

HABC Enrollment ID # H [] [] [] [] [] DAID	Acrostic [] [] [] [] [] [] DAACROS	Date Form Completed [] [] / [] [] / 2 0 0 [] [] Month Day Year DADATE	Staff ID # [] [] [] [] DASTFID
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YEAR 4 QUESTIONNAIRE

Date of last regularly scheduled contact: [] [] / [] [] / [] [] [] []
Month Day Year
DADATES
(Interviewer Note: Refer to Data from Prior Visits Report.)

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

- 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.

DABED12 ① Yes ⑥ 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.")

[] [] [] days **DABEDDAY**

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.

DACUT12 ① Yes ⑥ 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.")

[] [] [] days **DACUTDAY**

DALINK

Draft



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?

- ① Yes ② No ③ Don't know ④ Refused

DAMCNH

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?

- ① Yes ② No ③ Don't know ④ Refused

DAMCVN

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?

- ① Yes ② No ③ Don't know ④ Refused

DAFLU

a. Did you take your temperature?

- ① Yes ② No ③ Don't know

Go to Question #6b

Was your temperature 100° or higher?

- ① Yes * ② No ③ Don't know

DATEMP

DATEMPHI

b. Did a doctor or nurse tell you that you had the flu or a fever?

- ① Yes ② No ③ Don't know

DAFLUDR

***Interviewer Note: Please complete Substudy Workbook.**

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

- ① Yes ② No ③ Don't know ④ Refused

DAFSHOT

When did you get your most recent flu shot?
If you are unsure, please make your best guess.

/
 Month Year

DAMOYR



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

DADWQMEZ

8d. 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 #9
- ② No → Go to Question #8e
- ⑧ Don't know/don't do → Go to Question #8e

DADW1MYN

8e. 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

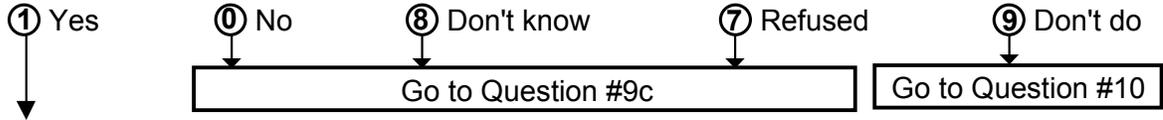
DADW1MEZ



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.") **DADW10YN**



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
- ⑤ Don't know

DADIF

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: Do NOT read response options. If "some other reason," probe for response. Mark only ONE answer.)

DAMNRS2

- | | |
|--|--|
| 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, |
| 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: _____) |
| 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 |

Go to Question #10



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

DADW10EZ

9d. 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 #10

① No

→ Go to Question #9e

⑧ Don't know/don't do

→ Go to Question #9e

DADW20YN

9e. 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

DADW20EZ

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

DAEQUIP 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?

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

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

DADIORHY

12. Do you have any difficulty bathing or showering?

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

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

① Yes ② No ③ Don't know

DABATHRH

13. Do you have any difficulty dressing?

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

Do you usually receive help from another person in dressing?

① Yes ② No ③ Don't know

DADDRHYN

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

DADIFSTA 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

DADSTAMT

How easy is it for you to stand up from a chair without using your arms?
(Interviewer Note: Read response options.)

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

DAEZSTA



15. 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?

DADIF10

① Yes

⑦ Refused

⑧ Don't know

⑦ Refused

DAD10AMT

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

Go to Question #16

How easy is it for you to lift or carry something weighing 10 pounds?
(Interviewer Note: Read response options.)

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

DAEZ10LB

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

DAD20LBS

① Yes

⑦ Refused

⑧ Don't know

Go to Question #16

How easy is it for you to lift or carry something weighing 20 pounds?
(Interviewer Note: Read response options.)

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

DAEZ20LB



16. Did you do heavy or major chores like scrubbing windows or walls, vacuuming, or cleaning gutters; home maintenance activities like painting; gardening or yardwork; or anything like these activities, at least 10 times, in the past 12 months?

DAHC12MO

① Yes

① No

⑧ Don't know

⑦ Refused

Go to Question #17

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

① Yes

① No

⑧ Don't know

DAHC7DAY

Go to Question #17

b. About how much time did you spend doing heavy chores or home maintenance activities in the past 7 days (not counting rest periods)?
(Interviewer Note: If less than 1 hour, record number of minutes.)

DAHCHRS

DAHCMINS

DAHCDK

① Don't know

Hours

Minutes



18. Did you walk up a flight of stairs (a flight is about 10 steps), at least 10 times, in the past 12 months?

① Yes

② No

③ Don't know

⑦ Refused

DAFS12MO

Go to Question #19

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

DAFS7DAY ① Yes

② No

③ Don't know

Go to Question #19

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

DAFSNUM

flights

④ Don't know

DAFSNUMD

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

DAFSLOA

flights

④ Don't know

DAFSLODK



19. 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, in the past 12 months?

DAHI12MO

① Yes

② No

③ Don't know

④ Refused

Go to Question #20

In the past 7 days, did you do high intensity exercise activities?
DAHI7DAY

① Yes

② No

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

- ① Bicycling/exercycle DAHIABE
- ① Swimming DAHIASWM
- ① Jogging DAHIAJOG
- ① Aerobics DAHIAAER
- ① Stair-stepping DAHIASS
- ① Racquet sports DAHIARS
- ① Rowing machine DAHIAROW
- ① Cross country ski machine DAHIASKI
- ① Other (Please specify): DAHIAOTH

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.*)

DAHIA1HR DAHIA1MN ① Don't know
Hours Minutes DAHIA1DK

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.*)

DAHIA2HR DAHIA2MN ① Don't know
Hours Minutes DAHIA2DK

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
- ④ Health problems DAHINDEX
- ⑤ Lost interest
- ⑥ Felt unsafe
- ⑦ Not necessary
- ⑧ Other
- ⑨ Don't know

Go to Question #20



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

20. Did you work for pay, either at a regular job, consulting, or doing odd jobs, for most of your adult life?

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

Go to Question #21

Now please think about the paid job that you had for the longest period of time.

a. Did you hold a managerial position?

1 Yes
 0 No
 8 Don't know
 DAVWMGR

b. As an official part of this job, did you supervise the work of other employees, have responsibility for, or tell other employees what work to do?

1 Yes
 0 No
 8 Don't know
 DAVWSUPV

c. Did you participate in making decisions about such things as the products or services offered, the total number of people employed, budgets, and so forth?

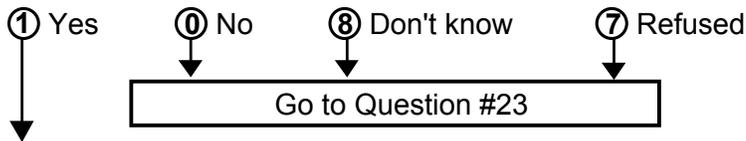
1 Yes
 0 No
 8 Don't know
 DAVWDEC

21. In general, how did your personal finances usually work out at the end of the month? Did you find that you usually ended up with some money left over, just enough to make ends meet, or not enough to make ends meet?

- 1 Some money left over
 - 2 Just enough to make ends meet
 - 3 Not enough to make ends meet
 - 8 Don't know
 - 7 Refused
- DAFIADQ**



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



DAVWCURJ

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

DAVWAHWR hours 1 Don't know **DAVWAHDK**

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

DAVWMOW months 1 Don't know **DAVWMODK**

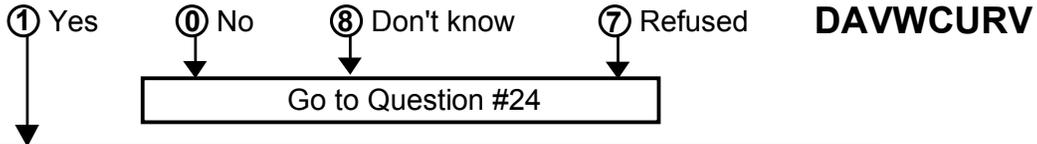
c. Which of the following categories best describes the type of activity that you do in your job? Would you say...
(Interviewer Note: REQUIRED - Show card #4.)

DAVWWACT

- 1 Mainly sitting
- 2 Sitting, some standing and/or walking
- 3 Mostly standing and/or walking
- 4 Mostly walking and lifting and/or carrying; heavy manual work
- 8 Don't know



23. Do you currently do any volunteer work?



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

DAVWAHVV hours
 1 Don't know
 DAVWADK

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

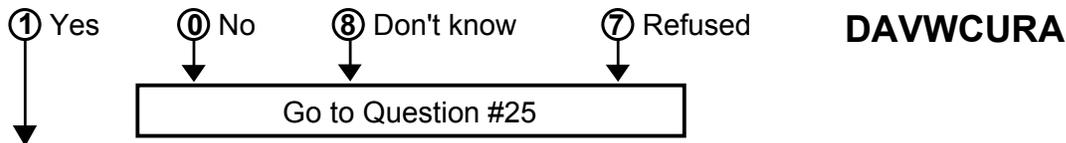
DAVWMOV months
 1 Don't know
 DAVWMDK

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

DAVWVACT

- 1 Mainly sitting
- 2 Sitting, some standing and/or walking
- 3 Mostly standing and/or walking
- 4 Mostly walking and lifting and/or carrying; heavy manual work
- 8 Don't know

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



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

DAVWAHAW hours
 1 Don't know
 DAVWDK



Now I have some questions about your appetite.

25. 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

DAAPPET

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

DAWTLBS pounds ⑧ Don't know ⑦ Refused **DALBS2**

27. Since we last spoke to you about 6 months ago, has your 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.)

DACHN5LB

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

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

- ① Gain
 - ② Lose
 - ⑧ Don't know
- DAGNLS**

b. Were you trying to gain/lose weight?

- ① Yes
 - ② No
 - ⑧ Don't know
- DATRGNLS**



Now please think about the past year.

28. Did you lose 5 or more pounds at any one time over the past 12 months?

1 Yes
 0 No
 8 Don't know
 7 Refused
 DALOS5LB

Go to Question #29

a. Thinking about the past 12 months, what was the greatest amount of weight that you lost at any one time? If you are unsure, please make your best guess.

DAAMTLOS pounds
 8 Don't know
 7 Refused
 DALOSREF

b. Were you trying to lose weight?

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

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

1 Yes
 0 No
 8 Don't know
 7 Refused
 DAGN5LB

a. Thinking about the past 12 months, what was the greatest amount of weight that you gained at any one time? If you are unsure, please make your best guess.

DAGN12MO pounds
 8 Don't know
 7 Refused
 DAGNREF

b. Were you trying to gain weight?

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

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

1 Yes
 0 No
 8 Don't know
 7 Refused
 DATRYLS2

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...?

31. 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.

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

32. 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.

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

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

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

Go to Question #34

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

- ① One
- ② Two or three
- ④ Four or five
- ⑥ Six or more
- ⑧ Don't know

DAAJFNUM

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

34. 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?

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

Were you hospitalized overnight for this problem?

① Yes

DAHOSMI

② No

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

a.

b.

c.

DAREF34A

DAREF34B

DAREF34C

Go to Question #35

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

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

Were you hospitalized overnight for this problem?

① Yes

DAHOSMI3

② No

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

a.

b.

c.

DAREF35A

DAREF35B

DAREF35C

Go to Question #36

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

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

Were you hospitalized overnight for this problem?

① Yes

DAHOSMI2

② No

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

a.

b.

c.

DAREF36A

DAREF36B

DAREF36C

Go to Question #37



37. 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.

DACHMGMT 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.

--	--	--	--	--

DAREF37A

b.

--	--	--	--	--

DAREF37B

c.

--	--	--	--	--

DAREF37C

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

DALCPNEU 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.

--	--	--	--	--

DAREF38A

b.

--	--	--	--	--

DAREF38B

c.

--	--	--	--	--

DAREF38C

39. 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)?

DAOSBR45 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.

--	--	--	--	--

DAREF39A

b.

--	--	--	--	--

DAREF39B

c.

--	--	--	--	--

DAREF39C



40. Were you hospitalized overnight for any other reasons since we last spoke to you about 6 months ago?

- DAHOSP12 Yes No Don't know Refused

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

<p>a. <input type="text" value="DAREF40A"/> Reason for hospitalization: _____</p>	<p>b. <input type="text" value="DAREF40B"/> Reason for hospitalization: _____</p>	<p>c. <input type="text" value="DAREF40C"/> Reason for hospitalization: _____</p>
<p>d. <input type="text" value="DAREF40D"/> Reason for hospitalization: _____</p>	<p>e. <input type="text" value="DAREF40E"/> Reason for hospitalization: _____</p>	<p>f. <input type="text" value="DAREF40F"/> Reason for hospitalization: _____</p>

41. Have you had any same day outpatient surgery since we last spoke to you about 6 months ago?

- DAOUTPA Yes No Don't know Refused

Was it for...?

- a. A procedure to open a blocked artery
DABLART Yes No Don't know
- b. Gall bladder surgery
DAGALLB Yes No Don't know
- c. Cataract surgery
DACATAR Yes No Don't know
- d. Hernia repair (Inguinal abdominal hernia.)
DAHERN Yes No Don't know
- e. TURP (MEN ONLY) (transurethral resection of prostate)
DATURP Yes No Don't know
- f. Other
DAOTH Yes No Don't know

→ *Complete a Health ABC Event Form, Section III. Record reference #:*

Reference #

--	--	--	--	--

DAREF41A

Please specify the type of outpatient surgery.

i. _____

ii. _____

iii. _____



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

DAOTILL

① Yes

② No

⑧ Don't know

⑦ Refused

Go to Question #43

Please describe for what:

43. 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

⑧ Don't know

⑦ Refused

DAELTIRE

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

DAELOFTN

44. 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 #5.)

DAELEV

--	--

Energy level

⑧ Don't know

⑦ Refused

DAELEVRF

--

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

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

Go to Question #52

46. Do you get it when you walk uphill or hurry? **DACSCPUP**

- ① Yes ② No ③ Never hurry or walk uphill ④ Don't know ⑤ Refused

Go to Question #51

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

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

48. What do you do if you get any pain or discomfort in your chest while you are walking? Do you...
(Interviewer Note: Read response options.)

- ① Stop or slow down, or continue at same pace after taking nitroglycerine
 - ② Continue at same pace
 - ③ Don't know
 - ④ Refused
- DACSWALK**

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

- ① Relieved ② Not relieved ③ Don't know ④ Refused **DACSSTIL**

How soon is it relieved?
 ① 10 minutes or less
 ② More than 10 minutes
 ③ Don't know

DACSREL



50. Where do you get this pain or discomfort?
(Interviewer Note: REQUIRED - Show card #6. Mark only ONE answer. If participant has had chest pain or discomfort in more than one area, ask them to indicate the ONE area where they had the worst pain or discomfort.)

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

DACSPLOC

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

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

DACSSVPN

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

- ① Yes
- ② No
- ⑧ Don't know

DACSSPDR

Go to Question #52

b. What did your doctor say it was?

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

DACSDIAG



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

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

↓

a. Does this pain ever begin when you are standing still or sitting?
 ① Yes ② No ③ Don't know **DACSLPSS**

b. Do you get it if you walk uphill or hurry?
 ① Yes ② No ③ Don't know **DACSLPUP**

c. Do you get it when you walk at an ordinary pace on a level surface?
 ① Yes ② No ③ Don't know **DACSLPLS**

d. What happens to it if you stop walking and stand still? Does it usually continue for more than 10 minutes, or does it usually disappear in 10 minutes or less?
 ① Usually continues for more than 10 minutes
 ② Usually disappears in 10 minutes or less **DACSSTST**
 ③ Don't know

e. Do you get this pain in your calf (or calves)?
 ① Yes ② No ③ Don't know **DACSLPCV**

f. Have you ever been hospitalized for this problem in your legs?
 ① Yes ② No ③ Don't know **DACSLPH**



ASSESSMENT OF ARTHRITIS and KNEE PAIN

53. 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 ② No ③ Don't know ④ Refused **DAAJARTH**

a. Did the doctor say it was...?	DAAJKNEE
i. Osteoarthritis or degenerative arthritis in your knee?	① Yes ② No ③ Don't know
ii. Osteoarthritis or degenerative arthritis in your hip?	① Yes ② No ③ Don't know
b. Do you take any medicines for arthritis or joint pain?	DAAJHIP DAAJMEDS

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.

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

① Yes ② No ③ Don't know ④ Refused **DAAJK12**

Go to Question #58

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

① Yes * ② No ③ Don't know **DAAJKMD**

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

① Right knee only **DAAJLRB1**
 ② Left knee only
 ③ Both right and left knee
 ④ Don't know

*** Interviewer Note: Year 4 Knee X-ray Eligibility Assessment Form in the Year 4 Clinic Visit Workbook must be completed. Participant may be eligible for knee x-ray.**



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

1 Yes
 0 No
 8 Don't know
 7 Refused
 DAAJRK30

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

1 Yes *
 0 No
 8 Don't know
 DAAJRKMS

b. In the past 30 days, how much pain have you had in your right knee for each activity I will describe. How much pain have you had while...?

(Interviewer Note: Read each activity separately. Read response options. OPTIONAL-Show card #7.)

	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
		DAAJRKFS				
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
		DAAJRKST				
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
		DAAJRKBD				
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
		DAAJRKUP				
e) Getting in or out of a chair <i>(Interviewer Note: A relatively hard, supportive chair)</i>	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2 *	<input type="radio"/> 3 *	<input type="radio"/> 4 *	<input type="radio"/> 8
		DAAJRKCH				
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
		DAAJRKI				

*** Interviewer Note: Year 4 Knee X-ray Eligibility Assessment Form in the Year 4 Clinic Visit Workbook must be completed. Participant may be eligible for knee x-ray.**

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

1 Yes 0 No 8 Don't know 7 Refused **DAAJLK30**

↓ ↓ ↓ ↓

Go to Question #58

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

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

b. In the past 30 days, how much pain have you had in your left knee for each activity I will describe. How much pain have you had while...?

(Interviewer Note: Read each activity separately. Read response options. OPTIONAL-Show card #7.)

	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
	DAAJLK F					
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
	DAAJLK ST					
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
	DAAJLK BD					
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
	DAAJLK UP					
e) Getting in or out of a chair <i>(Interviewer Note: A relatively hard, supportive chair)</i>	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2 *	<input type="radio"/> 3 *	<input type="radio"/> 4 *	<input type="radio"/> 8
	DAAJLK CH					
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
	DAAJLK IN					

*** Interviewer Note: Year 4 Knee X-ray Eligibility Assessment Form in the Year 4 Clinic Visit Workbook must be completed. Participant may be eligible for knee x-ray.**

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

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

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

DAAJL DAY days 8 Don't know **DAAJLDDK**

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

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

H					
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DBID

--	--	--	--	--

DBACROS

URINARY HISTORY

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

- 59.** On average, how many times a day do you go to the bathroom to urinate...?
- a. From when you get up **DBUHDY** **DBUHDYRF**
in the morning until times per day Don't know Refused
you go to bed?
- b. During the night **DBUHNT** **DBUHNTRF**
after going to bed? times per night Don't know Refused

- 60.** In the past 12 months, did a doctor tell you that you had a urinary tract infection, that is, an infection in your bladder or kidneys?
- Yes No Don't know Refused **DBUTIDX**

How many times in the past 12 months were you told by a doctor that you had a urinary tract infection?

DBUTI **DBUTIDK**
 times Don't know

- 61.** Many people complain that they accidentally leak urine. In the past 7 days, did you leak even a small amount of urine?
- Yes No Don't know Refused **DBUHLK**

During the past 7 days, how many times did you leak urine...

a. With an activity like coughing, lifting, or exercise? **DBUHLKA** **DBUHLKAD**
 times in the past 7 days Don't know

b. With a physical sense of urgency? **DBUHLKB** **DBUHLKBD**
You may have felt that you were unable to make it to the bathroom in time. times in the past 7 days Don't know

c. Unrelated to an activity or urge to urinate? **DBUHLKC** **DBUHLKCD**
 times in the past 7 days Don't know

DBLINK



62. In the past 12 months, did you leak even a small amount of urine?

- ① Yes
 - ② No
 - ③ Don't know
 - ④ Refused
- DBU12LK**

a. In the past 12 months, how often have you leaked urine?
(Interviewer Note: Read response options. OPTIONAL - Show card #8.)

- ① Less than once per month
- ② One or more times per month
- ③ One or more times per week **DBULKFRQ**
- ④ Every day
- ⑤ Don't know

b. When did you usually leak urine?
(Interviewer Note: Read response options. OPTIONAL - Show card #9. Mark only ONE answer.)

- ① With an activity like coughing, lifting, or exercise
- ② When you have the urge to urinate and can't get to a toilet fast enough **DBULKOCC**
- ③ You leak urine unrelated to an activity or urge
- ④ Don't know



**MARITAL STATUS
AND HOUSEHOLD OCCUPANCY**

63. What is your marital status? Are you...?
(Interviewer Note: Read response options.)

- ① Married
- ② Widowed
- ③ Divorced
- ④ Separated
- ⑤ Never married
- ⑧ Don't know
- ⑦ Refused

DBMARSTA

64. Beside yourself, how many other people live in your household?
(Interviewer Note: If no other people live in the household, record "00" and go to Question # 66.)

DBSSOPIH

--	--

other people in household ① Refused

DBSSOPRF

65. Who else lives in your household?
(Interviewer Note: Fill in the number of people in each applicable category. It is not necessary to write in "00" if the category does not apply.)

DBSSPOUS

--	--

 Spouse

DBSSGRCH

--	--

 Grandchildren

DBSSPARE

--	--

 Parents

DBSSOTRL

--	--

 Other relatives

DBSSIBL

--	--

 Siblings

DBSSFRND

--	--

 Friends

DBSSCHIL

--	--

 Children/Children-in-law

DBSSNONR

--	--

 Other non-relatives

DBSSHREF

① Refused



FEELINGS IN THE PAST WEEK

66. 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; Don't know; Most or All of the time. *(Interviewer Note: REQUIRED - Show card #10.)*

	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.	①	②	③	④	⑧	⑦
b. I did not feel like eating: my appetite was poor.	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.	①	②	③	④	⑧	⑦
d. I felt that I was just as good as other people.	①	②	③	④	⑧	⑦
e. I had trouble keeping my mind on what I was doing.	①	②	③	④	⑧	⑦
f. I was depressed.	①	②	③	④	⑧	⑦
g. I felt that everything I did was an effort.	①	②	③	④	⑧	⑦
h. I felt hopeful about the future.	①	②	③	④	⑧	⑦
i. I thought my life had been a failure.	①	②	③	④	⑧	⑦
j. I felt fearful.	①	②	③	④	⑧	⑦
k. My sleep was restless.	①	②	③	④	⑧	⑦
l. I was happy.	①	②	③	④	⑧	⑦
m. It seemed that I talked less than usual.	①	②	③	④	⑧	⑦
n. I felt lonely.	①	②	③	④	⑧	⑦
o. People were unfriendly.	①	②	③	④	⑧	⑦
p. I enjoyed life.	①	②	③	④	⑧	⑦
q. I had crying spells.	①	②	③	④	⑧	⑦
r. I felt sad.	①	②	③	④	⑧	⑦
s. I felt that people disliked me.	①	②	③	④	⑧	⑦
t. I could not get going.	①	②	③	④	⑧	⑦



67. 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 **DBLEACC**

68. Did a child, grandchild, close friend, or relative die in the past 12 months?
(Interviewer Note: The death of a spouse or partner should only be recorded in the next question, Question #69.)

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

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

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

↓ ↓ ↓
Go to Question #73



70. Please tell me which best describes how you feel right now.
(Interviewer Note: **REQUIRED - Show card #11.**)

	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. DBLETHNK	①	①	②	③	④	⑦
b. Memories of the person who died upset me. DBLEMEM	①	①	②	③	④	⑦
c. I feel I cannot accept the death of the person who died. DBLEACPT	①	①	②	③	④	⑦
d. I feel myself longing for the person who died. DBLELONG	①	①	②	③	④	⑦
e. I feel drawn to places and things associated with the person who died. DBLEDRWN	○	○	○	○	○	○
f. I can't help feeling angry about his/her death. DBLEANGR	○	○	○	○	○	○
g. I feel disbelief over what happened. DBLEDISB	○	○	○	○	○	○
h. I feel stunned or dazed over what happened. DBLEDAZE	○	○	○	○	○	○
i. Ever since s/he died it is hard for me to trust people. DBLETRST	○	○	○	○	○	○
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. DBLEDIST	○	○	○	○	○	○
k. I have pain in the same area of my body or have some of the same symptoms as the person who died. DBLEPAIN	○	○	○	○	○	○
l. I go out of my way to avoid reminders of the person who died. DBLEAVD	○	○	○	○	○	○
m. I feel that life is empty without the person who died. DBLEEMPT	○	○	○	○	○	○
n. I hear the voice of the person who died speak to me. DBLESPK	○	○	○	○	○	○
o. I see the person who died stand before me. DBLESTND	○	○	○	○	○	○
p. I feel that it is unfair that I should live when this person died. DBLELIVE	○	○	○	○	○	○
q. I feel bitter over this person's death. DBLEBITR	○	○	○	○	○	○
r. I feel envious of others who have not lost someone close. DBLEENV	○	○	○	○	○	○
s. I feel lonely a great deal of the time ever since s/he died. DBLELONE	○	○	○	○	○	○



71. 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 #12.)*

DBSSHAPY ⑧ Don't know ⑦ Refused **DBSSHADR**

72. 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 #13.)*

DBSSMEAN ⑧ Don't know ⑦ Refused **DBSFMDR**

73. 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 #13.)*

DBSSFFST ⑧ Don't know ⑦ Refused **DBSSFFDR**

74. 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 #13.)*

DBSSFFH ⑧ Don't know ⑦ Refused **DBSFHDR**

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

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

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

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

DBSSEAM

76. 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?

DBSSCAN ① Agree ② Disagree ⑧ Don't know ⑦ Refused

Would you say you agree strongly or agree somewhat?

① Agree strongly
② Agree somewhat
⑧ Don't know

DBSSCANA

Would you say you disagree strongly or disagree somewhat?

① Disagree strongly
② Disagree somewhat
⑧ Don't know

DBSSCAND

77. 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?

DBSSOFH ① Agree ② Disagree ⑧ Don't know ⑦ Refused

Would you say you agree strongly or agree somewhat?

① Agree strongly
② Agree somewhat
⑧ Don't know

DBSSDFHA

Would you say you disagree strongly or disagree somewhat?

① Disagree strongly
② Disagree somewhat
⑧ Don't know

DBSSDFHD



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

Please tell me if the information I have is still correct.
 Is the address that we currently have correct?

Yes No **DBADDYN**

Interviewer Note: ONLY record updated address. If current address has not changed, do NOT record anything in the space below.

DBFNAME

First Name

DBLNAME

Last Name

DBSTREET

Street Address

DBAPT

Apt/Room

DBSTATE

DBCITY

City

State

DBZIP -

Zip Code

79a. The telephone number(s) that we currently have for you is (are):
(Interviewer Note: Please read telephone number(s) from the Data from Prior Visits Report.)

Please tell me if these telephone number(s) are correct.
 Are the telephone number(s) that we currently have correct?

DBTELYN Yes No

Interviewer Note: ONLY record updated telephone numbers. If current telephone numbers have NOT changed, do NOT record anything in the space below.

Home Telephone #: () **DBPHONE**

Area Code

Number

Work Telephone #: () **DBWKPHONE**

Area Code

Number

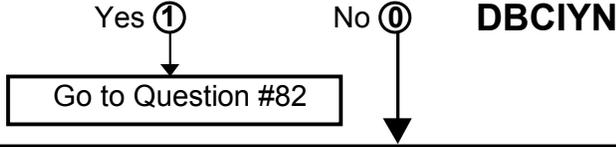


CONTACT INFORMATION

81. 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 to the Data from Prior Visits Report. Ideally, this contact should be a relative who lives with the participant.)

Is the contact information for someone who could provide information and answer questions for the participant correct?



Interviewer Note: Only record updated contact information. If contact information has not changed, do NOT record anything in the space below.

a. **DBCIFNAM**

First Name

DBCILNAM

Last Name

DBCISTRT

Street Address

DBCIAPT

Apt/Room

DBCISTAT

DBCICITY

City

State

DBCIZIP -

Zip Code

Telephone:

() **DBCITELE**

Area Code

Number

b. 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 **DBCIREL**
- ③ My niece or nephew ⑦ Friend/neighbor
- ④ My grandchild ⑧ Someone else *(Please say how related:)*

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

- ① Yes ② No ③ Don't know ④ Refused

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

- ① Yes ② No ③ Don't know ④ Refused

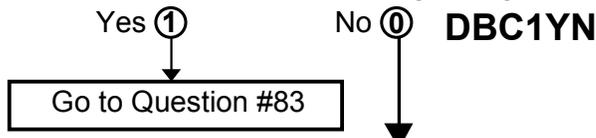


CONTACT INFORMATION

82. 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 the Data from Prior Visits Report. Ideally, these contacts should not live with the participant.)

Is the contact information for the two close friends or relatives who do not live with the participant and who would know how to reach the participant in case they move correct?



(Interviewer Note: Only record updated contact information. If contact information has not changed, do NOT record anything in the space below.)

Contact #1

a.

DBC1FNAM

First Name

DBC1LNAM

Last Name

DBC1STRT

Street Address

DBC1APT

Apt/Room

DBC1STAT

DBC1CITY

City

State

DBC1ZIP -

Zip Code

Telephone:

() **DBC1PHON**

Area Code

Number

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 **DBC1REL**
- ③** My grandchild **⑦** Someone else *(Please say how related:)*
- ④** My brother or sister

c. Is this person your next of kin? **DBC1NOK**

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

d. Have you given this person power of attorney? **DBC1POA**

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

Draft



CONTACT INFORMATION

(Interviewer Note: Only record updated contact information. If contact information has not changed, do NOT record anything in the space below.)

Contact #2

e.

DBC2FNAM

First Name

DBC2LNAM

Last Name

DBC2STRT

Street Address

DBC2APT

Apt/Room

DBC2STAT

DBC2CITY

City

State

DBC2ZIP -

Zip Code

Telephone:

() **DBC2PHONE**

Area Code

Number

f. 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

DBC2REL

③ My grandchild

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

④ My brother or sister

g. Is this person your next of kin?

DBC2NOK

① Yes

② No

③ Don't know

④ Refused

h. Have you given this person power of attorney?

DBC2POA

① Yes

② No

③ Don't know

④ Refused

Draft



84. Please tell me the name, address and phone number of your next of kin.

DBK2FNAM																											
First Name																											
DBK2LNAM																											
Last Name																											
DBK2STRT																											
Street Address																											
DBK2APT																											
Apt/Room										DBK2STAT																	
DBK2CITY																											
City																				State							
DBK2ZIP					-																						
Zip Code																											
Telephone:																											
()			DBK2PHON																		
Area Code									Number																		
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										DBK2REL							
③ My niece or nephew										⑦ Friend/neighbor																	
④ My grandchild										⑧ Someone else <i>(Please say how related:)</i>																	



CONTACT INFORMATION

86. Have you given anyone power of attorney?

- Yes
 No
 Don't know
 Refused
 DBP2YN

Please tell me the name, address, and phone number of this person.

DBP2FNAM

First Name

DBP2LNAM

Last Name

DBP2STRT

Street Address

DBP2APT

Apt/Room

DBP2STAT

DBP2CITY

City

State

DBP2ZIP -

Zip Code

Telephone:

() **DBP2PHON**

Area Code

Number

How is this person related to you?

- My husband or wife
 My brother or sister
 My son or daughter
 My mother or father
 DBP2REL
 My niece or nephew
 Friend/neighbor
 My grandchild
 Someone else (Please say how related:)



87. Interviewer Note: Please answer the following question based on your judgment 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

DBRELY



HABC Enrollment ID #	Acrostic	Date Form Completed	Staff ID #
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D1ID	D1ACROS	Month Day DATE Year	D1STFID

YEAR 4 CLINIC VISIT WORKBOOK

D1TIME1 :
 Arrival Time: Hours Minutes

D1TIME2 :
 Departure Time: Hours Minutes

YEAR 4 CLINIC VISIT PROCEDURE CHECKLIST

Measurement	Page #	Yes: Measurement fully completed	Yes: Measurement partially completed	No: Participant refused	No: Other reason	Comments
1. Was the Year 4 questionnaire administered?		①	③	④	② D1Y4ADM	
2. Standing height	2	①	③	④	② D1SH	
3. Weight	2	①	③	④	② D1WT	
4. Blood pressure	3	①	③	④	② D1BP	
5. Ankle-arm blood pressure	4	①	③	④	② D1AAP	
6. ECG	5	①	③	④	② D1ECG	
7. Leg symptoms	6	①	③	④	② D1LSX	
8. Vibration perception threshold	9	①	③	④	② D1VPT	
9. Peroneal motor nerve conduction	12	①	③	④	② D1PMNC	
10. Monofilament testing	15	①	③	④	② D1MT	
11. Bone density (DXA) scan	16	①	③	④	② D1DXA	
12. Isokinetic strength (Kin-Com)	18	①	③	④	② D1ISO	
13. Grip strength	22	①	③	④	② D1GRIP	
14. Chair stands	24	①	③	④	② D1CH	
15. Standing balance	25	①	③	④	② D1SB	
16. Balance walks	27	①	③	④	② D1BAL	
17. 20-meter walk	28	①	③	④	② D120M	
18. Long distance corridor walk	29	①	③	④	② D1LD	
19. Knee X-ray eligibility assessment	37	①	③	④	② D1XRAY	
20. Phlebotomy	38	①	③	④	② D1PHL	
21. Laboratory processing	41	①	③	④	② D1LAB	
22. Was the Weight Change Substudy Eligibility Assessment form completed?		① Yes	④ No	D1WTCHG1		
23. Was the Weight Change Substudy Workbook completed?		① Yes: Fully completed	③ Yes: Partially completed	④ No: Participant refused	② No: Not applicable	D1WTCHG2
24. Was the Flu Substudy Workbook completed?		① Yes: Fully completed	③ Yes: Partially completed	④ No: Participant refused	② No: Not applicable	D1FLU
25. Did participant agree to schedule a knee x-ray?		① Yes	④ No	⑤ Not applicable	⑨ Not eligible	D1KNXR

Memphis Only:

Would you like us to send a copy of your test results to your doctor? ① Yes ④ No

D1DOC

Draft



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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"/>
D2ID	D2ACROS	Month	Day	Year
				2 0 0 <input type="text"/>
				D2DATE

STANDING HEIGHT

① Measurement 1 **D2SH1** mm

② Measurement 2 **D2SH2** mm

③ Difference between Measurement 1 & Measurement 2 **D2SHD** mm

④ Is the difference between Measurement 1 and Measurement 2 greater than or equal to 4 mm?

① Yes ② No **D2SHDF4**

Go to Question #7.

⑤ Measurement 3 **D2SH3** mm

⑥ Measurement 4 **D2SH4** mm

⑦ Is participant standing sideways due to kyphosis?

(Examiner Note: Refer to Data from Prior Visits Report. Use the same position that was used at the baseline [Year 1] clinic visit.)

① Yes ② No **D2KYP**

D2STFID
Staff ID#:

WEIGHT

WEIGHT

D2WTK . kg

D2STFID2
Staff ID#

D2LINK



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"/> <input type="text"/>

D2STFID3

BLOOD PRESSURE

BLOOD PRESSURE

① Cuff Size ④ Small ① Regular ② Large ③ Thigh **D2OCUF**

② Arm Used **D2ARMRL** ① Right ② Left →
(Examiner Note: Refer to Data from Prior Visits Report.)

Please explain why right arm was not used:

Pulse Obliteration Level

③ Palpated Systolic **D2POPS** mmHg

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

Add 30*

④ Maximal Inflation Level (MIL) **D2POMX** † mmHg

† **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?
 ① Yes ① No **D2BPYN**

Sitting Blood Pressure

⑥ Systolic **D2SYS** mmHg

Comments (required for missing or unusual values):

⑦ Diastolic **D2DIA** mmHg

Standing Blood Pressure

⑧ Systolic **D2SY2** mmHg

Examiner Note:

a) Perform Standing Blood Pressure after participant has been standing for one minute.

⑨ Diastolic **D2DIA2** mmHg

b) Record these measurements on Long Distance Corridor Walk Eligibility Assessment Form (page 29, Question #3).



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ANKLE-ARM BLOOD PRESSURE

D2STFD4

D2AACF

- 1 Cuff Size 4 Small 1 Regular 2 Large 3 Thigh

D2AARL

- 2 Arm Used 1 Right 2 Left →
(Examiner Note: Refer to Data from Prior Visits Report.)

Please explain why right arm was not used:

- 3 Doppler Systolic **D2AADOP** mmHg

Add 30*

**Add +30 to Doppler Systolic measurement to obtain Maximal Inflation Level.*

- 4 Maximal Inflation Level **D2AAMX** mmHg

Systolic Measurement #1:

Systolic Measurement #2:

- 5 Brachial (arm) **D2AARB1** mmHg

- 8 Left Posterior Tibial **D2AALP2** mmHg

- 6 Right Posterior Tibial **D2AARP1** mmHg

- 9 Right Posterior Tibial **D2AARP2** mmHg

- 7 Left Posterior Tibial **D2AALP1** mmHg

- 10 Brachial (arm) **D2AARB2** mmHg

- 11 Was ankle-arm blood pressure measurement completed successfully?

- 1 Yes 0 No **D2AAPR**

Why wasn't the procedure completed? (Examiner Note: Mark all that apply.)

Left Leg

Right Leg

- 1 Unable to occlude **D2AALLUO**
- 1 Ulceration **D2AALLUL**
- 1 Amputation **D2AALLAM**
- 1 Unable to locate tibial artery **D2AALLTA**
- 1 Too painful **D2AALLTP**
- 1 Unable to lie in supine position **D2AALLSP**
- 1 Participant refused **D2AALLPR**
- 1 Other **D2AALLOT**
(Please specify: _____)

- 1 Unable to occlude **D2AARLUO**
- 1 Ulceration **D2AARLUL**
- 1 Amputation **D2AARLAM**
- 1 Unable to locate tibial artery **D2AARLTA**
- 1 Too painful **D2AARLTP**
- 1 Unable to lie in supine position **D2AARLSP**
- 1 Participant refused **D2AARLPR**
- 1 Other **D2AARLOT**
(Please specify: _____)



HABC Enrollment ID #	Acrostic	Staff ID #
H		

D2STFID5

ECG

1 Was an ECG obtained? 1 Yes 1 No D2OBT

Why wasn't an ECG obtained? (Examiner Note: Mark all that apply. Go to next test.)

- D2EFAIL 1 Equipment failure
- D2INSTR 1 Participant unable to understand instructions
- D2COOP 1 Participant unable to physically cooperate
- D2ECGPR 1 Participant refused
- D2ECGOT 1 Other

(Please specify:

 _____)

2 Was a hard copy of the ECG with no interpretation printed before the participant left?

1 Yes 1 No D2NOINT

3 Was a hard copy of the ECG with interpretation printed before the participant left?

1 Yes 1 No D2WINT

4 Was there any protocol deviation(s)?

1 Yes 1 No D2PRODV

Please describe:



Empty box for page link number

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D2STFID6

**PERIPHERAL NEUROPATHY:
LEG CRAMPS AND NEUROLOGIC SYMPTOMS**

LEG CRAMPS

- 1** In the past 12 months, have you had muscle cramps in your legs or feet?
 Yes No Don't know Refused **D2LC12LF**

Go to Question #10.

- 2** How often do you get them?
(Examiner Note: Read response options. Mark only ONE answer.)

- D2LCOFT**
- Less than once a month
 - At least once a month
 - At least once a week
 - Every day
 - Don't know
 - Refused

- 3** Where are the cramps the most severe. . . in your thigh or upper leg, calf or lower leg, feet, toes, or some other place?
(Examiner Note: Read response options. Mark only ONE answer.)

- D2LCSEV**
- Thigh/Upper leg
 - Calf/Lower leg
 - Feet/Toes
 - Other *(Please specify: _____)*
 - Don't know
 - Refused

- 4** Do you usually get cramps in both legs or feet?
D2LCBOTH Yes No Don't know Refused

- 5** Do the cramps usually occur during the day or at night?
(Examiner Note: Read response options. Mark only ONE answer.)

- D2LCDN**
- During the day
 - At night/in the evening
 - Don't know
 - Refused



6 Do the cramps usually occur when you are...?
(Examiner Note: Read response options. Mark only ONE answer.)

- D2LCOCR
- 1 Sitting
 - 2 Sleeping or lying still
 - 3 Standing
 - 4 Walking
 - 8 Don't know
 - 7 Refused

7 Do the cramps usually get worse at night?
D2LCWNGT 1 Yes 0 No 8 Don't know 7 Refused

8 Do the cramps usually get worse when you walk?
D2LCWWLK 1 Yes 0 No 8 Don't know 7 Refused

Go to Question #10.

9 Do the cramps usually get better when you walk?
D2LCBWLK 1 Yes 0 No 8 Don't know 7 Refused

RESTLESS LEGS

10 In the past 12 months, have you had any of the following, while sitting or lying down?

- D2RLURGE **a.** A repeated urge to move your legs? 1 Yes 0 No 8 Don't know 7 Refused
- D2RLFL **b.** Strange or uncomfortable feelings in your legs? 1 Yes 0 No 8 Don't know 7 Refused
- D2RLJKS **c.** Several leg jerks or jumps in a row? 1 Yes 0 No 8 Don't know 7 Refused

Examiner Note:

d. Did the participant answer "Yes" to any of the feelings described above?
D2RLYN 1 Yes 0 No

Go to Question #15.

11 Which of these feelings bothers you the most?
(Examiner Note: If participant had only one of the feelings described above, mark that one feeling below. Read response options. Mark only ONE answer.)

- 1 A repeated urge to move your legs
- D2RLMST 2 Strange or uncomfortable feelings in your legs
- 3 Several leg jerks or jumps in a row



Now I am going to ask you three questions about these feelings.

(Examiner Note: For the following three questions, ask the participant about the most bothersome feelings that are noted in Question #11. Read response options. Mark only ONE answer.)

- 12** How often do you get these feelings?
- 1 Less than once a month
- 2 At least once a month
- D2RLOFT** 4 At least once a week
- 6 Every day
- 8 Don't know
- 7 Refused

- 13** Do these feelings get better when you start walking?
- D2RLBWLK** 1 Yes 0 No 8 Don't know 7 Refused

- 14** Do these feelings get worse at night?
- D2RLWNGT** 1 Yes 0 No 8 Don't know 7 Refused

NEUROPATHY

- 15** In the past 12 months, have you ever had numbness, an "asleep feeling," a prickly feeling or tingling in your legs or feet?
- D2PNMB** 1 Yes 0 No 8 Don't know 7 Refused

- 16** In the past 12 months, have you ever had a sudden stabbing or burning pain, or a deep aching in your legs or feet?
- D2PNPAIN** 1 Yes 0 No 8 Don't know 7 Refused

- 17** In the past 12 months, have you had an open or persistent sore, or gangrene on either of your feet or legs?
- D2PNSORE** 1 Yes 0 No 8 Don't know 7 Refused

Examiner Note: Look at the participant's feet and legs and answer the following question.

- 18** Are open sores present on either foot?
- D2PNFT** 1 Yes 0 No 3 Participant not examined



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D2STFD7

PERIPHERAL NEUROPATHY: VIBRATION PERCEPTION THRESHOLD

- 19** Record surface temperature of the dorsum (top) of the right foot using the surface thermistor. Warm the foot to at least 30°C if initial surface temperature is below that level. If the right foot cannot be tested because of ulcer, trauma, surgery, or amputation, record the temperature of the left foot.

Script: "I need to make sure that your foot is warm enough to do this next test. I'm going to measure the temperature of your foot before we start."

Measure the participant's skin temperature on the dorsum of the foot.

Initial foot temperature: °C

If initial foot temperature is below 30°C, use heating pad to achieve at least 30°C.

Place the stimulating rod on a table so the participant can touch the vibrating rod with their hand.

Script: "Now we will do a practice test so you can see what this test feels like. Most people say it feels like a vibration or buzzing sensation."

Place the participant's hand on the rod and allow them to feel the vibration.

Record foot temperature following heating and proceed with testing. If, after 5 minutes of warming, foot temperature does not reach 30°C, record temperature below and proceed with testing.

Foot temperature following heating: °C *Leave blank if participant's initial foot temperature was at least 30°C.*

- 20** Have the participant clean their big toe with an alcohol pad. Place the paper foot guard on the platform, **being careful not to cover the vibrating rod in the hole.** Describe the test to the participant, and allow them to become familiar with the equipment.

Script: "This test measures your ability to feel very small vibrations in your feet. To do this, I'm going to ask you to place your foot on this machine, with your big toe on the rod that will vibrate (point to surface). It won't hurt at all. Let's start by getting used to how the vibration feels, and how to use the button."

"This white rod will vibrate. Place your big toe on the foam over the hole so it is flat with the surface of the platform. You don't need to press your toe down at all. Just lay your toe flat over the hole."

Help the participant place their foot and toe on the device. Place a bean bag over the top of the foot to ensure consistent contact with the vibrating rod.

Script: "Now we will do a practice test. When you feel the vibration, tell me right away. Just try to pay attention to your toe, and tell me when you feel the vibration. It may take some time, so don't become discouraged. Please say 'I feel it' as soon as you do, but please don't guess."

The participant should be seated so they cannot see the computer screen.

Script: "Please close your eyes. I am beginning the first test. Tell me as soon as you feel the vibration."

Click the "Start" button.

When the participant says "I feel it," press the space bar for "stop immediately." Record the "Stop" number from the computer screen.

Draft



PERIPHERAL NEUROPATHY: VIBRATION PERCEPTION THRESHOLD

21 "Stop" number on the computer screen: D2VPSTP microns

(Examiner Note: If the number is less than "20," go to Question #23 and record "0" for the Baseline value. If the number is 130 [maximum value] go to Question # 23 and record "90" for the Baseline value.)

Subtract 20.0 microns

22 "Stop" number minus 20: D2VPS10 microns

Round this number down to the nearest multiple of 10.

(Analyst note: protocol change between version 1.0 and version 1.1.)

23 Baseline value for the test: D2VPBV microns
(0,10, 20, 30, 40, etc.)

Script: "Now we'll begin the next test. The vibration will start very softly and get stronger. As soon as you feel the vibration, push the button to indicate that you have felt the vibration. **(Show the mouse and indicate how to push the button.)** We will do this several times in a row. After you press the button, there will be a delay before the next vibration starts. Each time you feel the vibration, just press the button right away to indicate that you have felt the vibration. The vibration will stop immediately. Over the next few minutes, you may feel the vibration several times. Just try to pay attention to your toe, and each time you feel the vibration, push the button. Remember that we want to know when you first begin to feel it. If you don't feel it we don't want you to guess. Again, please close your eyes before we begin the test. Ready?"

Administer the test.

24 Which great toe was tested?

D2VPTOE

① Right

② Left

③ Neither

Why wasn't the right toe tested?

- ① Amputation
- ② Ulcer
- ③ Trauma or surgery
- ④ Other *(Please specify: _____)*

D2VPRTOE

Why wasn't the test done?
(Examiner Note: Mark all that apply.)

- D2VPRF** ① Participant refused
- D2VPPNC** ① Participant physically unable to cooperate
- D2VPNDIR** ① Participant unable to follow directions
- D2VPAMP** ① Amputation of both great toes
- D2VPOTH** ① Other *(Please specify: _____)*

Go to Peroneal Motor Nerve Conduction Test.

25 Record the post-test surface temperature of the great toe using the surface thermistor.

Foot temperature after test: . °C

D2VPFTT

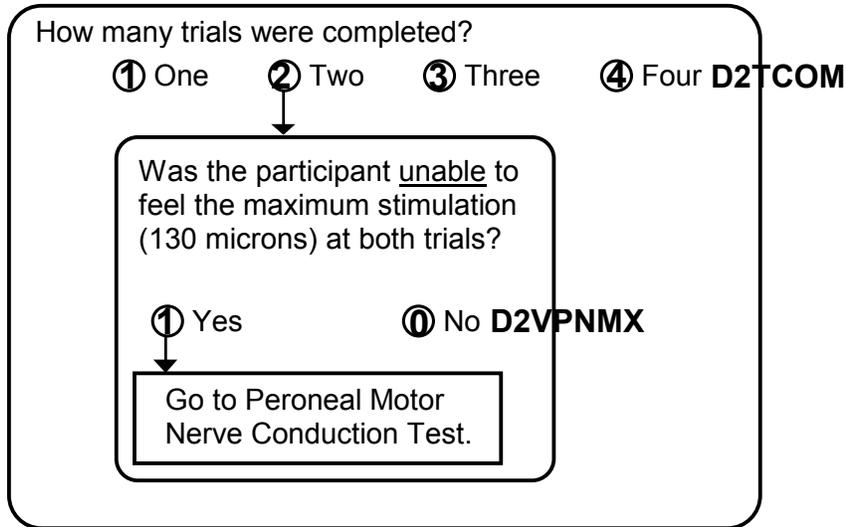
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26 Were five trials completed?

① Yes

① No **D25TCOM**



27 Record average result from computer screen:

	D2VPAV		.			microns
--	---------------	--	---	--	--	---------

28 Record variance from computer screen:

	D2VPVAR		.			microns
--	----------------	--	---	--	--	---------

(more boxes than in version 1.0)

If over 1000 microns, flag for quality control.



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D2STFID8

**PERIPHERAL NEUROPATHY:
PERONEAL MOTOR NERVE CONDUCTION**

1 Describe nerve conduction testing to the participant and conduct a mock test on the ankle.

Script: "This test measures how well a sensation travels down a big nerve in your leg. To do this, I will place small patches on your foot. Then I will use this tool (**show stimulator**) to stimulate your nerve. This test is not painful, but most people say that it feels uncomfortable for just a moment, like when you bump your funny bone. Your foot or leg may twitch during the test. If you want to stop the test at anytime, just say so. Before we begin, let's do a practice test so you can see what it feels like."

2 Conduct practice test at ankle.

Record the surface temperature on the dorsum of the right foot using the surface thermistor. If the right foot cannot be tested, record the temperature of the left foot.

Warm the limb to at least 30°C if initial temperature is below that level.

Script: "Before we begin, I need to check the temperature of your foot. If it isn't warm enough we'll warm it in a heating pad."

Initial foot temperature: . **D2PNIFT** °C

If the foot temperature is below 30°C, warm the foot and record the temperature again. If, after 5 minutes of warming, the foot does not reach 30°C, record the temperature and proceed with testing.

Foot temperature following heating: **D2PNFTH** °C *Leave blank if participant's initial foot temperature was at least 30°C.*

3 Before beginning testing of the peroneal nerve, say,

Script: "Now I'm going to start the test on your nerve."

4 Begin testing of the peroneal nerve. Data on maximum responses will be recorded in the computer and downloaded later.

5 Conclude the test when maximum responses have been evoked.

6 Was the peroneal motor nerve conduction test started?

1 Yes

0 No **D2PNTS**

Why wasn't test started?
(*Examiner Note: Mark all that apply.*)

D2PNPRF **1** Participant refused before the test began

D2PNAMP **1** Amputation of both legs

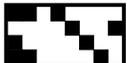
D2PNBKR **1** Bilateral knee replacements ←

D2PNOTH **1** Other (*Please specify:* _____)

version 1.0 did not include this response option

Go to Monofilament Testing.

Draft



7 Which leg was tested? ① Right ② Left **D2PNLRL**

D2PNNRL

Why wasn't the right leg tested?

- ① Amputation
- ② Ulcer
- ③ Trauma or surgery (including knee replacement)
- ④ Other (*Please specify:*

_____)

8 Was distal stimulation completed?

① Yes

② No

D2PNDS

a. What was the amplitude?

D2DSAMP mV

b. Was the amplitude greater than 1 mV?

① Yes ② No **D2DSAMP1**

Flag waveform for
quality control.

Why wasn't the distal stimulation completed?

D2NDS

- ⑦ Participant refused
- ⑨ Other (*Please specify:*

_____)

9 Was fibular head stimulation completed?

① Yes

② No

D2PNFHS

a. What was the amplitude?

D2FHAMP mV

b. Was the amplitude greater than 1 mV?

① Yes ② No **D2FHAMP1**

Flag waveform for
quality control.

Why wasn't the fibular head stimulation completed?

D2NFHS

- ⑦ Participant refused
- ⑨ Other (*Please specify:*

_____)

10 What was the conduction velocity between the ankle and fibular head?

D2CVAFH m/s

① Conduction velocity not obtained **D2CV1**

(more boxes than in version 1.0)

If less than 20 m/s or greater than 70 m/s, flag for quality control.

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D2STFID9

PERIPHERAL NEUROPATHY: MONOFILAMENT TESTING

1 Script: "This test is to see if you can feel a light touch on your toe. We press this flexible nylon thread (**show monofilament**) against your toe to see if you can feel it. It does not hurt, but it might tickle a little when you feel it. (**Demonstrate on participant's arm.**) I'm going to touch the thread to your toe several times, and you just need to tell me if and when you feel the thread. Please close your eyes. I'm going to start the test."

2 Test using the 4.17 monofilament on the dorsum of the right great toe 1 cm proximal to the nail bed. Apply the monofilament four times.

Script: "Tell me each time you feel the thread."

If the participant detects the 4.17 monofilament at least three of four times, do not continue testing with the 5.07 monofilament. If the participant does not detect the 4.17 monofilament, test with the 5.07 monofilament in the same way (four trials).

3 Which great toe was tested?

1 Right

2 Left

3 Test not done **D2MTTOE**

(Analyst note: protocol change between version 1.0 and version 1.1.)

Why wasn't the participant tested?
(**Examiner Note: Mark all that apply. Go to next test.**)

D2MTPRF **1** Participant refused

D2MTAMP **1** Amputation of both great toes

D2MTOH **1** Other (**Please specify:**

_____)

4 Was the participant able to detect light touch with the 4.17 monofilament at least three of four times?

D2MT2XS **1** Yes

0 No

7 Participant refused

Do not test using 5.07 monofilament.
Go to next test.

5 Test using the 5.07 monofilament on the dorsum of the the right great toe 1 cm proximal to the nail bed. Apply the monofilament four times.

Script: "Now we're going to try a different thread. Please close your eyes again, and tell me each time you feel this thread."

6 Was the participant able to detect light touch with the 5.07 monofilament at least three of four times?

D2MT5XS **1** Yes

0 No

7 Participant refused

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D2SFID10

BONE DENSITY (DXA) SCAN

- 1 Do you have breast implants?
 1 Yes 0 No 8 Don't know 7 Refused **D2BI**

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.?
 1 Yes 0 No 8 Don't know 7 Refused **D2MO**

- 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 D2HEAD
Left arm	1	2 D2LA
Right arm	1	2 D2RA
Left ribs	1	2 D2LR
Right ribs	1	2 D2RR
Thoracic spine	1	2 D2TS
Lumbar spine	1	2 D2LS
Pelvis	1	2 D2PEL
Left leg	1	2 D2LL
Right leg	1	2 D2RL



BONE DENSITY (DXA) SCAN

3 Have you had any of the following tests within the past ten days?

- | | Yes | No |
|--|-----|----------|
| a. Barium enema | ① * | ① D2BE |
| b. Upper GI X-ray series | ① * | ① D2UGI |
| c. Lower GI X-ray series | ① * | ① D2LGI |
| d. Nuclear medicine scan | ① * | ① D2NUKE |
| e. Other tests using contrast ("dye") or radioactive materials | ① * | ① D2OTH2 |

(*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 whole body scan obtained?

① Yes ① No D2WB

↓

Last 2 characters of scan ID #: D2SCAN

Date of scan: / / D2SCDTE

Month Day Year



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D3ID	D3ACROS	D3STFID

ISOKINETIC STRENGTH (KIN-COM)

Exclusion Criteria

1 Is the participant's sitting blood pressure greater than 199 mmHg (systolic) or greater than 109 mmHg (diastolic)?

(Examiner Note: Refer to Blood Pressure Form, page 3.)

D3BP2 **1** Yes **0** No **8** Don't know

↓
Do NOT test. Go to Question #11.

2 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?

D3ANEU **1** Yes **0** No **8** Don't know **7** Refused

↓
Do NOT test. Go to Question #11.

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

D3CERHEM **1** Yes **0** No **8** Don't know **7** Refused

↓
Do NOT test. Go to Question #11.

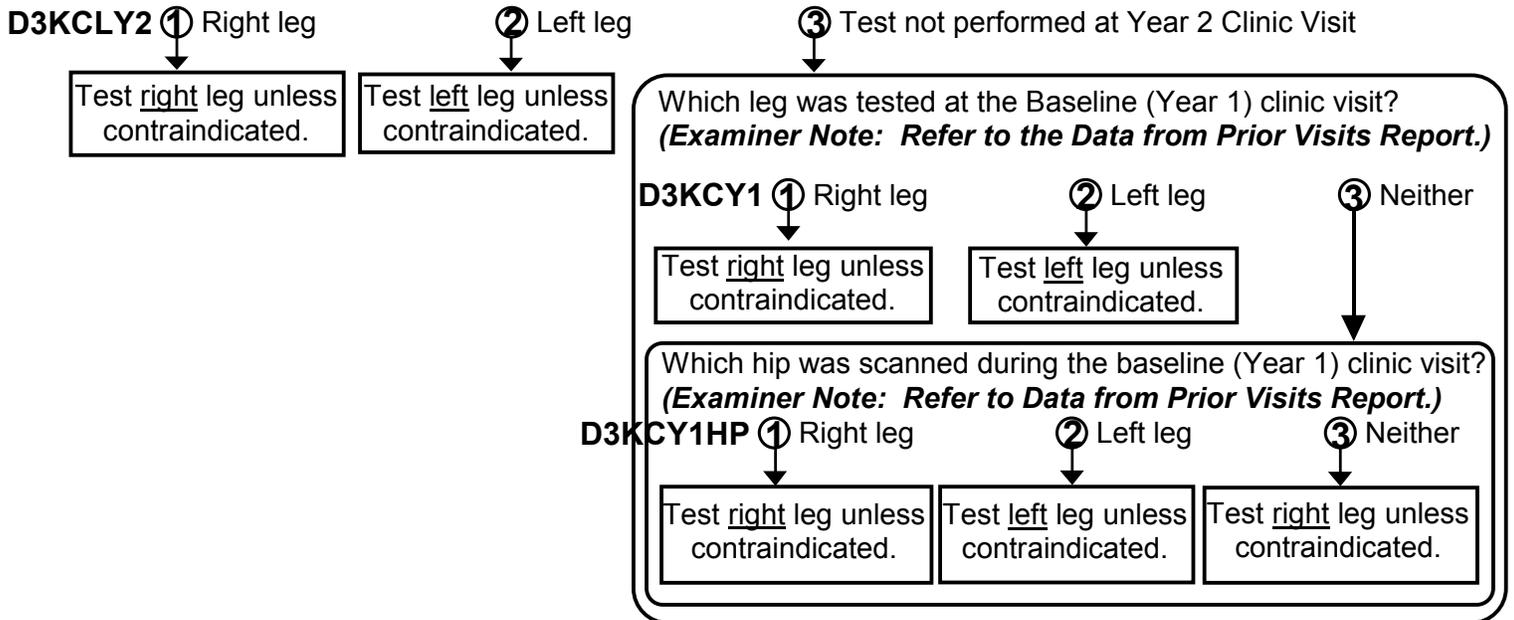
4 Have you ever had knee surgery on either leg where all or part of the joint was replaced?

D3KNRP **1** Yes **0** No **8** Don't know **7** Refused

Which leg?		
D3KRLB1 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 #11.



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



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

D3INYN ① Yes ① No ⑧ Don't know ⑦ Refused

Which leg is stronger?

D3WKR ① Right leg ② Left leg ⑧ Don't know

7 Is it difficult for you to 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 exam can be performed.)

D3KNEE ① Yes ① No ⑧ Don't know ⑦ Refused

Which knee?

D3KRLB2 ① Right knee ② Left knee ③ Both knees



Manual Positioning Settings

10 *Examiner Note: Refer to the Data from Prior Visits Report for dynamometer settings used at the Year 2 clinic visit. Position dynamometer exactly as before, unless a change in leg tested requires a change in settings. Enter Visit 4 settings below.*

- a. Dynamometer tilt **D3DTLT** °
- b. Dynamometer rotation **D3DROT** °
- c. Lever arm green C stop **D3LEVGR**
- d. Lever arm red D stop **D3LEVRD**
- e. Seat rotation **D3STROT** °
- f. Seat back angle **D3STBK** °
- g. Seat bottom depth **D3STBOT** cm
- h. Seat bottom angle **D3STBOTA** °
- i. Lever arm length **D3LENGTH** cm
- j. Maximum isometric effort to determine starting force **D3MAXFC** ÷ **2** = → *Enter as Start Forward Force*

Kin Com Test

11 Which leg was tested?

① Right

② Left

③ Test not done **D3RL3**

1. How many trials were attempted?

D3TRAT
 trials

2. Were three curves accepted?

D3CURV ① Yes ② No

a. Why not?

b. How many curves were accepted?

D3TRAC
 accepted

3. Peak Torque

D3PKTORQ
 Nm

4. Average Torque

D3AVTORQ
 Nm

Why wasn't the test done?

(Examiner Note: Mark all that apply.)

① Participant excluded based on eligibility criteria **D3EEC**

① Participant refused **D3KPRF**

① Other **D3OTEX**
(Please specify:

_____))

Was an extra record accidentally saved?

① Yes ② No **D3EXREC**

How many accepted curves were saved in extra record?

D3CURVS
 curves



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D3STFID2

GRIP STRENGTH (Hand-Held Dynamometry)

Exclusion Criterion:

1 Have you had any surgery on your hands or wrists in the past three months?

D3WRST1 **1** Yes **0** No **8** Don't know **7** Refused

Which hand?		
D3WRTRL 1 Right	2 Left	3 Both right and left
Do NOT test right.	Do NOT test left.	Do NOT test either hand. Go to Questions #4 and #5 and mark "Unable to test/exclusion."

2 Has any pain or arthritis in your right hand gotten worse recently?

D3ARWRSR **1** Yes **0** No **8** Don't know **7** Refused

Will the pain keep you from squeezing as hard as you can?
D3PSQ1 1 Yes 0 No 8 Don't know

3 Has any pain or arthritis in your left hand gotten worse recently?

D3ARWRSL **1** Yes **0** No **8** Don't know **7** Refused

Will the pain keep you from squeezing as hard as you can?
D3PSQ2 1 Yes 0 No 8 Don't know



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D3STFID3

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 D3NOTST

Trial 1 kg ⑦ Refused ⑨ Unable to complete D3RRUC1

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 D3RRUC2

Repeat the procedure on the left side.

5 Left Hand ① Unable to test/exclusion/didn't understand D3LNTST

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

Trial 1 kg ⑦ Refused ⑨ Unable to complete D3LRUC1

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 D3LRUC2



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D3STFID4

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!"

D3SGS	⑦ Participant refused	→	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.

D3RGS	⑦ Participant refused	
	⑨ Not attempted, unable	
	① Attempted, unable to complete 5 stands without using arms	→ D3COMP <input type="text"/> Number completed without using arms
	② Completes 5 stands without using arms	→ <input type="text"/> D3SEC <input type="text"/> Seconds to complete



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STANDING BALANCE

D3STFID5

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.

D3STS

- ⑦ Participant refused → Go to Balance Walks.
- ⑨ Not attempted, unable → Go to Balance Walks.
- ① Unable to attain position or cannot hold for at least one second → STOP Semi-Tandem Stand. Go to Balance Walks.
- ② Holds position between 1 and 29 seconds → D3STSTM 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:

D3TS1

- ⑦ Participant refused → 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 Trial 2.
- ② Holds position between 1 and 29 seconds → D3TSTM seconds. Go to Trial 2.
- ③ Holds position for 30 seconds → Go to One-Leg Stand.

Draft



STANDING BALANCE

TANDEM STAND

Perform a second trial: "Now, let's do the same thing one more time."

Trial 2:

- D3TS2**
- ⑦ Participant refused → 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 →

D3TS2TM

 seconds. Go to One-Leg Stand.
 - 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:

- D3TR1**
- ⑦ Participant refused → Go to Balance Walks.
 - ⑨ Not attempted, unable → Go to Balance Walks.
 - 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 →

D3TR1TM

 seconds. Go to Trial 2.
 - ③ Holds position for 30 seconds → Go to Balance Walks.

Perform a second trial: "Now, let's do the same thing one more time."

Trial 2:

- D3TR2**
- ⑦ Participant refused → Go to Balance Walks.
 - ⑨ Not attempted, unable → Go to Balance Walks.
 - ① Unable to attain position or cannot hold for at least one second → Go to Balance Walks.
 - ② Holds position between 1 and 29 seconds →

D3TR2TM

 seconds. Go to Balance Walks.
 - ③ Holds position for 30 seconds → Go to Balance Walks.

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D3STFID6

BALANCE WALKS

Describe: "This is the balance walk test. First I want you to walk down the hall normally, at a comfortable pace, ignoring the colored lines. For the second walk, I will ask you to walk keeping your feet inside the lines. Each walk will be done at least twice."

USUAL PACE

Demonstrate and say: "Place your feet with your toes behind, but touching the starting line. Wait until I say GO.' Remember, I want you to walk at a comfortable pace ignoring the colored lines."

Examiner Note: Demonstrate and return. "Walk a few steps past the finish line each time. Any questions?"

Test: **Examiner Note: To start the test, drop your arm and say, "Ready, Go."**

Trial 1:
 Time: seconds
 Number of steps: steps

D3UPRU1

⑦ Participant refused →
 ⑨ Not attempted, unable to walk →

Trial 2:
 Time: seconds
 Number of steps: steps

D3UPRU2

⑦ Participant refused →
 ⑨ Not attempted, unable to walk →

20 cm NARROW WALK

Describe: "Now for the second walk, please keep your feet inside the lines. It is important that you do your best to keep your feet inside the lines."

Demonstrate and say: "I'll demonstrate. Keep your feet inside the lines. Be sure to walk a few steps past the finish line. Any questions?"

Test: **Examiner Note: Time as before, but do not count steps. Drop your arm and say, "Ready, GO."**

⑦ Participant refused
D320CNA
 ⑨ Not attempted, unable to walk

Did the participant stay within the lines?

Examiner Note: "Not staying within the lines" is defined as stepping on, or going outside of the colored tape two or more times. Perform up to 3 trials to obtain 2 valid times.

Trial 1: ① Yes → seconds ② No **D320CT1**

Trial 2: ① Yes → seconds ② No **D320CT2**

Trial 3: ① Yes → seconds ② No **D320CT3**

Draft



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20-METER WALK

D3STFD7

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."

Examiner Note: *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 finish 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. You will need to carry the form on a clipboard.

Number of steps for usual-pace 20-meter walk: **D320STP1** steps

- 7** Participant refused
- 9** Not attempted, unable
- 1** Attempted, unable to complete

Record the time it took to do the usual-pace 20-meter walk.

(Examiner Note: Do not record time.)

Time on stop watch: **D320TM1A** : **D320TM1B**
 Min Second Hundreths/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.

Number of steps for fast-pace 20-meter walk: **D320STP2** steps

- 7** Participant refused
- 9** Not attempted, unable
- 1** Attempted, unable to complete

Record the time it took to do the fast-paced 20-meter walk.

(Examiner Note: Do not record time.)

Time on stop watch: **D320TM2A** : **D320TM2B**
 Min Second Hundreths/Sec

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

D3WLK AID **1** Yes **0** No



4 Does the participant use a walking aid, such as a cane?

D3WKAID2 Yes No

Do NOT test. Go to Question #3 on page 34 and Question #7 on page 36.

5 Describe Test

Script: "The next tests assess your physical fitness by having you walk quickly for 2 minutes and after that, having you walk about 1/4 mile at a steady pace."

Exclusion Questions:

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

1. Within the past 3 months, have you had a heart attack?

D3HA Yes →

Do NOT test. Go to Question #3 on page 34 and Question #7 on page 36.

No

2. Within the past 3 months, have you had angioplasty?

D3ANG Yes →

Do NOT test. Go to Question #3 on page 34 and Question #7 on page 36.

No

3. Within the past 3 months, have you had heart surgery?

D3HS Yes →

Do NOT test. Go to Question #3 on page 34 and Question #7 on page 36.

No

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

a. Chest pain

D3CP Yes →

Do 2-minute walk only,
and then go to Question #7
on page 36.

No

b. Angina

D3ANGI Yes →

Do 2-minute walk only,
and then go to Question #7
on page 36.

No



1 Attachment of heart rate monitor:

Script: "This device measures your pulse, or how often your heart beats."

Attach the monitor.

2 Demonstrate and introduce both walks:

Demonstrate how to walk around the cone and describe the 2 minute walk.

Script: "This is a two-part walking test. For the first part I would like you to walk for 2 minutes, trying to cover as much ground as possible at a pace you can maintain. Starting at the line labelled START, walk to the cone at the other end of the hall, go around it and return, go around this cone and keep walking in the same fashion, until 2 minutes are up. When the 2 minutes are up I will tell you to stop. Please stay where you are so that I can record the distance you covered."

3 Give the participant "stop" symptoms and final instructions:

Script: "Please tell me if you feel any chest pain, tightness or pressure in your chest, if you become short of breath or if you feel faint, lightheaded or dizzy, or if you feel knee, hip, calf, or back pain. If you feel any of these symptoms, you may slow down or stop. Do you have any questions?"



2-minute Walk

Accompany participant to stand behind the starting line for the 2 minute walk.

Record the participant's heart rate.

Ready stop watch.

Script: "Now let's start the 2-minute walk. Cover as much ground as possible at a pace you can maintain. Ready, GO."

Start timing with the first footfall over the starting line (participant's foot touches the floor on the first step).

Provide standard encouragement after each lap, and tell participant the time that is remaining.

Script: "Keep up the good work. You are doing well. One and a half minutes to go."

Throughout the test, draw a line through the number on the form that corresponds to each completed lap the participant walks.

If the participant's heart rate exceeds 135 bpm during the 2-minute walk, let the participant rest for 5 minutes. Then restart the test. Cross off the numbers on the 'Trial 2' lap chart if the participant restarts the test. If the heart rate goes above 135 bpm a second time, tell the participant to slow down, but continue walking until 2 minutes are up. If the participant indicates they are not feeling well (i.e., reports other symptoms) discontinue the 2-minute walk. Indicate on the 2-minute walk data collection form that the heart rate exceeded 135 bpm during the 2-minute walk and whether the participant completed the 2-minute walk. If the heart rate exceeds 135 bpm at any time during the 2-minute walk, do not administer the 400-meter walk.

When the stopwatch reads 1:30, tell the participant, "30 seconds remaining."

At 1:50, tell the participant "10 seconds remaining." Approach the participant so that you meet them at the 2:00 stop time. When the stop watch reads 2:00, say, "STOP."

Record heart rate, number of laps and meter mark on form (each meter is marked with tape on the floor.)

Stopping Criteria for 2-Minute Walk: If the participant's heart rate falls below 40 bpm or if they report chest pain, tightness or pressure in the chest, shortness of breath, feeling faint, lightheaded or dizzy, or report knee, hip, calf or back pain, stop the test.

Record why the test was not completed in Question #3 on page 34 and Question #7 on page 36.



400 Meter Walk

Accompany the participant to the starting line for the 400 meter walk.

Record the participant's heart rate.

Describe the 400 meter walk.

Script: "For the second part, you will be walking 10 complete laps around the course, about 1/4 mile. We would like you to walk as quickly as you can, without running, at a pace you can maintain over the 10 laps. After you complete the 10 laps I will tell you to stop, and measure your blood pressure and heart rate."

Script: "Start walking when I say 'GO' and try to complete 10 laps as quickly as you can, without running, at a pace you can maintain. Ready, Go."

Start the stop watch.

Every lap offer standard encouragement, and call out the number of laps completed and the number remaining. Record each lap on form.

Script: "Keep up the good work. You are doing well. Looking good. Well done. Good job."

When the participant completes 400 meters (10 laps, first footfall across the finish line), stop the stop watch.

Record time and heart rate. Restart the stopwatch to time the 2-minute recovery time.

Assess blood pressure. Record on form.

At 2 minutes, record heart rate again. Record on form.

Remove the heart rate monitor. Escort the participant to the next station.

Stopping Criteria for 400 Meter Walk: If the participant's heart rate falls below 40 bpm, or if they report chest pain, tightness or pressure in the chest, shortness of breath, feeling faint, lightheaded or dizzy, or report knee, hip, calf, or back pain, stop the test.

Record why the test was not completed in Question #7, page 36.



① Heart rate: **D3HR2MW** bpm

② a. Cross off as each lap is completed:

1	2	3	4	5	6	7	8
---	---	---	---	---	---	---	---

Trial 1

b. Is heart rate >135 bpm? ① Yes ② No **D3B2PL**

Go to Question #2e.

Examiner Note: Wait 5 minutes and begin the walk again. Cross off the laps on the 'Trial 2' lap chart below.

c. Cross off as each lap is completed:

1	2	3	4	5	6	7	8
---	---	---	---	---	---	---	---

Trial 2

d. Is heart rate >135 bpm? ① Yes ② No **D3PLS2**

Tell the participant to slow down, but continue walking until 2 minutes are up. If the participant indicates they are not feeling well, ie. reports other symptoms, discontinue the 2-minute walk.

e. Number of laps completed: **D32LAP** laps

f. Meter mark: **D32MTR** meters

g. Heart rate at end of 2-minute walk: **D32BPM** bpm

h. Did the heart rate exceed 135 bpm at any time during the 2-minute walk?
(Examiner Note: Refer to Question #2b, #2d, and #2g.)

D32PLS ① Yes ② No

Do NOT do 400-m walk. Go to Question #3 below and Question #7 on page 36.

③ Did the participant complete the 2-minute walk?
D3C2MW ① Yes ② No

(Examiner Note: Mark all that apply.)

- D3PEX** ① Participant excluded based on eligibility criteria
- D3PCP** ① During the test the participant reported chest pain
- D3PSOB** ① During the test the participant reported shortness of breath
- D3PF** ① During the test the participant reported feeling faint
- D3PKP** ① During the test the participant reported knee pain
- D3PHP** ① During the test the participant reported hip pain
- D3PCF** ① During the test the participant reported calf pain
- D3PBP** ① During the test the participant reported back pain

Do NOT do 400-meter walk.
Go to Question #7 on page 36.

- D3PRFOT** ⑦ Participant refused
- ⑨ Other (Please specify: _____)



400-METER WALK

① a. Cross off as each lap is completed:

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

D34LAP

--	--

 laps

c. Did participant complete all 10 laps? ① Yes ② No **D3CLAPS**

How many additional meters did the participant walk after the last full completed lap?
D3ADDMS

--	--

 meters

② Record time at 400 m or at stop: **D34TIMEA.**

--	--

 . **D34TIMEB**

--	--

Min Second Hundreths/Sec

Restart stopwatch

③ Did the heart rate exceed 135 bpm at any time during the 400-m walk?
 ① Yes ② No **D3XCD**

④ Heart rate at 400-m or at stop: **D34BPM**

--	--	--

 bpm

⑤ Blood pressure at 400-m or at stop:

a. Systolic blood pressure: **D34SYS**

--	--	--

 mmHg

b. Diastolic blood pressure: **D34DIA**

--	--	--

 mmHg

⑥ Heart rate 2 minutes after completion of 400-m walk:
D34HR

--	--	--

 bpm



7 Did the participant complete the 400-meter walk?

D3CM4MW Yes No

(Examiner Note: Mark all that apply.)

- D34PEX Participant excluded based on eligibility criteria
- D34PHR Participant's heart rate exceeded 135 bpm during the 2-minute walk
- D34PCP During the test the participant reported chest pain
- D34PSOB During the test the participant reported shortness of breath
- D34PF During the test the participant reported feeling faint
- D34PKP During the test the participant reported knee pain
- D34PHP During the test the participant reported hip pain
- D34PCF During the test the participant reported calf pain
- D34PBP During the test the participant reported back pain
- D34PRF Participant refused
- D34OTH Other *(Please specify: _____)*

Examiner Note: Ask the following question of all participants who attempted the 2-minute and/or the 400-meter walk.

8 While you were walking, did you have any of the following symptoms..?

(Examiner Note: Read response options.)

a. Chest pain	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know	<input type="radio"/> Refused	D3WCPC
b. Shortness of breath	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know	<input type="radio"/> Refused	D3WSOB
c. Knee pain	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know	<input type="radio"/> Refused	D3WKPC
d. Hip pain	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know	<input type="radio"/> Refused	D3WHPC
e. Calf pain	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know	<input type="radio"/> Refused	D3WCFC
f. Foot pain	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know	<input type="radio"/> Refused	D3WFPC
g. Numbness or tingling in your legs or feet	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know	<input type="radio"/> Refused	D3WNUMB
h. Leg cramps	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know	<input type="radio"/> Refused	D3WLPC
i. Back pain	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know	<input type="radio"/> Refused	D3WBPC
j. Other <i>(Please specify: _____)</i>	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know	<input type="radio"/> Refused	D3WOTH



HABC Enrollment ID #	Acrostic	Staff ID #
H		

D3STFID9

KNEE X-RAY ELIGIBILITY ASSESSMENT

1 Did the participant have knee symptoms that met eligibility criteria for a knee x-ray in Year 2 or Year 3?
(Examiner Note: Refer to Data from Prior Visits Report.)

D3KSY2A **1** Yes

1 No

a. Does the participant have knee symptoms at this Year 4 clinic visit?

(Examiner Note: Review Questions #54, #55 and #56 on Year 4 Questionnaire -- participant must have at least one asterisked "" answer.)*

1 Yes

1 No D3KSY4A

STOP.

b. Did the participant have a knee x-ray in Year 2 or Year 3?

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

1 Yes

1 No D3KXY23

Do NOT schedule x-ray.

Schedule knee x-ray.

Does the participant have knee symptoms at this Year 4 clinic visit?

(Examiner Note: Review Questions #54, #55 and #56 on Year 4 Questionnaire -- participant must have at least one asterisked "" answer.)*

1 Yes

1 No D3KSY4B

Schedule knee x-ray.

Do NOT schedule knee x-ray.



HABC Enrollment ID #	Acrostic	Date Form Completed	Staff ID #
H [] [] [] [] []	[] [] [] [] []	[] / [] / 2 0 0 [] []	[] [] [] []
D4ID	D4ACROS	Month / Day / Year	D4STFID

PHLEBOTOMY

Bar Code Label

1 Do you bleed or bruise easily?
D4BLBR **1** Yes **0** No **8** Don't know **7** Refused

D4BRCD

2 Have you ever experienced fainting spells while having blood drawn?
D4FNT **1** Yes **0** No **8** Don't know **7** Refused

3 Have you ever had a radical mastectomy? **(Female Participants Only)**
D4RADMAS **1** Yes **0** No **8** Don't know **7** Refused

Which side?

D4RMSIDE **1** Right **2** Left **3** Both

Draw blood on left side.	Draw blood on right side.	Do NOT draw blood. Go to Question #10 on page 40.
--------------------------	---------------------------	---

4 Have you ever had a graft or shunt for kidney dialysis?
D4KIDNEY **1** Yes **0** No **8** Don't know **7** Refused

Which side?

D4KDSIDE **1** Right **2** Left **3** Both

Draw blood on left side.	Draw blood on right side.	Do NOT draw blood. Go to Question #10 on page 40.
--------------------------	---------------------------	---



5 Time at start of venipuncture:

D4VTM	
Hours	Minutes

① am ② pm **D4AMP4**

6 Time blood draw completed:

D4BLDRTM	
Hours	Minutes

① am ② pm **D4AMP5**

7 Total tourniquet time:

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

D4TOUR	
minutes	

Comments on phlebotomy:

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

a. Date of last food:

--	--

 /

--	--

 /

--	--	--	--

D4LMD
Month Day Year
D4MHM

b. Time of last food:

--	--

 :

--	--

 ① am ② pm **D4LMAPM**
Hours Minutes

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

D4FAST	
hours	(Question 6 minus Question 8b. Round to nearest hour.)

9 Quality of venipuncture:

- ① Clean ② Traumatic **D4QVEN**

Please describe. Mark all that apply:

D4PVC ① Vein collapse

D4PH ① Hematoma

D4PVHTG ① Vein hard to get

D4PMS ① Multiple sticks

D4PEDD ① Excessive duration of draw

D4PLVS ① Leakage at venipuncture site

D4POTH ① Other *(Please specify:)*

10 Was any blood drawn?

- ① Yes ② No **D4BLDR**

Please describe why not: _____

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

<u>Tube</u>	<u>Volume</u>	<u>Filled to Capacity?</u>		<u>Comment</u>
		Yes	No	
1. EDTA	7 ml	①	② →	D4BV1 _____
2. Serum	10 ml	①	② →	D4BV2 _____



HABC Enrollment ID #	Acrostic	Date Form Completed	Staff ID #
H <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
		Month Day Year	D4STFID2

LABORATORY PROCESSING

Bar Code Label

D4TIMESP

Time at start of processing: : am pm

D4AMPMS

D4BRCD2

Collection Tubes	Cryo #	Vol.	Type	To	Fill in Bubble	Problems	Not Filled
					D401X	D401HPB	
#1 whole blood	01	1.0	W/1.5	L	①	① H ② P ③ B	① D401NX
					D402X	D402HPB	
#1 EDTA plasma	02	0.5	W/0.5	M	①	① H ② P ③ B	① D402NX
					D403X	D403HPB	
	03	0.5	W/0.5	M	①	① H ② P ③ B	① D403NX
					D404X	D404HPB	
	04	0.5	W/0.5	M	①	① H ② P ③ B	① D404NX
					D405X	D405HPB	
	05	0.5	W/0.5	M	①	① H ② P ③ B	① D405NX
					D406X	D406HPB	
#2 serum	06	0.5	R/0.5	L	①	① H ② P ③ B	① D406NX
					D407X	D407HPB	
	07	0.5	R/0.5	M	①	① H ② P ③ B	① D407NX
					D408X	D408HPB	
	08	0.5	R/0.5	M	①	① H ② P ③ B	① D408NX
					D409X	D409HPB	
	09	0.5	R/0.5	M	①	① H ② P ③ B	① D409NX
					D410X	D410HPB	
	10	0.5	R/0.5	M	①	① H ② P ③ B	① D410NX
					D411X	D411HPB	
	11	0.5	R/0.5	M	①	① H ② P ③ B	① D411NX
					D412X	D412HPB	
	12	0.5	R/0.5	M	①	① H ② P ③ B	① D412NX
					D413X	D413HPB	
	13	0.5	R/0.5	M	①	① H ② P ③ B	① D413NX

L=LCBR; M=McKesson; H=Hemolyzed; P=Partial; B=Both; R=red; W=white

LCBR Use only: Received Date: _____ Time: _____

Frozen Yes No

Draft



HABC Enrollment ID # H [] [] [] [] [] [] D5ID	Acrostic [] [] [] [] [] [] D5ACROS	Date Form Completed [] [] / [] [] / 2 0 0 [] [] Month Day Year D5DATE	Staff ID # [] [] [] [] D5STFID
---	--	--	--

YEAR 4 RETURN VISIT PHLEBOTOMY

Bar Code Label

1 Do you bleed or bruise easily?
D5BLBR Yes No Don't know Refused

D5BRCD

2 Have you ever experienced fainting spells while having blood drawn?
D5FNT Yes No Don't know Refused

3 Have you ever had a radical mastectomy? (Female Participants Only)
 Yes No Don't know Refused D5RADMAS

Which side?

Right Left Both D5RMSIDE

Draw blood on left side. Draw blood on right side. Do NOT draw blood. Go to Question #10 on page 40.

4 Have you ever had a graft or shunt for kidney dialysis?
 Yes No Don't know Refused D5KIDNEY

Which side?

Right Left Both D5KDSIDE

Draw blood on left side. Draw blood on right side. Do NOT draw blood. Go to Question #10 on page 40.

Examiner Note: If the participant is having a repeat blood draw only because they were not fasting during their Year 4 clinic visit, only draw a 3 to 5 ml serum tube. In Question #10.2, mark "Yes" when asked whether the serum tube was filled to capacity (even though the volume is less than 10 ml).

D5LINK

Draft



5 Time at start of venipuncture:

D5V.TM
Hours Minutes

1 am 2 pm D5AMP4

6 Time blood draw completed:

D5BLDRTM
Hours Minutes

1 am 2 pm D5AMP5

7 Total tourniquet time:

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

D5TOUR
minutes

Comments on phlebotomy:

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

a. Date of last food: [] [] / [] [] / [] [] [] [] D5LMD
Month Day Year

b. Time of last food: [] [] D5MHIM [] [] 1 am 2 pm D5LMAPM
Hours Minutes

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

D5FAST
[] [] hours (Question 6 minus Question 8b. Round to nearest hour.)



[] [] [] [] [] [] [] [] [] []

9 Quality of venipuncture:

1 Clean

2 Traumatic **D5QVEN**

Please describe. Mark all that apply:

D5PVC 1 Vein collapse

D5PH 1 Hematoma

D5PVHTG 1 Vein hard to get

D5PMS 1 Multiple sticks

D5PEDD 1 Excessive duration of draw

D5PLVS 1 Leakage at venipuncture site

D5POTH 1 Other *(Please specify:)*

10 Was any blood drawn?

1 Yes

0 No **D5BLDR**

Please describe why not: _____

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

Tube	Volume	Filled to Capacity?		Comment
		Yes	No	
1. EDTA	7 ml	1	0 →	_____
2. Serum	10 ml	1	0 →	_____

D5BV1

D5BV2

***Examiner Note:** If the participant had a repeat blood draw only because they were not fasting during their Year 4 clinic visit, mark "Yes" to Question #10.2 when asked whether the serum tube was filled to capacity (even though the volume is less than 10 ml).



HABC Enrollment ID # H [] [] [] [] [] [] D6ID	Acrostic [] [] [] [] [] [] D6ACROS	Date Form Completed [] / [] / 200[] [] Month Day Year D6DATE	Staff ID # [] [] [] [] D6STFID
---	--	---	--

YEAR 4 RETURN VISIT LABORATORY PROCESSING

Bar Code Label

D6TIMESP
Time at start of processing: [] [] : [] [] am pm

D6AMPSP

D6BRCD2

Collection Tubes	Cryo #	Vol.	Type	To	Fill in Bubble	Problems	Not Filled
#1 whole blood	01	1.0	W/1.5	L	D601X ①	D601HPB ① H ② P ③ B	① D601NX
#1 EDTA plasma	02	0.5	W/0.5	M	D602X ①	D602HPB ① H ② P ③ B	① D602NX
	03	0.5	W/0.5	M	D603X ①	D603HPB ① H ② P ③ B	① D603NX
	04	0.5	W/0.5	M	D604X ①	D604HPB ① H ② P ③ B	① D604NX
	05	0.5	W/0.5	M	D605X ①	D605HPB ① H ② P ③ B	① D605NX
#2 serum	06*	0.5	R/0.5	L	D606X ①	D606HPB ① H ② P ③ B	① D606NX
	07	0.5	R/0.5	M	D607X ①	D607HPB ① H ② P ③ B	① D607NX
	08	0.5	R/0.5	M	D608X ①	D608HPB ① H ② P ③ B	① D608NX
	09	0.5	R/0.5	M	D609X ①	D609HPB ① H ② P ③ B	① D609NX
	10	0.5	R/0.5	M	D610X ①	D610HPB ① H ② P ③ B	① D610NX
	11	0.5	R/0.5	M	D611X ①	D611HPB ① H ② P ③ B	① D611NX
	12	0.5	R/0.5	M	D612X ①	D612HPB ① H ② P ③ B	① D612NX
	13	0.5	R/0.5	M	D613X ①	D613HPB ① H ② P ③ B	① D613NX

***Examiner Note: If the participant had a repeat blood draw only because they were not fasting during their Year 4 clinic visit, only fill cryovial #06.**

L=LCBR; M=McKesson; H=Hemolyzed; P=Partial; B=Both; R=red; W=white

LCBR Use only: Received Date: _____ Time: _____

Frozen Yes No

HABC Enrollment ID # H [] [] [] [] [] ZBID	Acrostic [] [] [] [] [] ZBACROS	Date Form Completed [] / [] / [] [] [] [] Month Day Year ZBDATE	Staff ID # [] [] [] ZBSTFID
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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 <input type="radio"/> 9 Not eligible	ZBXR

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
 - Very good
 - Good
 - Fair
 - Poor
 - Don't know
 - 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. **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**



★ 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.)

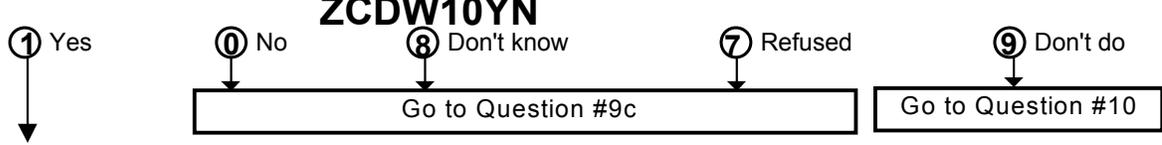
- ① Very easy
- ② Somewhat easy
- ③ Or not that easy
- ⑧ Don't know/Don't do

ZCDW1MEZ



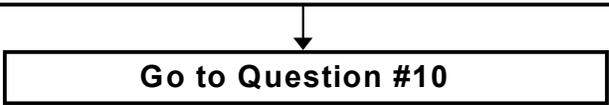
**CORE HOME VISIT WORKBOOK
PHYSICAL FUNCTION**

- ★ **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 →

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.

--	--	--	--	--

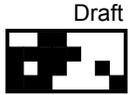
b.

--	--	--	--	--

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.

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

★ **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**

Was it for . . . ?		Reference #'s
★ a. A procedure to open a blocked artery ZCBLART	<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	<input type="text"/> ZCREF30A
★ b. Gall bladder surgery ZCGALLBL	<input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Don't know	
★ c. Cataract surgery ZCCATAR	<input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Don't know	
★ d. Hernia repair (Inguinal abdominal hernia.) ZCHERN	<input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Don't know	
★ e. TURP (MEN ONLY) (transurethral resection of prostate) ZCTURP	<input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Don't know	
★ f. Other ZCOTH	<input type="radio"/> 1 Yes → <input type="radio"/> 0 No <input type="radio"/> 8 Don't know	

Please specify the type of outpatient surgery.

i. _____

ii. _____

iii. _____



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

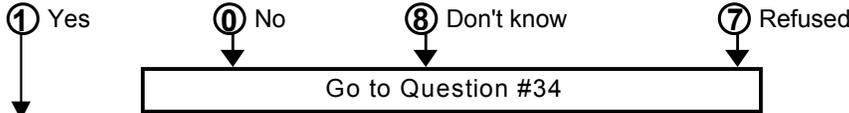
⑦ Refused

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**

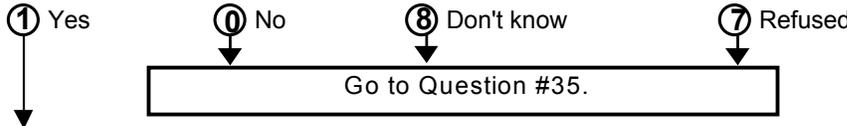
1 Yes * 0 No 8 Don't know

↓

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
- ⑥ 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
 - ③ Don't know
 - ④ Refused
- ZCCHN5LB**

a. Did you gain or lose weight?

① Gain ② Lose ③ 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 ③ Don't know

ZCTRGNLS

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

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

**CORE HOME VISIT WORKBOOK
LIFE EVENTS**

Year of annual contact:

3 Year 03 6 Year 06 **ZDTYPE**

4 Year 04 7 Year 07

5 Year 05 8 Other *(Please specify)*

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

1 Yes 0 No 8 Don't know 7 Refused

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

1 Yes 0 No 8 Don't know 7 Refused

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

1 Yes 0 No 8 Don't know 7 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

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:)*

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

Apt/Room

ZDC2APT

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.

ZDREASON

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

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
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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	MIFPRN 1 Y 0 N	MIFSEEN 1 Y 0 N <input checked="" type="checkbox"/> Rx 1
Reason for use: MIFREAS		Date Started: Month Year		Formulation Code: MIFFORM 0 MIFRX		
7.				____ D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Rx
Reason for use: _____		Date Started: Month Year		Formulation Code: _____ <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 <input checked="" type="checkbox"/> Rx
Reason for use: _____		Date Started: Month Year		Formulation Code: _____ <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 <input checked="" type="checkbox"/> Rx
Reason for use: _____		Date Started: Month Year		Formulation Code: _____ <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 <input checked="" type="checkbox"/> Rx
Reason for use: _____		Date Started: Month Year		Formulation Code: _____ <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 <input checked="" type="checkbox"/> Rx
Reason for use: _____		Date Started: Month Year		Formulation Code: _____ <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 <input checked="" type="checkbox"/> Rx
Reason for use: _____		Date Started: Month Year		Formulation Code: _____ <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</small> <input type="text"/> <small>N</small>	<input type="text"/> <small>Y</small> <input type="text"/> <small>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</small> <input type="text"/> <small>N</small>	<input type="text"/> <small>Y</small> <input type="text"/> <small>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</small> <input type="text"/> <small>N</small>	<input type="text"/> <small>Y</small> <input type="text"/> <small>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</small> <input type="text"/> <small>N</small>	<input type="text"/> <small>Y</small> <input type="text"/> <small>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</small> <input type="text"/> <small>N</small>	<input type="text"/> <small>Y</small> <input type="text"/> <small>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</small> <input type="text"/> <small>N</small>	<input type="text"/> <small>Y</small> <input type="text"/> <small>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
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CORE HOME VISIT WORKBOOK

Z4ID

Z4ACROS

Year of annual contact: Year 03 Year 06
 Year 04 Year 07
 Year 05 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**
Z4PLSMS2 beats per minute

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

= Average beats per minute
Z4PLSAV



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"/>

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**



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"/>

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**



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"/>

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

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.

Z44MW1

9 Not attempted, unable → Go to Ultrasound.

(Please comment: _____)

1 Attempted, but unable to complete → Go to Ultrasound.

(Please comment: _____)

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

7 Participant refused → Go to Ultrasound.

Z44MW3

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

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"/>

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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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"/>

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.

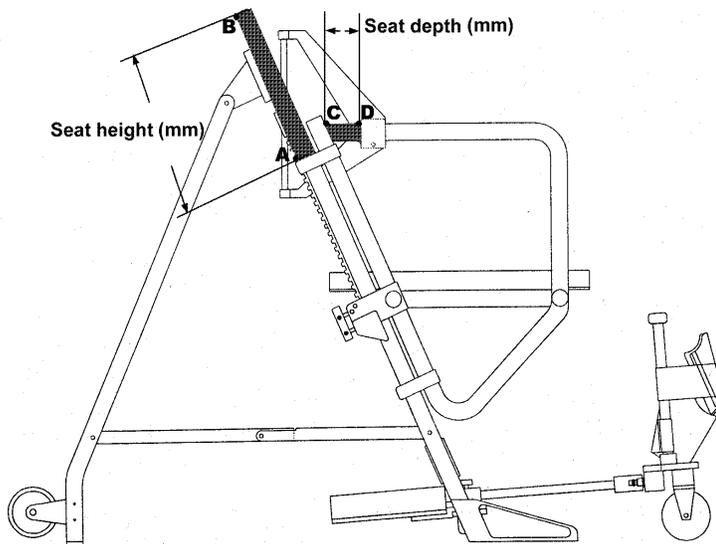
Z4KCLEG

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**

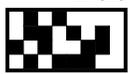


5 What is the length of the lower leg to be tested? meters **Z4LEG1**

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?
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.)

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

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"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> Z4MT1B											<table border="1"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> Z4MRT1B											<table border="1"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> Z4RT1B					<table border="1"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> Z4MVTD1B					① Yes ② No ↓ Z4KP1B STOP. Go to Question #9.
2.	<table border="1"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> Z4MT2B											<table border="1"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> Z4MRT2B											<table border="1"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> Z4RT2B					<table border="1"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> Z4MVTD2B					① Yes ② No ↓ Z4KP2B STOP. Go to Question #9.
3.	<table border="1"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> Z4MT3B											<table border="1"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> Z4MRT3B											<table border="1"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> Z4RT3B					<table border="1"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> Z4MVTD3B					Test complete. Go to Question #9.

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: **Z4KCOTH3** _____)

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"/> <input type="text"/>

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

- 1 Yes
 0 No
 8 Don't know
 7 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

1 Yes
 0 No
 8 Don't know

Which side was most recently broken? **Z4BKSIDE**

1 Right
 2 Left
 8 Don't know

2 Have you ever broken your right heel bone? **Z4BKRHL**

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

3 Do you have any permanent weakness in your legs, ankles or feet from an old injury or stroke? **Z4WKLEGS**

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

Which side is weaker? **Z4SIDEWK**

1 Right
 2 Left
 3 Right and left are equally weak

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 →

Did BUA result have an asterisk?

- ① Yes ② No

SOS **Z4BUSOS1** . m/s

Z4BUAST1

Measurement #2:

QUI . units **Z4BUQUI2**

BUA **Z4BUBUA2** . units →

Did BUA result have an asterisk?

- ① Yes ② No

SOS **Z4BUSOS2** . m/s

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 →

Did BUA result have an asterisk?

- ① Yes ② No

SOS **Z4BUSOS3** . m/s

Z4BUAST3

Draft



CORE HOME VISIT WORKBOOK BONE DENSITY (DXA) SCAN

Z4STID11

1 Do you have breast implants?

Yes 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.?

Yes 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

**CORE HOME VISIT WORKBOOK
BONE DENSITY (DXA) SCAN**

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

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.)

<input type="radio"/> Alzheimer's disease	<input type="radio"/> Parkinson's disease
<input type="radio"/> Confusion	<input type="radio"/> Stroke
YAMEMPRB <input type="radio"/> Delirium	<input type="radio"/> Nothing wrong
<input type="radio"/> Dementia	<input type="radio"/> Other (<i>Please specify</i>)
<input type="radio"/> Depression	_____
<input type="radio"/> Multiinfarct	<input type="radio"/> Don't know



★ **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
 ② Good ⑧ Don't know
 YAAPPET 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 / / 200	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
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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 type="checkbox"/> N MIFPRN	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N MIFSEEN Formulation Code: MIFFORM
2. MIFNAME Reason for use:			D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input checked="" type="checkbox"/> Rx <input type="checkbox"/> Non Rx
3. Reason for use:			D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input checked="" type="checkbox"/> Rx <input type="checkbox"/> Non Rx
4. Reason for use:			D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input checked="" type="checkbox"/> Rx <input type="checkbox"/> Non Rx
5. Reason for use:			D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input checked="" type="checkbox"/> Rx <input type="checkbox"/> Non Rx

**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		PRN? Check "X": Yes or No	Container Seen? Check "X": Yes or No
			Day, Week or Month	& Circle		
1. <input type="text" value="MIFNAME"/>	<input type="text" value="MIF STRE"/>	<input type="text" value="MIF UNIT"/>	<input type="text" value="MIFDWM"/>	<input type="text" value="1 Y 0 N"/>	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	<input type="text" value="1 Y 0 N"/>
Reason for use: <input type="text" value="MIFREAS"/>			<input type="text" value="MIFMONTH"/>	<input type="text" value="MIFYEAR"/>	<input type="text" value="Formulation Code: MIFFORM"/>	<input checked="" type="checkbox"/> Rx <input type="checkbox"/> Non Rx
2. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="___ D W M"/>	<input type="text" value="___ Y ___ N"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="text" value="___ Y ___ N"/>
Reason for use: <input type="text"/>			<input type="text"/>	<input type="text"/>	<input type="text" value="Formulation Code: ___"/>	<input type="checkbox"/> Rx <input checked="" type="checkbox"/> Non Rx
3. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="___ D W M"/>	<input type="text" value="___ Y ___ N"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="text" value="___ Y ___ N"/>
Reason for use: <input type="text"/>			<input type="text"/>	<input type="text"/>	<input type="text" value="Formulation Code: ___"/>	<input type="checkbox"/> Rx <input checked="" type="checkbox"/> Non Rx
4. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="___ D W M"/>	<input type="text" value="___ Y ___ N"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="text" value="___ Y ___ N"/>
Reason for use: <input type="text"/>			<input type="text"/>	<input type="text"/>	<input type="text" value="Formulation Code: ___"/>	<input type="checkbox"/> Rx <input checked="" type="checkbox"/> Non Rx
5. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="___ D W M"/>	<input type="text" value="___ Y ___ N"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="text" value="___ Y ___ N"/>
Reason for use: <input type="text"/>			<input type="text"/>	<input type="text"/>	<input type="text" value="Formulation Code: ___"/>	<input type="checkbox"/> Rx <input checked="" type="checkbox"/> Non Rx
6. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="___ D W M"/>	<input type="text" value="___ Y ___ N"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="text" value="___ Y ___ N"/>
Reason for use: <input type="text"/>			<input type="text"/>	<input type="text"/>	<input type="text" value="Formulation Code: ___"/>	<input type="checkbox"/> Rx <input checked="" type="checkbox"/> Non Rx
7. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="___ D W M"/>	<input type="text" value="___ Y ___ N"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="text" value="___ Y ___ N"/>
Reason for use: <input type="text"/>			<input type="text"/>	<input type="text"/>	<input type="text" value="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**

<p>8. <input style="width:90%;" type="text" value="MIFNAME"/></p> <p>Reason for use: <input style="width:90%;" type="text" value="MIFREAS"/></p>	<p><input type="text" value="MIFSTRE"/></p>	<p><input type="text" value="MIFUNIT"/></p>	<p><input type="text" value="MIFDWM"/></p>	<p><input type="text" value="1"/> Y <input checked="" type="text" value="0"/> N</p>	<p><input type="text" value="1"/> Y <input type="text" value="0"/> N</p>
<p>Date Started: _____ / _____ / _____</p>			<p>Formulation Code: <input type="text" value="MIFFORM"/> <input checked="" type="text" value="1"/> Rx <input checked="" type="text" value="X"/> Non Rx</p>		
<p>9. <input style="width:90%;" type="text"/></p> <p>Reason for use: _____</p>	<p><input type="text"/></p>	<p><input type="text"/></p>	<p><input type="text" value="___"/> D <input type="text" value="___"/> W <input type="text" value="___"/> M</p>	<p><input type="text" value="___"/> Y <input type="text" value="___"/> N</p>	<p><input type="text" value="___"/> Y <input type="text" value="___"/> N</p>
<p>Date Started: _____ / _____ / _____</p>			<p>Formulation Code: <input type="text"/> <input type="text"/> Rx <input checked="" type="text" value="X"/> Non Rx</p>		
<p>10. <input style="width:90%;" type="text"/></p> <p>Reason for use: _____</p>	<p><input type="text"/></p>	<p><input type="text"/></p>	<p><input type="text" value="___"/> D <input type="text" value="___"/> W <input type="text" value="___"/> M</p>	<p><input type="text" value="___"/> Y <input type="text" value="___"/> N</p>	<p><input type="text" value="___"/> Y <input type="text" value="___"/> N</p>
<p>Date Started: _____ / _____ / _____</p>			<p>Formulation Code: <input type="text"/> <input type="text"/> Rx <input checked="" type="text" value="X"/> Non Rx</p>		
<p>11. <input style="width:90%;" type="text"/></p> <p>Reason for use: _____</p>	<p><input type="text"/></p>	<p><input type="text"/></p>	<p><input type="text" value="___"/> D <input type="text" value="___"/> W <input type="text" value="___"/> M</p>	<p><input type="text" value="___"/> Y <input type="text" value="___"/> N</p>	<p><input type="text" value="___"/> Y <input type="text" value="___"/> N</p>
<p>Date Started: _____ / _____ / _____</p>			<p>Formulation Code: <input type="text"/> <input type="text"/> Rx <input checked="" type="text" value="X"/> Non Rx</p>		
<p>12. <input style="width:90%;" type="text"/></p> <p>Reason for use: _____</p>	<p><input type="text"/></p>	<p><input type="text"/></p>	<p><input type="text" value="___"/> D <input type="text" value="___"/> W <input type="text" value="___"/> M</p>	<p><input type="text" value="___"/> Y <input type="text" value="___"/> N</p>	<p><input type="text" value="___"/> Y <input type="text" value="___"/> N</p>
<p>Date Started: _____ / _____ / _____</p>			<p>Formulation Code: <input type="text"/> <input type="text"/> Rx <input checked="" type="text" value="X"/> Non Rx</p>		
<p>13. <input style="width:90%;" type="text"/></p> <p>Reason for use: _____</p>	<p><input type="text"/></p>	<p><input type="text"/></p>	<p><input type="text" value="___"/> D <input type="text" value="___"/> W <input type="text" value="___"/> M</p>	<p><input type="text" value="___"/> Y <input type="text" value="___"/> N</p>	<p><input type="text" value="___"/> Y <input type="text" value="___"/> N</p>
<p>Date Started: _____ / _____ / _____</p>			<p>Formulation Code: <input type="text"/> <input type="text"/> Rx <input checked="" type="text" value="X"/> Non Rx</p>		
<p>14. <input style="width:90%;" type="text"/></p> <p>Reason for use: _____</p>	<p><input type="text"/></p>	<p><input type="text"/></p>	<p><input type="text" value="___"/> D <input type="text" value="___"/> W <input type="text" value="___"/> M</p>	<p><input type="text" value="___"/> Y <input type="text" value="___"/> N</p>	<p><input type="text" value="___"/> Y <input type="text" value="___"/> N</p>
<p>Date Started: _____ / _____ / _____</p>			<p>Formulation Code: <input type="text"/> <input type="text"/> Rx <input checked="" type="text" value="X"/> Non Rx</p>		

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 MIDATE/MADATE	Staff ID # [] [] [] MASTAFF
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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
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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

† *If MIL is ≥ 300 mmHg, repeat the MIL. If MIL is still ≥ 300 mmHg, terminate blood pressure measurements.*

YCPOMX

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

Sitting Blood Pressure Measurement #1

⑥ Systolic YCSYS mmHg

Comments (required for missing or unusual values):

⑦ Diastolic YCDIA mmHg

Sitting Blood Pressure Measurement #2

⑧ Systolic YCSY2 mmHg

Comments (required for missing or unusual values):

⑨ Diastolic YCDIA2 mmHg



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

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

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 | → | YCCOMP |
| | | Number completed without using arms |
| ② Completes 5 stands without using arms | → | YCSEC |
| | | Seconds to complete |



HABC Enrollment ID #	Acrostic	Staff ID #
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YCSTFID6

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

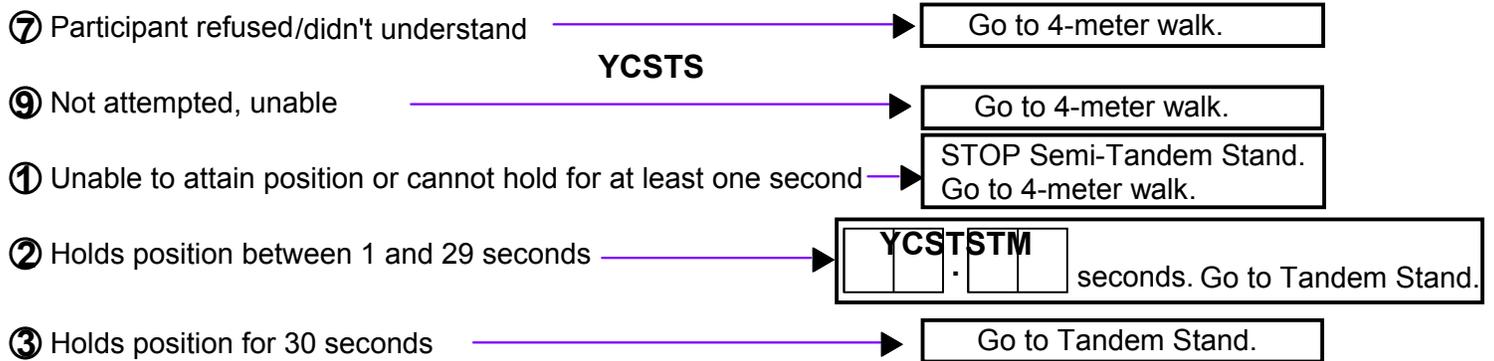
Describe: "First I would like you to try to stand with the side of the heel of one foot touching the big toe of the other foot for about 30 seconds. Please watch while I demonstrate."

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

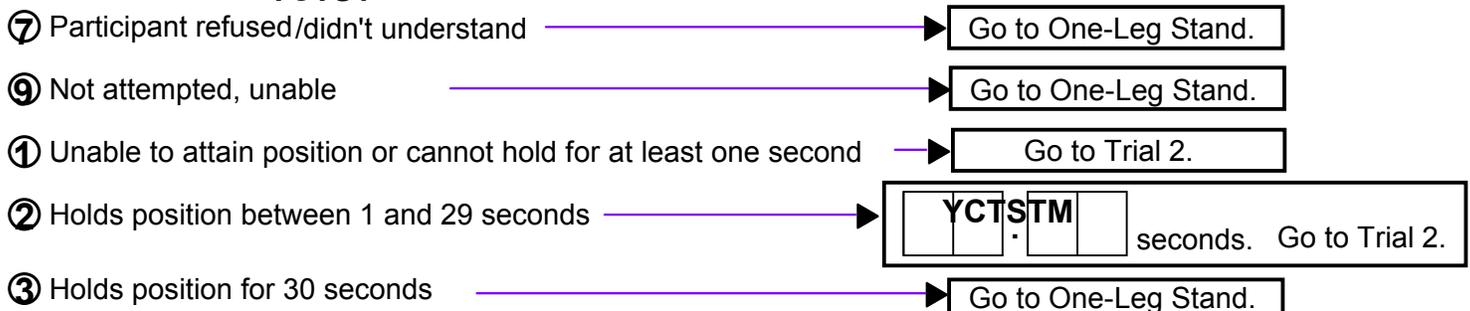
Describe: "Now I would like you to try to stand with the heel of one foot in front of and touching the toes of the other foot. I'll demonstrate."

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**



Draft



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> </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> </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> </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 #
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PROXY CONTACT HOME VISIT WORKBOOK YCSTFID7

4-METER WALK

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?
YC4MW **1** 4-meter **2** 3-meter **0** None: No 3-meter space was available → Go to Knee Crepitus.

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.)

Time on stopwatch: . **YC4MWTM1** →

Second Hundredths/Sec

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

7 Participant refused/didn't understand → Go to Knee Crepitus.

YC4MW1 **9** Not attempted, unable → Go to Knee Crepitus.

1 Attempted, but unable to complete → Go to Knee Crepitus.

- 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: . **YC4MWTM2** →

Second Hundredths/Sec

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

7 Participant refused/didn't understand → Go to Knee Crepitus.

YC4MW2 **9** Not attempted, unable → Go to Knee Crepitus.

1 Attempted, but unable to complete → Go to Knee Crepitus.

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"/>

**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 right leg unless contraindicated.

Test left 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

--	--	--

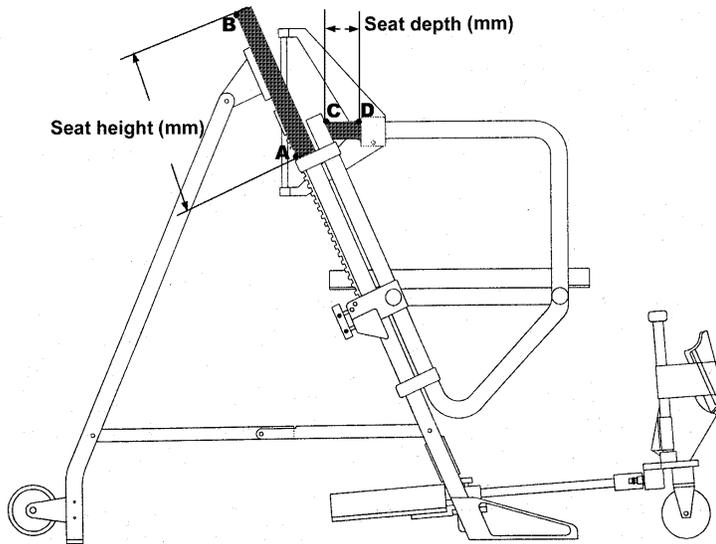
 mm

- 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> <td style="width: 20px; height: 20px;"></td> <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> <td style="width: 20px; height: 20px;"></td> <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> <td style="width: 20px; height: 20px;"></td> <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> <td style="width: 20px; height: 20px;"></td> <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> <td style="width: 20px; height: 20px;"></td> <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> <td style="width: 20px; height: 20px;"></td> <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
---	---	---	---	---	---	---

 . units

BUA

Y	C	B	U	B	U	A
---	---	---	---	---	---	---

 . units

SOS

Y	C	B	U	S	O	S
---	---	---	---	---	---	---

 . m/s

Did BUA result have an asterisk?
 Yes No
YCBUAST1

Measurement #2:

QUI

Y	C	B	U	Q	U	I
---	---	---	---	---	---	---

 . units

BUA

Y	C	B	U	B	U	A
---	---	---	---	---	---	---

 . units

SOS

Y	C	B	U	S	O	S
---	---	---	---	---	---	---

 . 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
---	---	---	---	---	---	---

 . units

a. Was the difference between BUA measurement #1 and BUA measurement #2 ≥ 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
---	---	---	---	---	---	---

 . units

BUA

Y	C	B	U	B	U	A
---	---	---	---	---	---	---

 . units

SOS

Y	C	B	U	S	O	S
---	---	---	---	---	---	---

 . 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

Date of scan: / / 200

Month Day Year

YCSCDTE1

b. Hip

① Yes ① No YCHIP
↓

Last 2 characters of scan ID #: YCSCAN2

Date of scan: / / 200

Month Day Year

YCSCDTE2

HABC Enrollment ID #	Acrostic	Date Form Completed	Staff ID #
H <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
BJID	BJACROS	Month 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"/>
BLID	BLACROS	Month Day Year	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 ② No ③ Don't know ④ 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 ② No ③ Don't know ④ 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 ② No ③ Don't know ④ Refused

a. Did you take your temperature?

BLTEMP ① Yes ② No ③ Don't know

↓ ↓ ↓

Go to Question #6b

Was your temperature 100° or higher?

① Yes* ② No ③ Don't know **BLTEMPHI**

b. Did a doctor or nurse tell you that you had the flu or a fever?

BLFLUDR ① Yes ② No ③ Don't know

c. Did you have body aches, chills, or muscle weakness that lasted two or more days?

BLACHES ① Yes ② No ③ Don't know

d. Were you hospitalized overnight for pneumonia or bronchitis following the illness?

BLPNEU ① Yes ② No ③ Don't know

Analyst Note: The wording was later changed to: "Was your temperature taken?"

*** 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
- ③ Or not that easy
- ⑧ Don't know/Don't do

BLDW10EZ

8d. Do you get tired when you walk up 10 steps without resting?

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

BLDW10WX

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 →
- ② No →
- ⑧ Don't know/Don't do →

BLDW20YN

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
- ③ Or not that easy
- ⑧ Don't know/Don't do

BLDW20EZ



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

- BLAPPET
- ① Very good
 - ② Good
 - ③ Moderate
 - ④ Poor
 - ⑤ Very poor
 - ⑥ Don't know
 - ⑦ Refused

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
 Complete a Health ABC Event Form, Section III. Record reference #:
BLREF20A

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.

