health. We would also like to hear from you if (name of Health ABC participant) moves or if (his/her) mailing address changes. We will be calling you in about 6 months from now to find out how (name of Health ABC participant) has been doing.



| | | | |
|---------------------------|----------|---------------------------------|------------|
| HABC Enrollment ID # H | Acrostic | Date Form Completed / / 2000 | Staff ID # |
| YBID | YBACROS | Month Day Year | YBSTFID |

PROXY CONTACT HOME VISIT WORKBOOK

Year of Contact:

Year 3 annual contact Year 6 annual contact
YBVISIT Year 4 annual contact Year 7 annual contact
 Year 5 annual contact Other *(Please specify)* _____

PROXY CONTACT HOME VISIT PROCEDURE CHECKLIST

| Measurement | Page # | Yes: Measurement fully completed | Yes: Measurement partially completed | No: Participant/Proxy refused | No: Other reason/ Not Applicable |
|---|--------|----------------------------------|--------------------------------------|-------------------------------|----------------------------------|
| 1. Was the Proxy Interview completed? | | ① | ③ | ① | ② YBPROXY |
| 2. Medication inventory update | 2 | ① | ③ | ① | ② YBMI |
| 3. Weight | 7 | ① | ③ | ① | ② YBWT |
| 4. Radial pulse | 7 | ① | ③ | ① | ② YBRP |
| 5. Blood pressure | 8 | ① | ③ | ① | ② YBBP |
| 6. Grip strength | 9 | ① | ③ | ① | ② YBGRIP |
| 7. Chair stands | 11 | ① | ③ | ① | ② YBCS |
| 8. Standing balance | 12 | ① | ③ | ① | ② YBSB |
| 9. 4-meter walk | 14 | ① | ③ | ① | ② YB4MW |
| 10. Knee crepitus | 16 | ① | ③ | ① | ② YBKNEE |
| 11. Isometric strength (Isometric chair) | 17 | ① | ③ | ① | ② YBISO |
| 12. Ultrasound | 20 | ① | ③ | ① | ② YBULTRA |
| 13. Bone density (DXA) scan | 22 | ① | ③ | ① | ② YBDXA |
| 14. Was blood collected? | | ① | ③ | ① | ② YBBLOOD |
| 15. Was urine collected? | | ① | ③ | ① | ② YBURINE |
| 16. Was participant scheduled for an x-ray? | | ① | ③ | ① | ② YBXR |

YBLINK

Page Link #

Draft





| | | | |
|---|--|--|--|
| HABC Enrollment ID # H [] [] [] [] [] MAID/MIFIF | Acrostic [] [] [] [] [] MAACROS | Date Form Completed [] [] / [] [] / [] [] Month Day Year MIFDATE/MADATE | Staff ID # [] [] [] [] MASTAFF |
|---|--|--|--|

PROXY CONTACT HOME VISIT MEDICATION INVENTORY FORM -- Page A

Section A Medication Reception

Refer to *Data From Prior Visits Report*. Ask the proxy if the participant has used each prescription and over-the-counter medication listed on *Data From Prior Visits Report* within the past 2 weeks. Record on the *Proxy Contact Medication Inventory Form* all prescription and over-the-counter medications (including pills, dermal patches, eye drops, creams, salves, and injections) used in the previous two weeks, even if already listed on the *Data From Prior Visits Report*. If possible, record the complete drug name exactly as written on the container label. Confirm strength, units, number used, etc.

"We are interested in all the prescription and over-the-counter medications that (name of Health ABC participant) took during the past 2 weeks. We are also interested in drugs not usually prescribed by a doctor, such as supplements, vitamins, pain medications, laxatives or bowel medicines, cold and cough medications, antacids or stomach medicines, and ointments or salves."

Did the participant take any prescription or non-prescription medications in the past 2 weeks?

MAMEDS Yes No Don't know Refused

Section B Prescription Medication.

Copy the name of the prescription, the strength in milligrams (mg) or other units, and 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 & Circle Day, Week or Month | PRN? Check "X": Yes or No | Container Seen? Check "X": Yes or No |
|---|----------|----------|--|--|--|
| 1. MIFNAME Reason for use: MIFREAS | MIF STRE | MIF UNIT | MIFDWM D W M MIFMONTH MIFYEAR | <input checked="" type="checkbox"/> Y <input checked="" type="checkbox"/> N Formulation Code: MIFFORM | <input checked="" type="checkbox"/> Y <input checked="" type="checkbox"/> N Formulation Code: MIFSEEN |
| 2. MIFNAME Reason for use: | | | D W M | <input type="checkbox"/> Y <input type="checkbox"/> N Formulation Code: | <input checked="" type="checkbox"/> Y <input type="checkbox"/> N Formulation Code: |
| 3. Reason for use: | | | D W M | <input type="checkbox"/> Y <input type="checkbox"/> N Formulation Code: | <input checked="" type="checkbox"/> Y <input type="checkbox"/> N Formulation Code: |
| 4. Reason for use: | | | D W M | <input type="checkbox"/> Y <input type="checkbox"/> N Formulation Code: | <input checked="" type="checkbox"/> Y <input type="checkbox"/> N Formulation Code: |
| 5. Reason for use: | | | D W M | <input type="checkbox"/> Y <input type="checkbox"/> N Formulation Code: | <input checked="" type="checkbox"/> Y <input type="checkbox"/> N Formulation Code: |

**PROXY CONTACT HOME VISIT
MEDICATION INVENTORY FORM -- Page B**

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 |
| | | | | MIFPRN | MIFSEEN |

| | | | | | |
|------------|-------------|-------------|-----------------|---------|---------|
| 6. MIFNAME | MIF STRE | MIF UNIT | MIFDWM D W M | 1 Y 0 N | 1 Y 0 N |
|------------|-------------|-------------|-----------------|---------|---------|

Reason for use: MIFREAS Date Started: / / Formulation Code: Rx Non Rx

| | | | | | |
|--|---|---|-------|-----|-----|
| 7. <input style="width:100%" type="text"/> | <input style="width:100%" type="text"/> | <input style="width:100%" type="text"/> | D W M | Y N | Y N |
|--|---|---|-------|-----|-----|

Reason for use: _____ Date Started: _____ / _____ / _____ Formulation Code: _____ Rx Non Rx

| | | | | | |
|--|---|---|-------|-----|-----|
| 8. <input style="width:100%" type="text"/> | <input style="width:100%" type="text"/> | <input style="width:100%" type="text"/> | D W M | Y N | Y N |
|--|---|---|-------|-----|-----|

Reason for use: _____ Date Started: _____ / _____ / _____ Formulation Code: _____ Rx Non Rx

| | | | | | |
|--|---|---|-------|-----|-----|
| 9. <input style="width:100%" type="text"/> | <input style="width:100%" type="text"/> | <input style="width:100%" type="text"/> | D W M | Y N | Y N |
|--|---|---|-------|-----|-----|

Reason for use: _____ Date Started: _____ / _____ / _____ Formulation Code: _____ Rx Non Rx

| | | | | | |
|---|---|---|-------|-----|-----|
| 10. <input style="width:100%" type="text"/> | <input style="width:100%" type="text"/> | <input style="width:100%" type="text"/> | D W M | Y N | Y N |
|---|---|---|-------|-----|-----|

Reason for use: _____ Date Started: _____ / _____ / _____ Formulation Code: _____ Rx Non Rx

| | | | | | |
|---|---|---|-------|-----|-----|
| 11. <input style="width:100%" type="text"/> | <input style="width:100%" type="text"/> | <input style="width:100%" type="text"/> | D W M | Y N | Y N |
|---|---|---|-------|-----|-----|

Reason for use: _____ Date Started: _____ / _____ / _____ Formulation Code: _____ Rx Non Rx

| | | | | | |
|---|---|---|-------|-----|-----|
| 12. <input style="width:100%" type="text"/> | <input style="width:100%" type="text"/> | <input style="width:100%" type="text"/> | D W M | Y N | Y N |
|---|---|---|-------|-----|-----|

Reason for use: _____ Date Started: _____ / _____ / _____ 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=injectable, 11=transdermal patch, 12=powder, 99=other

**PROXY CONTACT HOME VISIT
MEDICATION INVENTORY FORM -- Page C**

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, and 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 |
|---|-----------------------------|----------|---|--|--|
| MIFNAME | MIF STRE | MIF UNIT | MIFDWM ___ D W M | MIFPRN 1 Y 0 N | MIFSEEN 1 Y 0 N |
| 1. _____ | _____ | _____ | ___ D W M | <input checked="" type="checkbox"/> Y <input type="checkbox"/> N | <input checked="" type="checkbox"/> Y <input type="checkbox"/> N |
| Reason for use: _____ | Date Started: _____ / _____ | | Formulation Code: _____ | <input checked="" type="checkbox"/> Rx | <input checked="" type="checkbox"/> Non Rx |
| 2. _____ | _____ | _____ | ___ D W M | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Reason for use: _____ | Date Started: _____ / _____ | | Formulation Code: _____ | <input type="checkbox"/> Rx | <input checked="" type="checkbox"/> Non Rx |
| 3. _____ | _____ | _____ | ___ D W M | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Reason for use: _____ | Date Started: _____ / _____ | | Formulation Code: _____ | <input type="checkbox"/> Rx | <input checked="" type="checkbox"/> Non Rx |
| 4. _____ | _____ | _____ | ___ D W M | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Reason for use: _____ | Date Started: _____ / _____ | | Formulation Code: _____ | <input type="checkbox"/> Rx | <input checked="" type="checkbox"/> Non Rx |
| 5. _____ | _____ | _____ | ___ D W M | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Reason for use: _____ | Date Started: _____ / _____ | | Formulation Code: _____ | <input type="checkbox"/> Rx | <input checked="" type="checkbox"/> Non Rx |
| 6. _____ | _____ | _____ | ___ D W M | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Reason for use: _____ | Date Started: _____ / _____ | | Formulation Code: _____ | <input type="checkbox"/> Rx | <input checked="" type="checkbox"/> Non Rx |
| 7. _____ | _____ | _____ | ___ D W M | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Reason for use: _____ | Date Started: _____ / _____ | | Formulation Code: _____ | <input type="checkbox"/> Rx | <input checked="" type="checkbox"/> Non Rx |

**PROXY CONTACT HOME VISIT
MEDICATION INVENTORY FORM -- Page D**

Section C Over-the-counter Medications and Supplements -- Continued

Medication Name (Generic Name or Trade Name) Strength Units Indicate Number Used PRN? Container Seen?

Circle Check "X": Check "X":
Day, Week or Month Yes or No Yes or No
MIFPRN **MIFSEEN**

| | | | | | |
|---|-------------|-------------|-------------------------------|---|---|
| 8. MIFNAME _____ Reason for use: MIFREAS _____ | MIF STRE | MIF UNIT | MIFDWM ___ D W M | 1 Y 0 N | 1 Y 0 N |
| Date Started: _____ / _____ / _____ Formulation Code: _____ | | | MIFMONTH MIFYEAR ___ / ___ | 1 Rx <input checked="" type="checkbox"/> Non Rx | MIFFORM MIFRX _____ |
| 9. _____ Reason for use: _____ | _____ | _____ | ___ D W M | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Date Started: _____ / _____ / _____ Formulation Code: _____ | | | _____ / _____ | <input type="checkbox"/> Rx <input checked="" type="checkbox"/> Non Rx | _____ |
| 10. _____ Reason for use: _____ | _____ | _____ | ___ D W M | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Date Started: _____ / _____ / _____ Formulation Code: _____ | | | _____ / _____ | <input type="checkbox"/> Rx <input checked="" type="checkbox"/> Non Rx | _____ |
| 11. _____ Reason for use: _____ | _____ | _____ | ___ D W M | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Date Started: _____ / _____ / _____ Formulation Code: _____ | | | _____ / _____ | <input type="checkbox"/> Rx <input checked="" type="checkbox"/> Non Rx | _____ |
| 12. _____ Reason for use: _____ | _____ | _____ | ___ D W M | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Date Started: _____ / _____ / _____ Formulation Code: _____ | | | _____ / _____ | <input type="checkbox"/> Rx <input checked="" type="checkbox"/> Non Rx | _____ |
| 13. _____ Reason for use: _____ | _____ | _____ | ___ D W M | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Date Started: _____ / _____ / _____ Formulation Code: _____ | | | _____ / _____ | <input type="checkbox"/> Rx <input checked="" type="checkbox"/> Non Rx | _____ |
| 14. _____ Reason for use: _____ | _____ | _____ | ___ D W M | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Date Started: _____ / _____ / _____ Formulation Code: _____ | | | _____ / _____ | <input type="checkbox"/> Rx <input checked="" 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



| | | | |
|---|--|--|--------------------------------------|
| HABC Enrollment ID # H [] [] [] [] [] MAID/MIFIF | Acrostic [] [] [] [] [] MAACROS | Date Form Completed [] [] / [] [] / [] [] Month Date Year MIFDATE/MAIDATE | Staff ID # [] [] [] MASTAFF |
|---|--|--|--------------------------------------|

PROXY CONTACT HOME VISIT

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. 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**

1S. Y N Y N

Reason for use: Date Started: / Formulation Code: Rx Non Rx

2S. Y N Y N

Reason for use: Date Started: / Formulation Code: Rx Non Rx

3S. Y N Y N

Reason for use: Date Started: / Formulation Code: Rx Non Rx

4S. Y N Y N

Reason for use: Date Started: / Formulation Code: Rx Non Rx

5S. Y N Y N

Reason for use: Date Started: / Formulation Code: Rx Non Rx

6S. Y N Y N

Reason for use: Date Started: / Formulation Code: Rx Non Rx

7S. Y N Y N

Reason for use: Date Started: / Formulation Code: Rx Non Rx

| | |
|--|---|
| HABC Enrollment ID # | Acrostic |
| 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"/> |
| YCID | YCACROS |

PROXY CONTACT HOME VISIT WORKBOOK

Year of annual contact: ③ Year 03 ⑥ Year 06
 ④ Year 04 ⑦ Year 07 YCVISIT
 ⑤ Year 05 ⑧ Other (Please specify:)

WEIGHT AND RADIAL PULSE

WEIGHT

YCWT . ① lbs ② kg YCLBSKG YCSTFID1 Staff ID#

RADIAL PULSE

YCSTFID2 Staff ID#

Measurement 1 **YCPLSSM**
 1 beats per 30 seconds

Measurement 2 **YCPLSMS2**
 beats per 30 seconds

YCLINK

Page Link #



| | | |
|---|---|--|
| HABC Enrollment ID # | Acrostic | 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"/> |

YCSTFID3

PROXY CONTACT HOME VISIT WORKBOOK BLOOD PRESSURE

① Cuff Size YCOCUF ④ Small ① Regular ② Large ③ Thigh

② Arm Used YCARMRL ① Right ② Left →
(Examiner Note: Refer to Data from Prior Visits Report.)

Please explain why right arm was not used:

Pulse Obliteration Level YCPOPS

③ Palpated Systolic mmHg

* Add +30 to Palpated Systolic to obtain Maximal Inflation Level.

Add 30*

④ Maximal Inflation Level (MIL) † mmHg

YCPOMX

† 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 MIL was ≥ 300 mmHg after second reading?
YCBPYN ① Yes ② No

Sitting Blood Pressure Measurement #1

⑥ Systolic YCSYS mmHg

⑦ Diastolic YCDIA mmHg

Comments (required for missing or unusual values):

Sitting Blood Pressure Measurement #2

⑧ Systolic YCSY2 mmHg

⑨ Diastolic YCDIA2 mmHg

Comments (required for missing or unusual values):



PROXY CONTACT HOME VISIT WORKBOOK YCSTFID4
GRIP STRENGTH (Hand-Held Dynamometry)

Exclusion Criterion:

1 Have you had any surgery on your hands or wrists in the past three months?

YCWRST1 **1** Yes **0** No **8** Don't know/ Didn't understand **7** Refused

Which hand?

1 Right → Do NOT test right.

2 Left → Do NOT test left.

YCWRTRL **3** Both right & left → Do NOT test either hand. Go to Questions #4 and #5 and mark "Unable to test/exclusion."

8 Don't know/ Didn't understand

2 Has any pain or arthritis in your right hand gotten worse recently?

YCARWRSR **1** Yes **0** No **8** Don't know/ Didn't understand **7** Refused

Will the pain keep you from squeezing as hard as you can?

YCPSQ1 **1** Yes **0** No **8** Don't know/ Didn't understand

3 Has any pain or arthritis in your left hand gotten worse recently?

YCARWRSL **1** Yes **0** No **8** Don't know/ Didn't understand **7** Refused

Will the pain keep you from squeezing as hard as you can?

YCPSQ2 **1** Yes **0** No **8** Don't know/ Didn't understand

PROXY CONTACT HOME VISIT WORKBOOK

GRIP STRENGTH (Hand-Held Dynamometry)

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. Please slowly squeeze the bars as hard as you can."

Examiner Note: *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?"

Examiner Note: *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! Now, STOP."

4 Right Hand ① Unable to test/exclusion/didn't understand

YCNÖTST

Trial 1

| | |
|--|--|
| | |
|--|--|

 kg ⑦ Refused ⑨ Unable to complete

YCRTR1

YCRRUC1

Examiner Note: *Wait 15-20 seconds before second trial.*

"Now, one more time. Squeeze as hard as you can. Ready. Squeeze! Squeeze! Squeeze! Now, STOP."

Trial 2

| | |
|--|--|
| | |
|--|--|

 kg ⑦ Refused ⑨ Unable to complete **YCRRUC2**

YCRTR2

Repeat the procedure on the left side.

5 Left Hand ① Unable to test/exclusion /didn't understand

YCLNTST

Trial 1

| | |
|--|--|
| | |
|--|--|

 kg ⑦ Refused ⑨ Unable to complete **YCLRUC1**

YCLTR1

Examiner Note: *Wait 15-20 seconds before second trial.*

"Now, one more time. Squeeze as hard as you can. Ready. Squeeze! Squeeze! Squeeze! Now, STOP."

Trial 2

| | |
|--|--|
| | |
|--|--|

 kg ⑦ Refused ⑨ Unable to complete **YCLRUC2**

YCLTR2

PROXY CONTACT HOME VISIT WORKBOOK YCSTFID5

CHAIR STANDS

SINGLE CHAIR STAND

Describe: "This is a test of strength in your legs in which you stand up 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!"

YCSCS

- | | | |
|---|---|------------------------------|
| ③ No suitable chair | → | Go to Standing Balance. |
| ⑦ Participant refused/didn't understand | → | Go to Standing Balance. |
| ⑨ Not attempted, unable | → | Go to Standing Balance. |
| ⑩ Attempted, unable to stand | → | Go to Standing Balance. |
| ① Rises using arms | → | Go to Standing Balance. |
| ② Stands without using arms | → | Go to Repeated Chair Stands. |

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 you say "Go." Count: "1, 2, 3, 4, 5" as the participant sits down each time.*

- | | | |
|---|---|--|
| ⑦ Participant refused/didn't understand | → | YCRCS |
| ⑨ Not attempted, unable | | |
| ① Attempted, unable to complete 5 stands without using arms | → | <div style="display: inline-block; border: 1px solid black; width: 30px; height: 30px; text-align: center; vertical-align: middle;">YCCOMP</div> Number completed without using arms |
| ② Completes 5 stands without using arms | → | <div style="display: inline-block; border: 1px solid black; width: 30px; height: 30px; text-align: center; vertical-align: middle;">YCSEC</div> Seconds to complete |



PROXY CONTACT HOME VISIT WORKBOOK

STANDING BALANCE

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

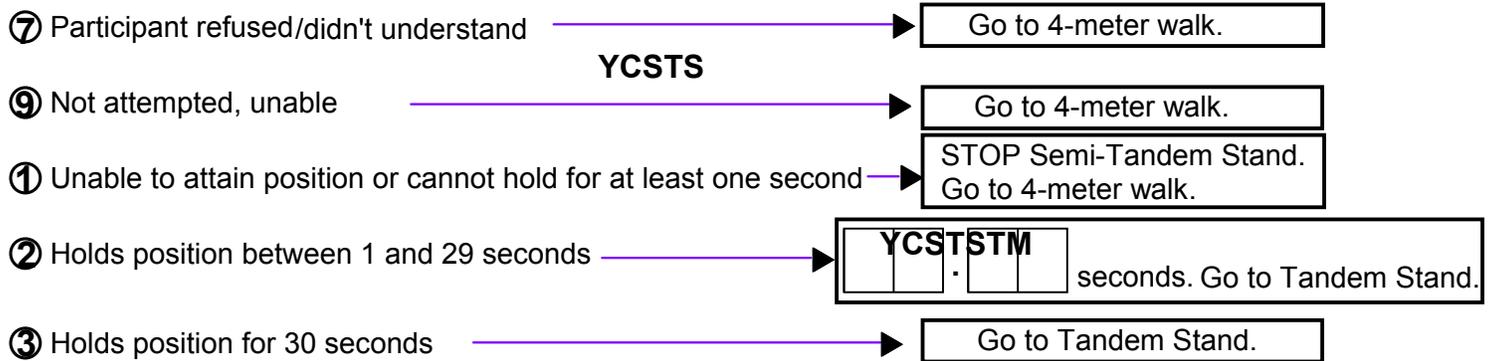
Describe: "First I would like you to try to stand with the side of the heel of one foot touching the big toe of the other foot for about 30 seconds. Please watch while I demonstrate."

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.



TANDEM STAND

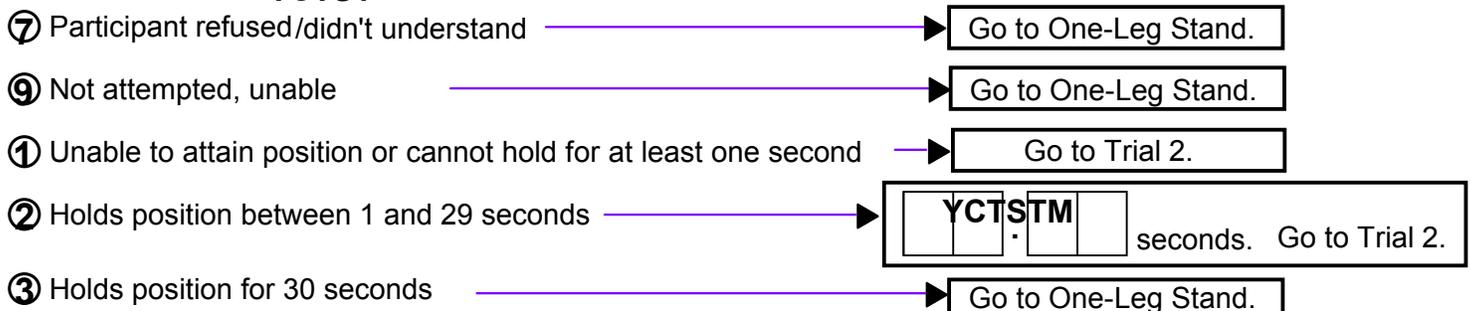
Describe: "Now I would like you to try to stand with the heel of one foot in front of and touching the toes of the other foot. I'll demonstrate."

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: **YCTS1**



TANDEM STAND

Perform a second trial: "Now, let's do the same thing one more time."

Trial 2:

| | | | | | | | | |
|--------------|----|--|---|---|-------|----|--|--|
| YCTS2 | ⑦ | Participant refused/didn't understand | → | Go to One-Leg Stand. | | | | |
| | ⑨ | Not attempted, unable | → | Go to One-Leg Stand. | | | | |
| | ① | Unable to attain position or cannot hold for at least one second | → | Go to One-Leg Stand. | | | | |
| | ② | Holds position between 1 and 29 seconds | → | <table border="1" style="display: inline-table; text-align: center; width: 100px;"> <tr> <td style="width: 20px;">YCTS2</td> <td style="width: 20px;">TM</td> </tr> <tr> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> </tr> </table> seconds. Go to One-Leg Stand. | YCTS2 | TM | | |
| YCTS2 | TM | | | | | | | |
| | | | | | | | | |
| | ③ | Holds position for 30 seconds | → | Go to One-Leg Stand. | | | | |

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:

| | | | | | | | | |
|--------------|----|--|---|---|-------|----|--|--|
| YCTR1 | ⑦ | Participant refused/didn't understand | → | Go to 4-meter walk. | | | | |
| | ⑨ | Not attempted, unable | → | Go to 4-meter walk. | | | | |
| | ① | Unable to attain position or cannot hold for at least one second | → | Go to Trial 2. | | | | |
| | ② | Holds position between 1 and 29 seconds | → | <table border="1" style="display: inline-table; text-align: center; width: 100px;"> <tr> <td style="width: 20px;">YCTR1</td> <td style="width: 20px;">TM</td> </tr> <tr> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> </tr> </table> seconds. Go to Trial 2. | YCTR1 | TM | | |
| YCTR1 | TM | | | | | | | |
| | | | | | | | | |
| | ③ | Holds position for 30 seconds | → | Go to 4-meter walk. | | | | |

Perform a second trial: "Now, let's do the same thing one more time."

Trial 2:

| | | | | | | | | |
|--------------|----|--|---|--|-------|----|--|--|
| YCTR2 | ⑦ | Participant refused/didn't understand | → | Go to 4-meter walk. | | | | |
| | ⑨ | Not attempted, unable | → | Go to 4-meter walk. | | | | |
| | ① | Unable to attain position or cannot hold for at least one second | → | Go to 4-meter walk. | | | | |
| | ② | Holds position between 1 and 29 seconds | → | <table border="1" style="display: inline-table; text-align: center; width: 100px;"> <tr> <td style="width: 20px;">YCTR2</td> <td style="width: 20px;">TM</td> </tr> <tr> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> </tr> </table> seconds. Go to 4-meter walk. | YCTR2 | TM | | |
| YCTR2 | TM | | | | | | | |
| | | | | | | | | |
| | ③ | Holds position for 30 seconds | → | Go to 4-meter walk. | | | | |

Draft



| | | |
|--|--|--|
| HABC Enrollment ID # | Acrostic | 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"/> |

**PROXY CONTACT HOME VISIT WORKBOOK YCSTFID8
KNEE CREPITUS**

Examiner Note: If participant has an artificial leg or total knee replacement, do not test for knee crepitus on that side. Crepitus is defined as palpable continuous noise or grinding sensation (series of small clicks, pops, or grinding similar to sandpaper scratching sensation). Place your palm over the participant's patella. Ask the participant to actively move their leg to a full extended position (zero degrees) twice, then rest a moment, then twice more.

- 1** Have you had a knee replacement in your right knee?
YCKNREPR ① Yes ② No ③ Don't know/ Didn't understand ④ Refused

Do NOT examine right knee.
Go to Question #3.

- 2** Is there crepitus in the right knee?
 ① Absent on all trials
 ② Present on just one trial
 ③ Present on two or three trials
YCAJCRPR ④ Present all four trials
 ⑤ Uncertain
 ⑥ Unable to examine due to knee pain
 ⑦ Unable to examine for other reason (e.g. artificial leg)

Consensus with 2nd examiner
 ① Absent on all trials
 ② Present on just one trial
 ③ Present on two or three trials
YCRN2EX ④ Present all four trials
 ⑤ Uncertain
 ⑥ Unable to examine due to knee pain
 ⑦ Unable to examine for other reason
 2nd examiner Staff ID#: **YC2EXID1**

- 3** Have you had a knee replacement in your left knee?
 ① Yes ② No ③ Don't know/ Didn't understand ④ Refused **YCKNREPL**

Do NOT examine left knee.

- 4** Is there crepitus in the left knee?
 ① Absent on all trials
 ② Present on just one trial
 ③ Present on two or three trials
YCAJCRPL ④ Present all four trials
 ⑤ Uncertain
 ⑥ Unable to examine due to knee pain
 ⑦ Unable to examine for other reason (e.g. artificial leg)

Consensus with 2nd examiner
 ① Absent on all trials
 ② Present on just one trial
 ③ Present on two or three trials
YCLN2EX ④ Present all four trials
 ⑤ Uncertain
 ⑥ Unable to examine due to knee pain
 ⑦ Unable to examine for other reason
 2nd examiner Staff ID#: **YC2EXID2**

Examiner Note: If the participant cannot fully extend their leg, assist them by holding the leg at the ankle and pumping through a full range of motion.

Draft



| | | |
|---|---|--|
| HABC Enrollment ID # | Acrostic | Staff ID # |
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YCSTFID9

PROXY CONTACT HOME VISIT WORKBOOK ISOMETRIC STRENGTH (ISOMETRIC CHAIR)

1 Have you ever had knee surgery on either leg where all or part of the joint was replaced?
YCKNRP2 ① Yes ② No ③ Don't know/ Didn't understand ④ Refused

Which leg?
YCKRLB3 ① Right leg ② Left leg ③ Both legs

| | | |
|------------------------|-----------------------|---|
| Do NOT test right leg. | Do NOT test left leg. | Do NOT test either leg. Go to Question #10. |
|------------------------|-----------------------|---|

2 Has the participant ever had the isometric chair measurement?
(Examiner Note: Refer to the Data from Prior Visits Report.)

YCISO ① Yes ② No

Which leg was tested during the most recent isometric chair measurement?
(Examiner Note: Refer to the Data from Prior Visits Report.)

YCISOLEG ① Right leg ② Left leg

| | |
|---|--|
| Test <u>right</u> leg unless contraindicated. | Test <u>left</u> leg unless contraindicated. |
|---|--|

Has the participant ever had the Kin-Com exam?
YCKC ① Yes ② No

Test right leg unless contraindicated.

Which leg was tested during the most recent Kin-Com exam?
(Examiner Note: Refer to the Data from Prior Visits Report.)

YCKCLEG ① Right leg ② Left leg

| | |
|---|--|
| Test <u>right</u> leg unless contraindicated. | Test <u>left</u> leg unless contraindicated. |
|---|--|



- 3** What is the seat height?
(Examiner Note: Record the seat height by measuring the distance between point "A" and "B" as noted below. Use a ruler marked in millimeters.)

YCSEATHT

| | | | |
|--|--|--|--|
| | | | |
|--|--|--|--|

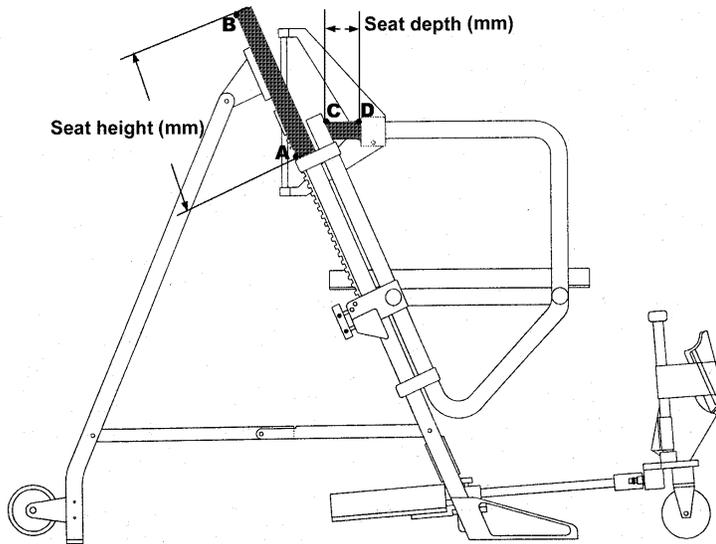
 mm

- 4** What is the seat depth?
(Examiner Note: Record the seat depth by measuring the distance between point "C" and "D" as noted below. Use a ruler marked in millimeters. Be sure that the depth is exactly the same measurement on both sides of the chair.)

YCSEATDP

| | | | |
|--|--|--|--|
| | | | |
|--|--|--|--|

 mm



- 5** What is the length of the lower leg to be tested? YCLEG1

| | | | |
|--|--|--|--|
| | | | |
|--|--|--|--|

 meters

- 6** Which leg was tested?
 YCRL4 **1** Right leg **2** Left leg **3** Test not performed

Go to Question #10.

| Trial | Maximum Torque (Nm) | Max Rate Torque (Nm/sec) | Reaction Time (msec) | Time to 50% MVTD (msec) | Did participant have knee pain? | | | | | | | | | | | | | | | | | | |
|-----------|--|--------------------------|----------------------|-------------------------|---------------------------------|--|---|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|
| 1. | <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> </tr> </table> YCMT1A | | | | | | <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> </tr> </table> YCMRT1A | | | | | | <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> </tr> </table> YCRT1A | | | | | <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> </tr> </table> YCMVTD1A | | | | | YCKP1A 1 Yes 2 No ↓ Test other leg. Go to Question #7. |
| | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | |
| 2. | <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> </tr> </table> YCMT2A | | | | | | <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> </tr> </table> YCMRT2A | | | | | | <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> </tr> </table> YCRT2A | | | | | <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> </tr> </table> YCMVTD2A | | | | | YCKP2A 1 Yes 2 No ↓ Test other leg. Go to Question #7. |
| | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | |
| 3. | <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> </tr> </table> YCMT3A | | | | | | <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> </tr> </table> YCMRT3A | | | | | | <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> </tr> </table> YCRT3A | | | | | <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> </tr> </table> YCMVTD3A | | | | | Test complete. Go to Question #9. |
| | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | |



7 What is the length of the lower leg?
(Examiner Note: Only test the other leg if three trials were not possible on the first leg. This should be the length of the other leg to be tested.)

YCLEG2 meters

8 Which other leg is being tested?
YCRL5 ① Right leg ② Left leg ③ Test not performed

Go to Question #10.

| Trial | Maximum Torque (Nm) | Max Rate Torque (Nm/sec) | Reaction Time (msec) | Time to 50% MVTD (msec) | Did participant have knee pain? |
|-------|--|---|---|---|--|
| 1. | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> YCMT1B | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> YCMRT1B | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YCRT1B | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YCMVTD1B | YCKP1B ① Yes ② No STOP. Go to Question #9. |
| 2. | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> YCMT2B | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> YCMRT2B | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YCRT2B | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YCMVTD2B | YCKP2B ① Yes ② No STOP. Go to Question #9. |
| 3. | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> YCMT3B | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> YCMRT3B | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YCRT3B | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YCMVTD3B | Test complete. Go to Question #9. |

9 What size connecting rod was used?
YCROD ① Small ② Medium ③ Large

10 Was the participant able to complete the isometric strength test?
YCISOTST ① Yes ② No

Why not?
(Examiner Note: Mark all that apply.)

YCKCBKR3 ① Not eligible: bilateral knee replacement

YCKCPN3 ① Knee pain

YCKCEQ3 ① Equipment problems

YCKCREF3 ① Participant refused/didn't understand

YCKCFAT3 ① Participant fatigue

YCKCOTH3 ① Other (Please specify: _____)

| | | |
|----------------------|----------|------------|
| HABC Enrollment ID # | Acrostic | Staff ID # |
| H | | |

YCSTID10

PROXY CONTACT HOME VISIT WORKBOOK ULTRASOUND

1 Have you broken any bones in your legs, ankles, or feet in the past 12 months?
(Examiner Note: Do not include isolated toe fractures.)

YCBKFEET ① Yes ② No ③ Don't know/ Didn't understand ④ Refused

Scan same foot as most recent ultrasound measurement.
If no previous ultrasound measurement scan right foot.

Which side?

① Right side

Scan left foot.

② Left side

Scan right foot.

③ Both right & left side

Scan same foot as most recent ultrasound measurement.

④ Don't know/Didn't understand

Scan same foot as most recent ultrasound measurement.

YCBKRLB

2 Sahara serial #: YCSERIAL

3 Which foot was scanned? **YCBUSCAN**

① Right ② Left ③ Scan not attempted ④ Scan not completed

YCBULEFT

Why was the left foot scanned?

- ① Fracture
- ② Permanent weakness on right side
- ③ Hardware
- ④ Other

(Please specify: _____)

YCBUCOMP

Why wasn't the scan attempted?

- ① Participant refused
- ② Equipment problem
- ③ Foot too big/edema/deformity
- ④ Other

(Please specify: _____)

YCBUNOSC

Why wasn't the scan completed?

- ① Out of range reading
- ② Invalid measurement
- ③ Other

(Please specify: _____)



4 Measurement #1:

QUI

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Y | C | B | U | Q | U | I | 1 |
|---|---|---|---|---|---|---|---|

 . units

BUA

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Y | C | B | U | B | U | A | 1 |
|---|---|---|---|---|---|---|---|

 . units

SOS

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Y | C | B | U | S | O | S | 1 |
|---|---|---|---|---|---|---|---|

 . m/s

Did BUA result have an asterisk?
 Yes No
YCBUAST1

Measurement #2:

QUI

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Y | C | B | U | Q | U | I | 2 |
|---|---|---|---|---|---|---|---|

 . units

BUA

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Y | C | B | U | B | U | A | 2 |
|---|---|---|---|---|---|---|---|

 . units

SOS

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Y | C | B | U | S | O | S | 2 |
|---|---|---|---|---|---|---|---|

 . m/s

Did BUA result have an asterisk?
 Yes No
YCBUAST2

5 What is the difference between BUA measurement #1 and BUA measurement #2?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Y | C | B | U | D | I | F | 1 |
|---|---|---|---|---|---|---|---|

 . units

a. Was the difference between BUA measurement #1 and BUA measurement #2 \geq 10 units?

YCBUDIF2 Yes No

Repeat scan and record results in section #6 below.

b. Did both BUA measurement #1 and BUA measurement #2 have an asterisk?

YCBU2AST Yes No

Repeat scan and record results in section #6 below.

6

QUI

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Y | C | B | U | Q | U | I | 3 |
|---|---|---|---|---|---|---|---|

 . units

BUA

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Y | C | B | U | B | U | A | 3 |
|---|---|---|---|---|---|---|---|

 . units

SOS

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Y | C | B | U | S | O | S | 3 |
|---|---|---|---|---|---|---|---|

 . m/s

Did BUA result have an asterisk?
 Yes No **YCBUAST3**

PROXY CONTACT HOME VISIT WORKBOOK BONE DENSITY (DXA) SCAN

1 Do you have breast implants?

YCBI ① Yes ① No ⑧ Don't know/ Didn't understand ⑦ Refused

- ◆ Flag scan for review by DXA Reading Center.
- ◆ Indicate in the table below whether breast implant is in "Left ribs" or "Right ribs" subregion.

2 Do you have any metal objects in your body, such as a pacemaker, staples, screws, plates, etc.?

YCMO ① Yes ① No ⑧ Don't know/ Didn't understand ⑦ Refused

- a. Flag scan for review by DXA Reading Center.
- b. Indicate in the table the location of joint replacement, hardware or other artifacts (sub regions are those defined by the whole body scan analysis.)

| Sub | Hardware | Other Artifacts |
|----------------|----------|-----------------|
| Head | ① | ② YCHEAD |
| Left arm | ① | ② YCLA |
| Right arm | ① | ② YCRA |
| Left ribs | ① | ② YCLR |
| Right ribs | ① | ② YCRR |
| Thoracic spine | ① | ② YCTS |
| Lumbar spine | ① | ② YCLS |
| Pelvis | ① | ② YCPEL |
| Left leg | ① | ② YCLL |
| Right leg | ① | ② YCRL |

3 Have you had any of the following tests within the past ten days?

| | Yes | No | Don't know/ Didn't understand |
|--|-----|----|----------------------------------|
| a. Barium enema | ①* | ① | ⑧ YCBE |
| b. Upper GI X-ray series | ①* | ① | ⑧ YCUGI |
| c. Lower GI X-ray series | ①* | ① | ⑧ YCLGI |
| d. Nuclear medicine scan | ①* | ① | ⑧ YCNUKE |
| e. Other tests using contrast ("dye") or radioactive materials | ①* | ① | ⑧ YCOTH2 |

*(*Examiner Note: If "Yes" to any, reschedule bone density measurement so that at least 10 days will have passed since the tests were performed.)*

4 Was a bone density measurement obtained for...?

a. Whole Body

① Yes ① No YCWB
↓

| |
|---|
| Last 2 characters of scan ID #: YCSCAN1 <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> |
| Date of scan: <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> 2 0 0 <input style="width: 20px; height: 20px;" type="text"/> |
| <div style="display: flex; justify-content: space-around; font-size: small;"> Month Day Year </div> <p>YCSCDTE1</p> |

b. Hip

① Yes ① No YCHIP
↓

| |
|---|
| Last 2 characters of scan ID #: YCSCAN2 <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> |
| Date of scan: <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> 2 0 0 <input style="width: 20px; height: 20px;" type="text"/> |
| <div style="display: flex; justify-content: space-around; font-size: small;"> Month Day Year </div> <p>YCSCDTE2</p> |

| 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"/> |
| BJID | BJACROS | Month BJDATE Day Year | BJSTFID |

MISSEDFOLLOW-UPCONTACT

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

① Annual Clinic Visit →

Which visit? **BJVISIT**

| | |
|-----------|-----------|
| ② Year 02 | ⑤ Year 05 |
| ③ Year 03 | ⑥ Year 06 |
| ④ Year 04 | ⑦ Year 07 |

BJVISIT

② Semi-Annual Phone Interview →

Which contact? **BJCONTAC**

| | | |
|---------|---------|---------|
| ① 6-mo | ④ 42-mo | ⑦ 78-mo |
| ② 18-mo | ⑤ 54-mo | |
| ③ 30-mo | ⑥ 66-mo | |

BJCONTAC

2 Reason Follow-up Contact Missed BJREASON

Please check the primary reason for the missed follow-up visit or telephone contact. Check **only one** reason.

- | | |
|---|--|
| ① Illness/health problem(s) | ⑩ Moved out of area |
| ② Hearing difficulties | ⑪ Travelling/on vacation |
| ③ Cognitive difficulties | ⑫ Personal problem(s) |
| ④ In nursing home/long-term care facility | ⑬ Unable to contact/unable to locate |
| ⑤ Too busy; time and/or work conflict | ⑭ Refused to give reason |
| ⑥ Caregiving responsibilities | ⑮ Modified follow-up regimen (e.g. will only agree to one contact per year) |
| ⑦ Physician's advice | ⑯ Withdrew from study/withdrew informed consent |
| ⑧ Family member's advice | ⑰ Deceased |
| ⑨ Clinic too far/travel time | ⑱ Other (Please specify: _____) |

3 Comments



| 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"/> <input type="text"/> |
| BLID | BLACROS | Month Day Year BLDATE | BLSTFID |

SEMI-ANNUAL TELEPHONE CONTACT

Telephone contact: **5** 54-mo **8** Other (*Please specify*)
BLCONTAC **3** 30-mo **6** 66-mo
4 42-mo **7** 78-mo

Date of last contact: / / **BLDTCON**
Month Day Year

I would like to ask you some questions that we asked you about 6 months ago, on (date of last contact). The reason for asking them again is to find out how you've been doing during the past six months.

1. In general, how would you say your health is? Would you say it is. . .
(Interviewer Note: Read response options.)

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

2. Since we last spoke to you 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.

- BLBED12** **1** Yes **0** No **8** Don't know **7** Refused

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.
(Interviewer Note: If necessary, probe - "If you are unsure, please make your best guess.")

BLBEDDAY days

3. Since we last spoke to you 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? Please include days in bed.

- BLCUT12** **1** Yes **0** No **8** Don't know **7** Refused

How many days did you cut down on the things you usually do because of illness or injury? Please include days in bed.
(Interviewer Note: If necessary, probe - "If you are unsure, please make your best guess.")

BLCUTDAY days

4. Since we last spoke to you about 6 months ago, did you stay overnight as a patient in a nursing home or rehabilitation center?

BLMCNH (1) Yes (0) No (8) Don't know (7) Refused

5. Since we last spoke to you about 6 months ago, did you receive care at home from a visiting nurse, home health aide, or nurse's aide?

BLMCVN (1) Yes (0) No (8) Don't know (7) Refused

6. Since we last spoke to you about 6 months ago, have you had a cold or flu that was bad enough to keep you in bed for all or most of the day?

BLFLU (1) Yes (0) No (8) Don't know (7) Refused

a. Did you take your temperature?

Analyst Note: The wording was later changed to: "Was your temperature taken?"

BLTEMP (1) Yes (0) No (8) Don't know

Go to Question #6b

Was your temperature 100° or higher?

(1) Yes* (0) No (8) Don't know **BLTEMPHI**

b. Did a doctor or nurse tell you that you had the flu or a fever?

BLFLUDR (1) Yes (0) No (8) Don't know

c. Did you have body aches, chills, or muscle weakness that lasted two or more days?

BLACHES (1) Yes (0) No (8) Don't know

d. Were you hospitalized overnight for pneumonia or bronchitis following the illness?

BLPNEU (1) Yes (0) No (8) Don't know

*** Interviewer Note: Please complete Substudy Workbook.**

7. 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? *(Interviewer Note: If the participant responds "Don't do," probe to determine whether this is because of a health or physical problem. If the participant doesn't walk because of a health or physical problem, check "Yes." If the participant doesn't walk for other reasons, check "Don't do.")*

BLDWQMYN ① Yes

① No

⑧ Don't know

⑦ Refused

⑨ Don't do

Go to Question #7c

Go to Question #8

a. How much difficulty do you have? *(Interviewer Note: Read response options.)*

① A little difficulty

② Some difficulty

BLDWQMDF ③ A lot of difficulty

④ Or are you unable to do it?

⑧ Don't know

b. 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.)

① Arthritis

⑫ Hip fracture

② Back pain

⑬ Injury

(Please specify: _____)

③ Balance problems/unsteadiness on feet

⑭ Joint pain

④ Cancer

⑮ Lung disease

(asthma, chronic bronchitis, emphysema, etc)

⑤ Chest pain/discomfort

⑯ Old age

(no mention of a specific condition)

BLMNRS ⑥ Circulatory problems

⑰ Osteoporosis

⑦ Diabetes

⑱ Shortness of breath

⑧ Fatigue/tiredness (no specific disease)

⑲ Stroke

⑨ Fall

① Other symptom

(Please specify: _____) **BLMNRS4**

⑩ Heart disease
(including angina, congestive heart failure, etc)

② Multiple conditions/symptoms given;
unable to determine MAIN reason

⑪ High blood pressure/hypertension

⑧ Don't know

Go to Question #8

[]



7c. How easy is it for you to walk a quarter of a mile?
(Interviewer Note: Read response options.)

- ① Very easy
 - ② Somewhat easy
 - ③ Or not that easy
 - ⑧ Don't know/Don't do
- BLDWQMEZ

7d. Do you get tired when you walk a quarter of a mile?

- ① Yes
 - ② No
 - ⑧ Don't know/Don't do
- BLDWQMT2

7e. 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 → Go to Question #8
 - ② No → Go to Question #7f
 - ⑧ Don't know/Don't do → Go to Question #7f
- BLDW1MYN

7f. How easy is it for you to walk one mile?
(Interviewer Note: Read response options.)

- ① Very easy
 - ② Somewhat easy
 - ③ Or not that easy
 - ⑧ Don't know/Don't do
- BLDW1MEZ



8. Because of a health or physical problem, do you have any difficulty walking up 10 steps, that is about 1 flight, without resting? *(Interviewer Note: If the participant responds "Don't do," probe to determine whether this is because of a health or physical problem. If the participant doesn't walk up 10 steps because of a health or physical problem, check "Yes." If the participant doesn't walk up steps for other reasons, such as there are simply no steps in the area, check "Don't do.")*

BLDW10YN ① Yes

① No

⑧ Don't know

⑦ Refused

⑨ Don't do

Go to Question #8c

Go to Question #9

a. How much difficulty do you have?
(Interviewer Note: Read response options.)

① A little difficulty

② Some difficulty

BLDIF ③ A lot of difficulty

④ Or are you unable to do it?

⑧ Don't know

b. 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.)

① Arthritis

② Back pain

③ Balance problems/unsteadiness on feet

④ Cancer

⑤ Chest pain/discomfort

BLMNRS2 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

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

① Other symptom
(Please specify: _____) **BLMNRS3**

② Multiple conditions/symptoms given;
unable to determine MAIN reason

⑧ Don't know

Go to Question #9



8c. How easy is it for you to walk up 10 steps without resting?
(Interviewer Note: Read response options.)

① Very easy

② Somewhat easy

BLDW10EZ

③ Or not that easy

⑧ Don't know/Don't do

8d. Do you get tired when you walk up 10 steps without resting?

① Yes

BLDW10WX ① No

⑧ Don't know/Don't do

8e. 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



Go to Question #9

BLDW20YN ① No



Go to Question #8f

⑧ Don't know/Don't do



Go to Question #8f

8f. How easy is it for you to walk up 20 steps without resting?
(Interviewer Note: Read response options.)

① Very easy

② Somewhat easy

BLDW20EZ

③ Or not that easy

⑧ Don't know/Don't do



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

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

10. How much do you currently weigh?
(Interviewer Note: If necessary, probe - "If you are unsure, please make your best guess.")

BLWTLBS pounds ⑧ Don't know/don't remember ⑦ Refused **BLLBS2**

11. Since we last spoke to you about 6 months ago, has your weight changed by 5 or more pounds?

BLCHN5LB ① Yes ② No ⑧ Don't know ⑦ Refused

a. Did you gain or lose weight?

BLGNLS ① Gain ② Lose ⑧ Don't know/don't remember

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.")

BLHOW6 pounds ⑧ Don't know/don't remember ⑦ Refused **BLHOW6DN**

c. Were you trying to gain/lose weight?

BLTRGNLS ① Yes ② No ⑧ Don't know

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

BLTRYLOS ① Yes ② No ⑧ Don't know ⑦ Refused

Now I'm going to ask you about any medical problems you might have had since we last spoke to you about 6 months ago, which was on

/ /
 Month Day Year

13. Since we last spoke to you about 6 months ago, has a doctor told you that you had a heart attack, angina, or chest pain due to heart disease?

- BLHCHAMI** Yes No Don't know Refused

Were you hospitalized overnight for this problem?

BLHOSMI Yes No

Complete a Health ABC Event Form(s), Section I, for each overnight hospitalization. Record reference #'s below:

a. **BLREF13A**
 b. **BLREF13B**
 c. **BLREF13C**

Go to Question #14

14. Since we last spoke to you about 6 months ago, has a doctor told you that you had a stroke, mini-stroke, or TIA ?

- BLHCCVA** Yes No Don't know Refused

Were you hospitalized overnight for this problem?

BLHOSMI2 Yes No

Complete a Health ABC Event Form(s), Section I, for each overnight hospitalization. Record reference #'s below:

a. **BLREF14A**
 b. **BLREF14B**
 c. **BLREF14C**

Go to Question #15

15. Since we last spoke to you about 6 months ago, has a doctor told you that you had congestive heart failure?

- BLCHF** Yes No Don't know Refused

Were you hospitalized overnight for this problem?

BLHOMI3 Yes No

Complete a Health ABC Event Form(s), Section I, for each overnight hospitalization. Record reference #'s below:

a. **BLREF15A**
 b. **BLREF15B**
 c. **BLREF15C**

Go to Question #16



16. Since we last spoke to you 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 we last spoke to you.

BLCHMGMT Yes No Don't know Refused

Complete a Health ABC Event Form(s)
Section II, for each event.
Record reference #'s below:

| | | | | | | |
|-----------|--|--|--|--|--|-----------------|
| a. | | | | | | BLREF16A |
| b. | | | | | | BLREF16B |
| c. | | | | | | BLREF16C |

17. Since we last spoke to you about 6 months ago, has a doctor told you that you had pneumonia?

BLLCPNEU Yes No Don't know Refused

Complete a Health ABC Event Form(s),
Section II, for each event.
Record reference #'s below:

| | | | | | | |
|-----------|--|--|--|--|--|-----------------|
| a. | | | | | | BLREF17A |
| b. | | | | | | BLREF17B |
| c. | | | | | | BLREF17C |

18. Since we last spoke to you about 6 months ago, have you been told by a doctor that you broke or fractured a bone(s)?

BLOSBR45 Yes No Don't know Refused

Complete a Health ABC Event Form(s),
Section II, for each event.
Record reference #'s below:

| | | | | | | |
|-----------|--|--|--|--|--|-----------------|
| a. | | | | | | BLREF18A |
| b. | | | | | | BLREF18B |
| c. | | | | | | BLREF18C |

19. Were you hospitalized overnight for any other reasons since we last spoke to you about 6 months ago?

- BLHOSP12 Yes No Don't know Refused

*Complete a Health ABC Event Form(s), Section I, for each event.
Record reference #'s and reason for hospitalization below.*

| | | | | | |
|----------|-----------------------------|----------|-----------------------------|----------|-----------------------------|
| BLREF19A | <input type="text"/> | BLREF19B | <input type="text"/> | BLREF19C | <input type="text"/> |
| a. | Reason for hospitalization: | b. | Reason for hospitalization: | c. | Reason for hospitalization: |
| <hr/> | | | | | |
| BLREF19D | <input type="text"/> | BLREF19E | <input type="text"/> | BLREF19F | <input type="text"/> |
| d. | Reason for hospitalization: | e. | Reason for hospitalization: | f. | Reason for hospitalization: |
| <hr/> | | | | | |

20. Have you had any same day outpatient surgery since we last spoke to you about 6 months ago?

- BLOUTPA Yes No Don't know Refused

Was it for . . . ?

- a. A procedure to open a blocked artery Yes No Don't know
BLBLART
- b. Gall bladder surgery Yes No Don't know
BLGALLBL
- c. Cataract surgery Yes No Don't know
BLCATAR
- d. Hernia repair Yes No Don't know
BLHERN
- e. TURP (MEN ONLY) (transurethral resection of prostate) Yes No Don't know
BLTURP
- f. Other Yes No Don't know
BLOTH

Reference #'s **BLREF20A**

Complete a Health ABC Event Form, Section III. Record reference #:

Please specify the type of outpatient surgery.

i. _____

ii. _____

iii. _____

21. Do you expect to move or have a different mailing address in the next 6 months?

Yes **①**

No **②**

Don't know **③**

Refused **④** **BLMOVE**

What will be your new mailing address?

New address:

Street Address Apt/Room

City State Zip Code

① Permanent address

BLADDRESS **②** Winter address

③ Other (Please describe: _____)

Telephone: (_____) _____

Area Code Number

BLMOVDA

Date new address/phone number effective:

| | | | | | | | |
|--|--|---|--|--|---|--|--|
| | | / | | | / | | |
|--|--|---|--|--|---|--|--|

Month Day Year

Thank you very much for answering these questions. I enjoyed talking with you. Please remember to call us if you are admitted to a hospital or nursing home for any reason so that we can better understand changes in your health. We would also like to hear from you if you move or if your mailing address changes. I look forward to seeing you in the Health ABC clinic during your annual visit about 6 months from now.

Interviewer Note:

If participant reported having a cold or flu in the past 6 months that was bad enough to keep them in bed for all or most of the day AND they had a temperature of 100° or higher (refer to Question #6 on page 2), complete Substudy Workbook.

