

HABC Enrollment ID # H [ ] [ ] [ ] [ ] [ ] <b>FAID</b>	Acrostic [ ] [ ] [ ] [ ] [ ] <b>FAACROS</b>	Date Form Completed [ ] [ ] / [ ] [ ] / 2 0 0 [ ] [ ] Month Day Year <b>FADATE</b>	Staff ID # [ ] [ ] [ ] [ ] <b>FASTFID</b>
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**YEAR 6 QUESTIONNAIRE**

Date of last regularly scheduled contact: [ ] [ ] / [ ] [ ] / [ ] [ ] [ ] [ ] **NOT COLLECTED**  
Month Day Year

*(Interviewer Note: Refer to Data from Prior Visits Report. Please also record this date on the top of page 24.)*

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

- FAHSTAT**
- 1** Excellent
  - 2** Very good
  - 3** Good
  - 4** Fair
  - 5** Poor
  - 8** 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.

- FABED12** **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.")*

**FABEDDAY** [ ] [ ] [ ] 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.

- FACUT12** **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.")*

**FACUTDAY** [ ] [ ] [ ] days

**FALINK**



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

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

**FADWQMYN** **1** Yes      **0** No      **8** Don't know      **7** Refused      **9** Don't do

Go to Question #9d
Go to Question #10

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

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

- FAMNRS**
- 1** Arthritis
  - 2** Back pain
  - 3** Balance problems/unsteadiness on feet
  - 4** Cancer
  - 5** Chest pain/discomfort
  - 6** Circulatory problems
  - 7** Diabetes
  - 8** Fatigue/tiredness (no specific disease)
  - 9** Fall
  - 23** Foot/ankle pain
  - 10** Heart disease (including angina, congestive heart failure, etc)
  - 11** High blood pressure/hypertension
  - 12** Hip fracture
  - 13** Injury
  - 14** Joint pain  
*(Please specify: \_\_\_\_\_)*
  - 24** Leg 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
  - 20** Other symptom  
*(Please specify: \_\_\_\_\_)*
  - 21** Multiple conditions/symptoms unable to determine MAIN reason
  - 22** Don't know

**c.** Do you have any difficulty walking across a small room?

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

**Go to Question #10**



9d. How easy is it for you to walk a quarter of a mile?  
(Interviewer Note: Read response options.)

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

9e. 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?

- FADW1MYN
- ① Yes → Go to Question #10
  - ② No → Go to Question #9f
  - ⑧ Don't know/don't do → Go to Question #9f

9f. How easy is it for you to walk one mile?  
(Interviewer Note: Read response options.)

- FADW1MEZ
- ① Very easy
  - ② Somewhat easy
  - ③ Or not that easy
  - ⑧ Don't know/don't do





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

- FADW10EZ
- ① Very easy
  - ② Somewhat easy
  - ③ Or not that easy
  - ⑧ Don't know/don't do

10d. Because of a health or physical problem, do you have any difficulty walking up 20 steps, that is about 2 flights, without resting?

- FADW20YN
- ① Yes → Go to Question #11
  - ② No → Go to Question #10e
  - ⑧ Don't know/don't do → Go to Question #10e

10e. How easy is it for you to walk up 20 steps without resting?  
(Interviewer Note: Read response options.)

- FADW20EZ
- ① Very easy
  - ② Somewhat easy
  - ③ Or not that easy
  - ⑧ Don't know/don't do



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

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

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

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

Does someone usually help you get in and out of bed or chairs?

**FADIORHY** ① Yes      ② No      ③ Don't know

**13** Do you have any difficulty bathing or showering?

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

Does someone usually help you bathe or shower?

**FABATHRH** ① Yes      ② No      ③ Don't know

**14** Do you have any difficulty dressing?

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

Does someone usually help you to dress?

**FADDRHYN** ① Yes      ② No      ③ Don't know

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

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

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

**FADSTAMT**

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

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

**FAEZSTA**

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



**16** Do you have any difficulty stooping, crouching or kneeling?  
*(Interviewer Note: "Difficulty" refers to difficulty getting down AND/OR getting back up.)*

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

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

**FADSCKAM**

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

**17** Do you have any difficulty raising your arms up over your head?

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

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

**FADARMAM**

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

**18** Do you have any difficulty using your fingers to grasp or handle?

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

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

**FADIFNAM**

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



19 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?

FADIF10 1 Yes

0 No

8 Don't know

7 Refused

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

- 1 A little difficulty
- FAEZ10LB 2 Some difficulty
- FAD10AMT 3 A lot of difficulty
- 4 Or are you unable to do it
- 8 Don't know

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

*(Interviewer Note: Read response options.)*

- FAEZ10LB 1 Very easy
- 2 Somewhat easy
- 3 Or not that easy
- 8 Don't know

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

FAD20LBS 1 Yes

0 No

8 Don't know

Go to Question #20

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

*(Interviewer Note: Read response options.)*

- FAEZ20LB 1 Very easy
- 2 Somewhat easy
- 3 Or not that easy
- 8 Don't know



20 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?

FAHC12MO ① Yes      ② No      ③ Don't know      ④ Refused

Go to Question #21

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

FAHC7DAY ① Yes      ② No      ③ Don't know

Go to Question #21

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.)*

FAHCHRS          FAHCMINS

Hours      Minutes

④ Don't know FAHCDK



**21** Did you walk for exercise, or walk to work, the store, or church, or walk the dog, at least 10 times, in the past 12 months?

**FAEW12MO** ① Yes      ② No      ③ Don't know      ④ Refused

Go to Question #22

In the past 7 days, did you go walking?  
**FAEW7DAY** ① Yes      ② No

**a.** How many times did you go walking in the past 7 days?  
**FAEWTIME**   times      **FAEWTK** 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.)*  
**FAEWHRS**   Hours        Minutes      **FAEWMINS** ① Don't know      **FAEWTK**

**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?  
**FAEWPAVE**  
 ① Brisk      ② Moderate      ③ Stroll      ④ Don't know

What is the main reason you did not go walking in the past 7 days?  
*(Interviewer Note: OPTIONAL - Show card #1.)*

**FAEWREAS**

- ① Bad weather
- ② Not enough time
- ③ Injury
- ④ Health problems
- ⑤ Lost interest
- ⑥ Felt unsafe
- ⑦ Not necessary
- ⑧ Other
- ⑨ Don't know

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

**FAFS12MO** ① Yes      ② No      ③ Don't know      ④ Refused

Go to Question #23

**a.** In the past 7 days, did you walk up a flight of stairs?  
**FAFS7DAY** ① Yes      ② No      ③ Don't know  
 Go to Question #23

**b.** About how many flights did you walk up in the past 7 days? If you are unsure, please make your best guess.  
**FAFSNUM**    flights      ① Don't know      **FAFSNUMD**

**c.** About how many of these flights did you walk up carrying a small load like laundry, groceries, or an infant?  
**FAFSLOAD**    flights      ① Don't know      **FAFSLOADK**



**23** 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?

**FAHI12MO** ① Yes

② No

③ Don't know

④ Refused

Go to Question #24

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

**FAHI7DAY** ① Yes

② No

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

- ① Bicycling/exercycle **FAHIABE**
- ① Swimming **FAHIASWM**
- ① Jogging **FAHIAJOG**
- ① Aerobics **FAHIAAER**
- ① Stair-stepping **FAHIASS**
- ① Racquet sports **FAHIARS**
- ① Rowing machine **FAHIAROW**
- ① Cross country ski machine **FAHIASKI**
- ① Other *(Please specify):* **FAHIAOTH**

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\_\_\_\_\_

\_\_\_\_\_

**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.)*

**FAHIA1HR**

Hours Minutes

**FAHIA1MN**

① Don't know **FAHIA1DK**

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

- ① Bad weather
- ② Not enough time
- ③ Injury
- FAHINDEX** ④ Health problems
- ⑤ Lost interest
- ⑥ Felt unsafe
- ⑦ Not necessary
- ⑧ Other
- ⑨ Don't know



**24** Did you do any moderate intensity exercise, such as golf, bowling, dancing, skating, bocce, table tennis, hunting, sailing or fishing, at least 10 times, in the past 12 months?

FAMI12MO ① Yes      ② No      ③ Don't know      ④ Refused

Go to Question #25

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

FAMI7DAY ① Yes      ② No

a. What activity(ies) did you do?  
*(Interviewer Note: OPTIONAL - Show card #4. Mark all that apply.)*

- ① Golf **FAMIGOLF**
- ① Bowling **FAMIBOWL**
- ① Dancing **FAMIDANC**
- ① Skating **FAMISKAT**
- ① Bocce **FAMIBOCC**
- ① Table tennis **FAMITENN**
- ① Billiards/pool **FAMIPOOL**
- ① Hunting **FAMIHUNT**
- ① Sailing/boating **FAMIBOAT**
- ① Fishing **FAMIFISH**
- ① Other *(Please specify):* **FAMIOT1**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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.)*

FAMIA1HR          **FAMIA1MN**      ① Don't know **FAMIA1DK**

Hours      Minutes

What is the main reason you have not done any moderate intensity exercise in the past 7 days?  
*(Interviewer Note: OPTIONAL - Show card #5.)*

- FAMINDEX**
- ① Bad weather
  - ② Not enough time
  - ③ Injury
  - ④ Health problems
  - ⑤ Lost interest
  - ⑥ Felt unsafe
  - ⑦ Not necessary
  - ⑧ Other
  - ⑨ Don't know





**26** Do you currently do any volunteer work?

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

Go to Question #27

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

**FAVWAHVW**   hours      ① Don't know **FAVWADK**

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

**FAVWMOV**   months      ① Don't know **FAVWMDK**

c. Which of the following best describes the type of activity you do?  
(Interviewer Note: **REQUIRED - Show card #6.**)

- FAVWACT**
- 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
  - ⑤ Don't know

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

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

Go to Question #28

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

**FAVWAHAW**    hours      ① Don't know **FAVWDK**



28 How often does someone help you shop for groceries or personal items?  
(Interviewer Note: Read response options.)

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

29 How often does someone help you prepare or provide you with meals?  
(Interviewer Note: Read response options.)

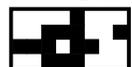
- FAHMEAL
- 4 Never
  - 3 Seldom
  - 2 Sometimes
  - 1 Always or very often
  - 8 Don't know
  - 7 Refused

30 How often does someone help you do light housework, such as washing dishes, straightening up, dusting, or light cleaning?  
(Interviewer Note: Read response options.)

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

31 How often does someone help you do heavy or major chores, such as washing windows, walls, or floors, vacuuming; home maintenance activities like painting or cleaning gutters; or gardening or yardwork?  
(Interviewer Note: Read response options.)

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



## TELEVISION WATCHING AND READING

32 About how many hours per week do you watch television?  
(Interviewer Note: **REQUIRED - Show card #7.**)

0 Zero

1 More than 0 but less than 7 hours/week

2 At least 7, but less than 14 hours/week

3 At least 14, but less than 21 hours/week

4 At least 21, but less than 28 hours/week

5 At least 28, but less than 35 hours/week

6 35 or more hours/week

8 Don't know

7 Refused

FAWWTV

Do you usually use a remote control  
for your TV?

1 Yes

0 No

8 Don't know

FAWTVRM

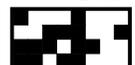
33 About how many hours per week do you spend reading, including books, newspapers, and magazines?

FAWVREAD

hours

8 Don't know

7 Refused FAWVRDRF



Now I have some questions about your appetite.

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

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

- 35 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 currently either 5 or more pounds heavier or lighter than they were 6 months ago.)

- FACHN5LB 1 Yes      0 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.)

- FAGNLS 1 Gain      2 Lose      8 Don't know

b. Were you trying to gain/lose weight?

- FATRGNLS 1 Yes      0 No      8 Don't know

- 36 At the present time, are you trying to lose weight?

- FATRYLS2 1 Yes      0 No      8 Don't know      7 Refused



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

FAAPPILL  Yes       No       Don't know       Refused

Please describe the illness or condition that interferes with your appetite or ability to eat?  
(Interviewer Note: Do NOT read response options. Mark all that apply.)

- Problems with your teeth FAAPPTD
- Swallowing problems FAAPPSP
- Pain on chewing FAAPPPC
- Poor taste FAAPPPT
- Poor smell FAAPPPS
- Stomach/abdominal pain FAAPPSAP
- Gas/bloating FAAPPGB
- Indigestion/heartburn FAAPPIH
- Constipation FAAPPCON
- Diarrhea FAAPPDIA
- Other (Please specify): FAAPPOTH

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\_\_\_\_\_

38 Do you have any remaining natural teeth?

FANTEETH  Yes       No       Don't know       Refused



**MEDICAL CONDITIONS**

HABC Enrollment ID #	Acrostic
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<b>FBID</b>	<b>FBACROS</b>

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...?**

**39** 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.

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

**40** 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.

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

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

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

↓      ↓      ↓      ↓  
Go to Question #42

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

**FBAJFNUM**

One  
 Two or three  
 Four or five  
 Six or more  
 Don't know

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

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

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

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



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

FBAJBP 1 Yes

0 No

8 Don't know

7 Refused

Go to Question #45

a. How often did you have back pain in the past 12 months?  
(Interviewer Note: Read response options. OPTIONAL - Show card #8.)

FBAJBP12

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

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

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

c. In what part of your back was the pain usually located?  
(Interviewer Note: OPTIONAL - Show card #9. Mark all that apply.)

1 Upper 1 Middle 1 Lower 1 Buttocks 1 Don't know  
FBBKUP FBBKMID FBBKLWR FBBKBUT FBBKDN

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

FBAJDLTD 1 Yes

0 No

8 Don't know

Go to Question #45

How many days did you limit your activities because of pain in your back?  
Your answer can range from 0 to 365 days. If you are unsure, please make your best guess.  
(Interviewer Note: Include days in bed.)

FBAJBDAY    days 1 Don't know FBAJBDRF



**45** In the past 12 months, have you had pain lasting at least one month in either shoulder?  
*(Interviewer Note: Pain lasting at least one month is defined as pain for 16 or more days during a month.)*

- FBAJSH12 ① Yes      ② No      ③ Don't know      ④ Refused
- ↓ ↓ ↓ ↓
- Go to Question #46

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

- FBAJSHPN ① Right shoulder only  
 ② Left shoulder only  
 ③ Both right and left shoulder  
 ④ Don't know

b. How severe was the pain usually?

*(Interviewer Note: Read response options. If pain in both right and left shoulder, say: "Answer for the worse side.")*

- FBAJSHSV ① Mild  
 ② Moderate  
 ③ Severe  
 ④ Extreme  
 ⑤ Don't know

**46** In the past 12 months, have you had pain lasting at least one month in your neck?  
*(Interviewer Note: Pain lasting at least one month is defined as pain for 16 or more days during a month.)*

- FBAJNP30 ① Yes      ② No      ③ Don't know      ④ Refused
- ↓ ↓ ↓ ↓
- Go to Question # 47

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

- FBAJNP3V ① Mild  
 ② Moderate  
 ③ Severe  
 ④ Extreme  
 ⑤ Don't know





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

/  /   
 Month Day Year

- 49 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?  
**FBCHAMI** ① Yes      ② No      ③ Don't know      ④ Refused

Were you hospitalized overnight for this problem?  
**FBHOSMI** ① Yes      ② No

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

a.       **FBREF49A**

b.       **FBREF49B**

c.       **FBREF49C**

Go to Question #50

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

Were you hospitalized overnight for this problem?  
**FBHOSMI3** ① Yes      ② No

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

a.       **FBREF50A**

b.       **FBREF50B**

c.       **FBREF50C**

Go to Question #51

- 51 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      ③ Don't know      ④ Refused **FBHCCVA**

Were you hospitalized overnight for this problem?  
**FBHOSMI2** ① Yes      ② No

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

a.       **FBREF51A**

b.       **FBREF51B**

c.       **FBREF51C**

Go to Question #52



**52** 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.

- FBCHMGMT**  Yes       No       Don't know       Refused

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

a. 

--	--	--	--	--

**FBREF52A**

b. 

--	--	--	--	--

**FBREF52B**

c. 

--	--	--	--	--

**FBREF52C**

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

- FBLCPNEU**  Yes       No       Don't know       Refused

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

a. 

--	--	--	--	--

**FBREF53A**

b. 

--	--	--	--	--

**FBREF53B**

c. 

--	--	--	--	--

**FBREF53C**

**54** 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)?

- FBOSBR45**  Yes       No       Don't know       Refused

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

a. 

--	--	--	--	--

**FBREF54A**

b. 

--	--	--	--	--

**FBREF54B**

c. 

--	--	--	--	--

**FBREF54C**



**55** Were you hospitalized overnight for any other reasons since we last spoke to you about 6 months ago?  
**FBHOSP12**  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"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>FBREF55A</b>                  Reason for hospitalization:                  _____</p>	<p>b. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>FBREF55B</b>                  Reason for hospitalization:                  _____</p>	<p>c. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>FBREF55C</b>                  Reason for hospitalization:                  _____</p>
<p>d. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>FBREF55D</b>                  Reason for hospitalization:                  _____</p>	<p>e. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>FBREF55E</b>                  Reason for hospitalization:                  _____</p>	<p>f. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>FBREF55F</b>                  Reason for hospitalization:                  _____</p>

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

<p>Was it for...?</p> <p>a. A procedure to open a blocked artery <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know  <b>FBBLART</b></p>	<p><b>Reference #</b>  <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>  <b>FBREF56A</b></p>
<p>b. Gall bladder surgery <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know  <b>FBGALLBL</b></p>	
<p>c. Cataract surgery <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know  <b>FBCATAR</b></p>	
<p>d. Hernia repair (Inguinal abdominal hernia.) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know  <b>FBHERN</b></p>	
<p>e. TURP (MEN ONLY) (transurethral resection of prostate) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know  <b>FBTURP</b></p>	
<p>f. Other <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know  <b>FBOTH</b></p>	<p>Complete a Health ABC Event Form, Section III. Record reference #:</p> <div style="border: 1px solid black; padding: 5px;">                 Please specify the type of outpatient surgery.                  i. _____                  ii. _____                  iii. _____             </div>



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

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

Go to Question #58

Please describe for what:

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

**FBSLEEP**   hours a day sleeping and lying down                      **FBSLDK** ⑤ Don't know                      ⑥ Refused

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

**FBUP**   hours a day sitting upright                      **FBUPDK** ⑤ Don't know                      ⑥ Refused

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

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

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

**FBELOFTN** ① All of the time  
 ② Most of the time  
 ③ Some of the time  
 ④ Don't know

**61** Using this card, please describe your usual energy level in the past month, where 0 is no energy and 10 is the most energy that you have ever had.

*(Interviewer Note: REQUIRED - Show card #11.)*

**FBELEV**   Energy level                      **FBELEVRF** ⑤ Don't know                      ⑥ Refused



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

- 62 At the present time, would you say your eyesight (with glasses or contact lenses, if you wear them) is excellent, good, fair, poor, or very poor or are you completely blind?  
(Interviewer Note: **OPTIONAL - Show card #12.**)

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

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

<p>a. Glaucoma?</p> <p>FBESGLAU 1 Yes    0 No    8 Don't know    7 Refused</p>
<p>b. Problems with your retina, retinopathy, or retinal disease or changes?</p> <p>FBESRET 1 Yes    0 No    8 Don't know    7 Refused</p>
<p>c. Macular degeneration?</p> <p>FBESMACD 1 Yes    0 No    8 Don't know    7 Refused</p>

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

- 64 Wearing glasses or contact lenses if you use them, how much difficulty do you have reading ordinary print in newspapers? Would you say you have. . . ?  
(Interviewer Note: **Read response options. OPTIONAL - Show card #13.**)

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

65 How much difficulty do you have doing work or hobbies that require you to see well up close, such as cooking, sewing, fixing things around the house, or using hand tools? Would you say you have . . . ?  
(Interviewer Note: Read response options. OPTIONAL - Show card #13.)

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

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

Are you limited in the kinds or amount of work or other activities you can do because of your eyesight?

FBESACT1 1 Yes 0 No 8 Don't know 7 Refused

How much are you limited? Would you say...  
(Interviewer Note: Read response options.)

- FBESACT2
- 4 A little of the time
  - 3 Some of the time
  - 2 Most of the time
  - 1 All of the time
  - 8 Don't know

DRIVING

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

FBESCAR 1 Yes 0 No, I never drove 2 No, I am no longer driving 8 Don't know 7 Refused

a. When did you stop driving?

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

b. Did you stop driving because of your eyesight?

FBESSITE 1 Yes 0 No 8 Don't know

**ACTIVITY ASSESSMENT**

**68** *Script: "For each of the following activities, please tell me how often you did them in the past 12 months: (REQUIRED: Show card #14). Not at all (0), Once or twice only (1), Less than once a month (2), At least monthly (3), Less than once a week (4), At least every week (5), Several times a week (6), or Daily (7). You can just say the number next to your choice if you want."*

*(Interviewer Note: If the activity is sporadic (e.g., several days in a row, a few times a year) and the participant cannot choose a response, choose at least monthly as the response.)*

Activity	Frequency									
	Not at all	Once or twice only	Less than once a month (3-11 times per year)	At least monthly	Less than once a week	At least every week	Several times a week	Daily	Don't know	Refused
a. Do a crossword or other word or jigsaw puzzle. <b>FBAA01N</b>	0	1	2	3	4	5	6	7	8 Dk	9 Ref
b. Read a newspaper or magazine article. <b>FBAA03</b>	0	1	2	3	4	5	6	7	8 Dk	9 Ref
c. Read a novel or non-fiction book such as a biography. <b>FBAA04N</b>	0	1	2	3	4	5	6	7	8 Dk	9 Ref
d. Play board games, bingo, bridge, or other card games. <b>FBAA06</b>	0	1	2	3	4	5	6	7	8 Dk	9 Ref
e. Use a computer. <b>FBAA07</b>	0	1	2	3	4	5	6	7	8 Dk	9 Ref
f. Write a letter, e-mail, article, poem, or story. <b>FBAA11</b>	0	1	2	3	4	5	6	7	8 Dk	9 Ref
g. Travel 100 miles or more from your home. <b>FBAA12</b>	0	1	2	3	4	5	6	7	8 Dk	9 Ref
h. Do handcrafts, sewing, needlework, carpentry, wood working, model building, art projects, sketching or drawing, photography, or painting. <b>FBAA13N</b>	0	1	2	3	4	5	6	7	8 Dk	9 Ref
i. Go out to a movie; attend a concert, the theater, or a sports event; or visit a museum, zoo, aquarium, or science center. <b>FBAA16N</b>	0	1	2	3	4	5	6	7	8 Dk	9 Ref
j. Take a class or adult education course. <b>FBAA20</b>	0	1	2	3	4	5	6	7	8 Dk	9 Ref
k. Attend a lecture, discussion, or public meeting. <b>FBAA21</b>	0	1	2	3	4	5	6	7	8 Dk	9 Ref
l. Participate in church, community, or social club activities (in addition to any mentioned above). <b>FBAA22</b>	0	1	2	3	4	5	6	7	8 Dk	9 Ref



69 In the past 4 weeks, how often have you been interested in doing your usual activities?  
(Interviewer Note: Read response options. OPTIONAL - Show card #15).

- FBAAF01
- 3 Most or all of the time
  - 2 Much of the time
  - 1 Some of the time
  - 0 Rarely or none of the time
  - 8 Don't know
  - 7 Refused

70 In the past 4 weeks, how often have you been interested in leaving your home and going out?  
(Interviewer Note: Read response options. OPTIONAL - Show card #15).

- FBAAF02
- 3 Most or all of the time
  - 2 Much of the time
  - 1 Some of the time
  - 0 Rarely or none of the time
  - 8 Don't know
  - 7 Refused

71 In the past 4 weeks, how often have you been interested in getting together with friends and relatives?  
(Interviewer Note: Read response options. OPTIONAL - Show card #15).

- FBAAF03
- 3 Most or all of the time
  - 2 Much of the time
  - 1 Some of the time
  - 0 Rarely or none of the time
  - 8 Don't know
  - 7 Refused



Now I have some questions about your feelings in the past 4 weeks. For each of the following statements, please tell me if you felt that way: Most or all the time; Much of the time; Some of the time; Rarely or none of the time.

- 72** Getting things done during the day is important to me.  
(Interviewer Note: Read response options. **OPTIONAL - Show card #15**).

- FBAAF04**
- 3 Most or all of the time
  - 2 Much of the time
  - 1 Some of the time
  - 0 Rarely or none of the time
  - 8 Don't know
  - 7 Refused

- 73** Seeing a job through to the end is important to me.  
(Interviewer Note: Read response options. **OPTIONAL - Show card #15**).

- FBAAF05**
- 3 Most or all of the time
  - 2 Much of the time
  - 1 Some of the time
  - 0 Rarely or none of the time
  - 8 Don't know
  - 7 Refused



**74** Now I have some questions about your feelings during the past week. For each of the following statements, please tell me if you felt that way: Rarely or None of the time; Some of the time; Much of the time; Most or All of the time. *(Interviewer Note: REQUIRED - Show card #16.)*

	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. <b>FBFBOTHR</b>	①	②	③	④	⑧	⑦
b. I did not feel like eating: my appetite was poor. <b>FBFEAT</b>	①	②	③	④	⑧	⑦
c. I felt that I could not shake off the blues even with help from family and friends. <b>FBFBLUES</b>	①	②	③	④	⑧	⑦
d. I felt that I was just as good as other people. <b>FBFGOOD</b>	①	②	③	④	⑧	⑦
e. I had trouble keeping my mind on what I was doing. <b>FBFMIND</b>	①	②	③	④	⑧	⑦
f. I was depressed. <b>FBFDOWN</b>	①	②	③	④	⑧	⑦
g. I felt that everything I did was an effort. <b>FBFEFFRT</b>	①	②	③	④	⑧	⑦
h. I felt hopeful about the future. <b>FBFHOPE</b>	①	②	③	④	⑧	⑦
i. I thought my life had been a failure. <b>FBFFAIL</b>	①	②	③	④	⑧	⑦
j. I felt fearful. <b>FBFFEAR</b>	①	②	③	④	⑧	⑦
k. My sleep was restless. <b>FBFSLEEP</b>	①	②	③	④	⑧	⑦
l. I was happy. <b>FBFHAPPY</b>	①	②	③	④	⑧	⑦
m. It seemed that I talked less than usual. <b>FBFTALK</b>	①	②	③	④	⑧	⑦
n. I felt lonely. <b>FBFLONE</b>	①	②	③	④	⑧	⑦
o. People were unfriendly. <b>FBFUNFR</b>	①	②	③	④	⑧	⑦
p. I enjoyed life. <b>FBFENJOY</b>	①	②	③	④	⑧	⑦
q. I had crying spells. <b>FBFCRY</b>	①	②	③	④	⑧	⑦
r. I felt sad. <b>FBFSAD</b>	①	②	③	④	⑧	⑦
s. I felt that people disliked me. <b>FBFDISME</b>	①	②	③	④	⑧	⑦
t. I could not get going. <b>FBFNOGO</b>	①	②	③	④	⑧	⑦

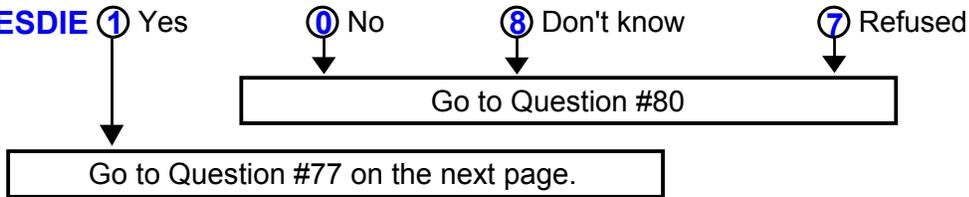


75 Did a child, grandchild, close friend, or relative die in the past 12 months?  
(Interviewer Note: The death of a spouse or partner should only be recorded in the next question, Question #76.)

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

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

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



**LIFE EVENTS**

**77**

Please tell me which best describes how you've been feeling lately.  
(Interviewer Note: **REQUIRED - Show card #17.**)

	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. <b>FBLETHNK ①</b>	①	②	③	④	⑧	⑦
b. Memories of the person who died upset me. <b>FBLEMEM ①</b>	①	②	③	④	⑧	⑦
c. I feel I cannot accept the death of the person who died. <b>FBLEACPT ①</b>	①	②	③	④	⑧	⑦
d. I feel myself longing for the person who died. <b>FBLELONG ①</b>	①	②	③	④	⑧	⑦
e. I feel drawn to places and things associated with the person who died. <b>FBLEDRWN ①</b>	①	②	③	④	⑧	⑦
f. I can't help feeling angry about his/her death. <b>FBLEANGR ①</b>	①	②	③	④	⑧	⑦
g. I feel disbelief over what happened. <b>FBLEDISB ①</b>	①	②	③	④	⑧	⑦
h. I feel stunned or dazed over what happened. <b>FBLEDAZE ①</b>	①	②	③	④	⑧	⑦
i. Ever since s/he died it is hard for me to trust people. <b>FBLETRST ①</b>	①	②	③	④	⑧	⑦
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. <b>FBLEDIST ①</b>	①	②	③	④	⑧	⑦
k. I have pain in the same area of my body or have some of the same symptoms as the person who died. <b>FBLEPAIN ①</b>	①	②	③	④	⑧	⑦
l. I go out of my way to avoid reminders of the person who died. <b>FBLEAVD ①</b>	①	②	③	④	⑧	⑦
m. I feel that life is empty without the person who died. <b>FBLEEMPT ①</b>	①	②	③	④	⑧	⑦
n. I hear the voice of the person who died speak to me. <b>FBLESPK ①</b>	①	②	③	④	⑧	⑦
o. I see the person who died stand before me. <b>FBLESTND ①</b>	①	②	③	④	⑧	⑦
p. I feel that it is unfair that I should live when this person died. <b>FBLELIVE ①</b>	①	②	③	④	⑧	⑦
q. I feel bitter over this person's death. <b>FBLEBITR ①</b>	①	②	③	④	⑧	⑦
r. I feel envious of others who have not lost someone close. <b>FBLEENV ①</b>	①	②	③	④	⑧	⑦
s. I feel lonely a great deal of the time ever since s/he died. <b>FBLELONE ①</b>	①	②	③	④	⑧	⑦



78 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 #18.**)

FBSSHAPY

8 Don't know

7 Refused FBSSHADR

79 Using this card, where 0 is extremely dissatisfied and 10 is very satisfied, how satisfied are you with the meaning and purpose of your life?  
(Interviewer Note: **REQUIRED - Show card #19.**)

FBSSEAN

8 Don't know

7 Refused FBSFMDR

80 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 #19.**)

FBSSEFFST

8 Don't know

7 Refused FBSSEFFDR

81 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 #19.**)

FBSSEFFH

8 Don't know

9 Don't need help

7 Refused FBSSEFHDR

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

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

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

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



83 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?

FBSSCAN ① Agree

② Disagree

⑧ Don't know

⑦ Refused

Do you agree strongly or agree somewhat?

- ① Agree strongly
- ② Agree somewhat
- ⑧ Don't know

FBSSCANA

Do you disagree strongly or disagree somewhat?

- ① Disagree strongly
- ② Disagree somewhat
- ⑧ Don't know

FBSSCAND

84 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?

FBSSOFH ① Agree

② Disagree

⑧ Don't know

⑦ Refused

Do you agree strongly or agree somewhat?

- ① Agree strongly
- ② Agree somewhat
- ⑧ Don't know

FBSSDFHA

Do you disagree strongly or disagree somewhat?

- ① Disagree strongly
- ② Disagree somewhat
- ⑧ Don't know

FBSSDFHD



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

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

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

- FBSSNDEG**
- ① A little
  - ② Quite a bit
  - ③ Extremely
  - ④ Don't know

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

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

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

- FBSSTDEG**
- ① A little
  - ② Quite a bit
  - ③ Extremely
  - ④ Don't know

87 During the past week, have you felt fearful?

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

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

- FBSSFDEG**
- ① A little
  - ② Quite a bit
  - ③ Extremely
  - ④ Don't know



**MARITAL STATUS  
AND HOUSEHOLD OCCUPANCY**

**88** What is your marital status? Are you...?  
*(Interviewer Note: Read response options. If participant reported that their spouse or partner died in the past 12 months in Question #76, don't ask question; mark "Widowed.")*

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

**89** Beside yourself, how many other people live in your household?

**FBSSOPIH**   Other people in household

① Participant lives alone

⑧ Don't know

⑦ Refused

**FBSSOPRF** → Go to Question #91

**90** Who do you live with (for example, with your spouse, relatives or friends)?  
*(Interviewer Note: Read response options. Mark all that apply.)*

- FB01** ① Live with spouse
- FB02** ① Live with a romantic partner
- FB03** ① Live with children
- FB04** ① Live with other relatives or friends
- FB05** ① Live with someone else
- FBDK** ① Don't know
- FBREF** ① Refused



91 In a typical week, how often do you get together with friends or neighbors? Would you say...  
(Interviewer Note: Read response options. REQUIRED - Show card #20.)

- FBSSFRNE
- ① At least once a day
  - ② 4 to 6 times per week
  - ③ 2 to 3 times per week
  - ④ 1 time per week
  - ⑤ Less than once per week
  - ⑧ Don't know
  - ⑦ Refused

92 In a typical week, how often do you get together with your children or other relatives?  
Would you say...  
(Interviewer Note: Read response options. REQUIRED - Show card #20.)

- FBSSCHRE
- ① At least once a day
  - ② 4 to 6 times per week
  - ③ 2 to 3 times per week
  - ④ 1 time per week
  - ⑤ Less than once per week
  - ⑧ Don't know
  - ⑦ Refused



**93** Where do you usually go for health care or advice about health care?  
(Interviewer Note: Read response options. Mark only ONE answer.)

FBHCSRC

- 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: \_\_\_\_\_ )

**Interviewer Note: Please update the name, address, and telephone number of the doctor or place that the participant usually goes to for health care on the HABC Participant Contact Information report.**

**94** Do you have a health insurance plan or other supplemental coverage which pays for a visit to a doctor?

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

What type of health insurance do you have?  
(Interviewer Note: Please record all types below. If participant is unsure whether they have Part B Medicare, ask if you may look at their Medicare card.)

- FBHCHI01  1 Part B Medicare
- FBHCHI02  1 Medicaid/public medical assistance (e.g., Family Care Network; Health Choices; Health Pass, Tenn Care) (Please specify: \_\_\_\_\_)
- FBHCHI03  1 Health Maintenance Organization (e.g., Best; Gateway; MedPlus; Access; Healthy Horizons) (Please specify: \_\_\_\_\_)
- FBHCHI04  1 Medi-Gap
- FBHCHI05  1 Private insurance (Please specify: \_\_\_\_\_)
- FBHCHI06  1 Other (Please specify: \_\_\_\_\_)



**95** 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 review the HABC Participant Contact Information report and confirm that the address you have for the participant is correct.)*

Is the address that we currently have correct?

Yes  No **NOT COLLECTED**

*Interviewer Note: Please record the street address, city, state and zip code for the participant on the HABC Participant Contact Information report.*

**96** The telephone number(s) that we currently have for you is (are):  
*(Interviewer Note: Please review the HABC Participant Contact Information report and confirm that the telephone number(s) that you have for the participant are correct.)*

Please tell me if these telephone number(s) are correct.

Are the telephone number(s) that we currently have correct?

Yes  No **NOT COLLECTED**

*Interviewer Note: Please record the telephone number(s) for the participant on the HABC Participant Contact Information report.*

**97** Do you expect to move or have a different address in the next 6 months?

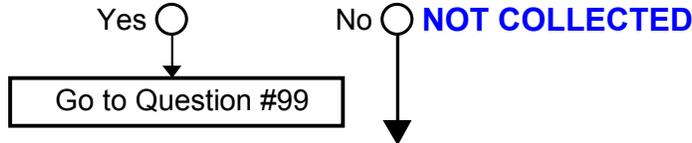
Yes  No  Don't know  Refused **NOT COLLECTED**

*Interviewer Note: Please record the new mailing address, and telephone number, and date the new address and telephone numbers are effective on the HABC Participant Contact Information report.*

**98** 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.

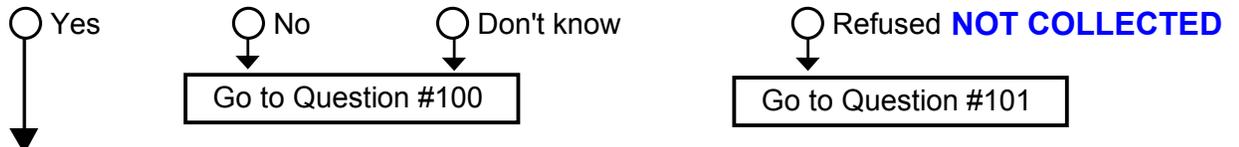
**(Interviewer Note: Please review the HABC Participant Contact Information report and confirm that the contact information for someone who could provide information and answer questions for the participant is correct.)**

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



**Interviewer Note: Please record the name, street address, city, state, zip code, and telephone number on the HABC Participant Contact Information report. Please determine whether this person is next of kin or has power of attorney.**

**99** Has the participant identified their next of kin?  
**(Interviewer Note: Refer to the HABC Participant Contact Information report.)**



**Interviewer Note: Please review the HABC Participant Contact Information report and confirm that the contact information for the next of kin is correct.**

You previously told us the name and address of your next of kin. Please tell me if the information I have is still correct.

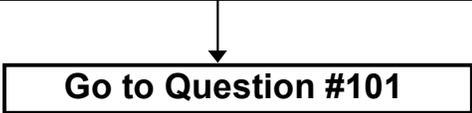
Is the name and address of the next of kin correct?

**NOT COLLECTED**  Yes  No  Don't know  Refused

Go to Question #101

Go to Question #101

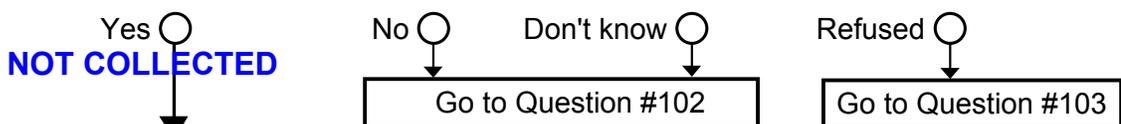
**Interviewer Note: Please record the name, street address, city, state, zip code, and telephone number, and how the person is related to the participant on the HABC Participant Contact Information report.**



**100** Please tell me the name, address, and telephone number of your next of kin.  
How is this person related to you?

*Interviewer Note: Please record the name, street address, city, state, zip code, and telephone number, and how the person is related to the participant on the HABC Participant Contact Information report.*

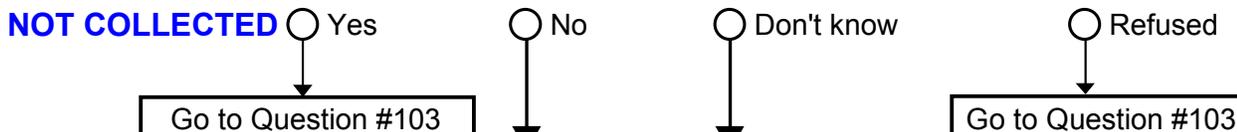
**101** Has the participant identified their power of attorney?  
(*Interviewer Note: Refer to the HABC Participant Contact Information report.*)



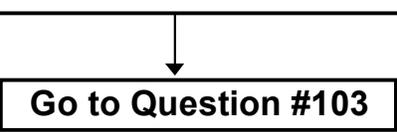
*Interviewer Note: Please review the HABC Participant Contact Information report and confirm that the contact information for the power of attorney is correct.*

You previously told us the name and address of your power of attorney. Please tell me if the information I have is still correct.

Is the name and address of the power of attorney correct?



*Interviewer Note: Please record the name, street address, city, state, zip code, and telephone number, and how the person is related to the participant on the HABC Participant Contact Information report.*



**102** Have you given anyone power of attorney?  
**NOT COLLECTED**  Yes     No     Don't know     Refused

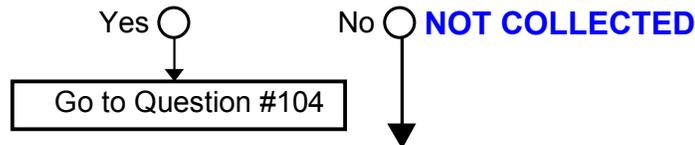
*Interviewer Note: Please record the name, street address, city, state, zip code, telephone number, and how the person is related to the participant on the HABC Participant Contact Information report.*



**103** 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: Please review the HABC Participant Contact Information report and confirm that the contact information for two close friends or relatives who do not live with the participant is correct.)*

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: Please record the name, street address, city, state, zip code, and telephone number on the HABC Participant Contact Information report. Please determine whether this person is next of kin or has power of attorney.*

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

**104** 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
- FBRELY**







HABC Enrollment ID # H <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>MAID/MIFID</b>	Acrostic <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>MAACROS</b>	Date Form Completed <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year <b>MIFDATE/MADATE</b>	Staff ID # <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>MASTAFF</b>
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## YEAR 6 MEDICATION INVENTORY FORM -- Page A

### Section A Medication Reception

Collect all prescription and over-the-counter medications used in the previous two weeks. Refer to *Data From Prior Visits Report*. Ask 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 *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*. Record the complete drug name exactly as written on the container label. Confirm strength, units, number used, etc.

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

**MAMEDS**  Yes       No       Took no prescription or non-prescription medicines

**MATOTAL** Total number brought in:  
     
 Did examiner call participant to complete MIF?  Yes       No      **MACALL**

### Section B Prescription Medications.

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 PRN ("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	Number Used & Circle Day, Week or Month	PRN? Check "X": Yes or No	Container Seen? Check "X": Yes or No
				<b>MIFPRN</b>	<b>MIFSEEN</b>
1. <b>MIFNAME</b>	<b>MIFSTREN</b>	<b>MIFUNIT</b>	<b>MIFDWM</b> ___ D W M 1 2 3	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: _____	<b>MIFREAS</b>		<b>MIFMONTH/MIFYEAR</b> Date Started: Month Year	Formulation Code: <b>MIFFORM</b>	<input checked="" type="checkbox"/> Rx <b>MIFRX</b> <input type="checkbox"/> Non Rx
2. <input type="text"/>	<input type="text"/>	<input type="text"/>	___ D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: _____			Date Started: Month Year	Formulation Code: _____	<input type="checkbox"/> Rx <input type="checkbox"/> Non Rx
3. <input type="text"/>	<input type="text"/>	<input type="text"/>	___ D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: _____			Date Started: Month Year	Formulation Code: _____	<input type="checkbox"/> Rx <input type="checkbox"/> Non Rx
4. <input type="text"/>	<input type="text"/>	<input type="text"/>	___ D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: _____			Date Started: Month Year	Formulation Code: _____	<input type="checkbox"/> Rx <input type="checkbox"/> Non Rx
5. <input type="text"/>	<input type="text"/>	<input type="text"/>	___ D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: _____			Date Started: Month Year	Formulation Code: _____	<input type="checkbox"/> Rx <input type="checkbox"/> Non Rx

Section B Prescription Medications -- Continued

Medication Name (Generic Name or Trade Name)	Strength	Units	Number Used & Circle Day, Week or Month	PRN? Check "X": Yes or No	Container Seen? Check "X": Yes or No
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6. <input style="width: 90%;" type="text" value="MIFNAME"/>	<input style="width: 80%;" type="text" value="MIF STREN"/>	<input style="width: 80%;" type="text" value="MIF UNIT"/>	<input style="width: 80%;" type="text" value="MIFDWM"/> D W M 1 2 3	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: <input style="width: 80%;" type="text" value="MIFREAS"/>			Date Started: Month Year	Formulation Code: <input style="width: 80%;" type="text" value="MIFFORM"/>	

7. <input style="width: 90%;" type="text"/>	<input style="width: 80%;" type="text"/>	<input style="width: 80%;" type="text"/>	<input style="width: 80%;" type="text"/> D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: _____			Date Started: Month Year	Formulation Code: _____	

8. <input style="width: 90%;" type="text"/>	<input style="width: 80%;" type="text"/>	<input style="width: 80%;" type="text"/>	<input style="width: 80%;" type="text"/> D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: _____			Date Started: Month Year	Formulation Code: _____	

9. <input style="width: 90%;" type="text"/>	<input style="width: 80%;" type="text"/>	<input style="width: 80%;" type="text"/>	<input style="width: 80%;" type="text"/> D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: _____			Date Started: Month Year	Formulation Code: _____	

10. <input style="width: 90%;" type="text"/>	<input style="width: 80%;" type="text"/>	<input style="width: 80%;" type="text"/>	<input style="width: 80%;" type="text"/> D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: _____			Date Started: Month Year	Formulation Code: _____	

11. <input style="width: 90%;" type="text"/>	<input style="width: 80%;" type="text"/>	<input style="width: 80%;" type="text"/>	<input style="width: 80%;" type="text"/> D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: _____			Date Started: Month Year	Formulation Code: _____	

12. <input style="width: 90%;" type="text"/>	<input style="width: 80%;" type="text"/>	<input style="width: 80%;" type="text"/>	<input style="width: 80%;" type="text"/> D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: _____			Date Started: Month Year	Formulation Code: _____	

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=injecte

**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 PRN ("as needed basis") and whether or not the container was actually seen. In addition, record reason for use, date started, and formulation code.

1.	Medication Name (Generic Name or Trade Name)	Strength	Units	Number Used & Circle Day, Week or Month	PRN? Check "X": Yes or No	Container Seen? Check "X": Yes or No
	MIFNAME	MIF STREN	MIF UNIT	MIFDWM ___ D W M 1 2 3	MIFPRN <input checked="" type="checkbox"/> Y <input type="checkbox"/> N	MIFSEEN <input checked="" type="checkbox"/> Y <input type="checkbox"/> N
	Reason for use: MIFREAS			MIFMONTH / MIFYEAR ___ / ___	Formulation Code: MIFFORM	<input checked="" type="checkbox"/> Rx <input type="checkbox"/> Non Rx
2.				___ D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	Reason for use: _____			___ / ___	Formulation Code: _____	<input type="checkbox"/> Rx <input type="checkbox"/> Non Rx
3.				___ D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	Reason for use: _____			___ / ___	Formulation Code: _____	<input 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 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 type="checkbox"/> Rx <input type="checkbox"/> Non Rx
6.				___ D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	Reason for use: _____			___ / ___	Formulation Code: _____	<input type="checkbox"/> Rx <input type="checkbox"/> Non Rx
7.				___ D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	Reason for use: _____			___ / ___	Formulation Code: _____	<input type="checkbox"/> Rx <input type="checkbox"/> Non Rx

Section C Over-the-counter Medications and Supplements -- Continued

Medication Name (Generic Name or Trade Name)	Strength	Units	Number Used & Circle Day, Week or Month	PRN? Check "X": Yes or No MIFPRN	Container Seen? Check "X": Yes or No MIFSEEN
8. <input type="text" value="MIFNAME"/>	<input type="text" value="MIF STREN"/>	<input type="text" value="MIF UNIT"/>	<input type="text" value="MIFDWM"/> D W M 1 2 3 MIFMONTH / MIFYEAR	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: <input type="text" value="MIFREAS"/>	Date Started: Month Year		Formulation Code: <input type="text" value="MIFFORM"/>	<input checked="" type="checkbox"/> Rx	<input type="checkbox"/> Non Rx
9. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: _____	Date Started: Month Year		Formulation Code: _____	<input type="checkbox"/> Rx	<input type="checkbox"/> Non Rx
10. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: _____	Date Started: Month Year		Formulation Code: _____	<input type="checkbox"/> Rx	<input type="checkbox"/> Non Rx
11. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: _____	Date Started: Month Year		Formulation Code: _____	<input type="checkbox"/> Rx	<input type="checkbox"/> Non Rx
12. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: _____	Date Started: Month Year		Formulation Code: _____	<input type="checkbox"/> Rx	<input type="checkbox"/> Non Rx
13. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: _____	Date Started: Month Year		Formulation Code: _____	<input type="checkbox"/> Rx	<input type="checkbox"/> Non Rx
14. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: _____	Date Started: Month Year		Formulation Code: _____	<input type="checkbox"/> Rx	<input type="checkbox"/> Non Rx

Continued on MIF Supplement

**Formulation Codes**

0=unidentifiable, 1=oral tablet, 2=oral capsule, 3=oral liquid, 4=topical cream, lotion, or ointment, 5=other liquid, 6=ophthalmic, 7=missing, 8=rectal or vaginal, 9=inhaled or nasal, 10=injected, 11=transdermal patch, 12=powder, 99=other



HABC Enrollment ID # H <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>MAID/MIFID</b>	Acrostic <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>MAACROS</b>	Date Form Completed <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MIF/DATE/MADATE Month Day Year	Staff ID # <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>MASTAFF</b>
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## YEAR 6 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 PRN ("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	Number Used & Circle Day, Week or Month	PRN? Check "X": Yes or No	Container Seen? Check "X": Yes or No
				MIFPRN	MIFSEEN
1S. <input style="width: 90%;" type="text" value="MIFNAME"/>	<input style="width: 10%;" type="text" value="MIF STREN"/>	<input style="width: 10%;" type="text" value="MIF UNIT"/>	<input style="width: 10%;" type="text" value="MIFDWM"/> D W M 1 2 3	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: <input style="width: 80%;" type="text" value="MIFREAS"/>	Date Started: <input style="width: 10%;" type="text"/> / <input style="width: 10%;" type="text"/>		Formulation Code: <input style="width: 10%;" type="text"/>	<input checked="" type="checkbox"/> Rx	<input type="checkbox"/> Non Rx
2S. <input style="width: 90%;" type="text"/>	<input style="width: 10%;" type="text"/>	<input style="width: 10%;" type="text"/>	<input style="width: 10%;" type="text"/> D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: <input style="width: 80%;" type="text"/>	Date Started: <input style="width: 10%;" type="text"/> / <input style="width: 10%;" type="text"/>		Formulation Code: <input style="width: 10%;" type="text"/>	<input type="checkbox"/> Rx	<input type="checkbox"/> Non Rx
3S. <input style="width: 90%;" type="text"/>	<input style="width: 10%;" type="text"/>	<input style="width: 10%;" type="text"/>	<input style="width: 10%;" type="text"/> D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: <input style="width: 80%;" type="text"/>	Date Started: <input style="width: 10%;" type="text"/> / <input style="width: 10%;" type="text"/>		Formulation Code: <input style="width: 10%;" type="text"/>	<input type="checkbox"/> Rx	<input type="checkbox"/> Non Rx
4S. <input style="width: 90%;" type="text"/>	<input style="width: 10%;" type="text"/>	<input style="width: 10%;" type="text"/>	<input style="width: 10%;" type="text"/> D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: <input style="width: 80%;" type="text"/>	Date Started: <input style="width: 10%;" type="text"/> / <input style="width: 10%;" type="text"/>		Formulation Code: <input style="width: 10%;" type="text"/>	<input type="checkbox"/> Rx	<input type="checkbox"/> Non Rx
5S. <input style="width: 90%;" type="text"/>	<input style="width: 10%;" type="text"/>	<input style="width: 10%;" type="text"/>	<input style="width: 10%;" type="text"/> D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: <input style="width: 80%;" type="text"/>	Date Started: <input style="width: 10%;" type="text"/> / <input style="width: 10%;" type="text"/>		Formulation Code: <input style="width: 10%;" type="text"/>	<input type="checkbox"/> Rx	<input type="checkbox"/> Non Rx
6S. <input style="width: 90%;" type="text"/>	<input style="width: 10%;" type="text"/>	<input style="width: 10%;" type="text"/>	<input style="width: 10%;" type="text"/> D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: <input style="width: 80%;" type="text"/>	Date Started: <input style="width: 10%;" type="text"/> / <input style="width: 10%;" type="text"/>		Formulation Code: <input style="width: 10%;" type="text"/>	<input type="checkbox"/> Rx	<input type="checkbox"/> Non Rx
7S. <input style="width: 90%;" type="text"/>	<input style="width: 10%;" type="text"/>	<input style="width: 10%;" type="text"/>	<input style="width: 10%;" type="text"/> D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: <input style="width: 80%;" type="text"/>	Date Started: <input style="width: 10%;" type="text"/> / <input style="width: 10%;" type="text"/>		Formulation Code: <input style="width: 10%;" type="text"/>	<input type="checkbox"/> Rx	<input type="checkbox"/> Non Rx



HABC Enrollment ID #	Acrostic	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"/>

**F3STFID3**

**RADIAL PULSE**

**F3PLSSM1**

Measurement 1    beats per 30 seconds

+

**F3PLSSM2**

Measurement 2    beats per 30 seconds

=

Average  
beats per minute

**F3PLSAV**

*(Examiner Note: Record Radial Pulse on Long Distance Corridor Walk Eligibility Assessment Form, page 31, Question #3.)*



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"/>

**F3STFD4**

**BLOOD PRESSURE**

**BLOOD PRESSURE**

- ① Cuff Size      ④ Small      ① Regular      ② Large      ③ Thigh **F3OCUF**

**F3ARMRL**

- ② Arm Used      ① Right      ② Left  
*(Examiner Note: Use arm listed on Data from Prior Visits Report.)*

*Please explain why right arm was not used:*

---



---

**Pulse Obliteration Level**

**F3POPS**

- 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  $\geq 300$  mmHg, repeat the MIL. If MIL is still  $\geq 300$  mmHg, terminate blood pressure measurements.*

**F3POMX**

- ⑤ Was blood pressure measurement terminated because MIL was  $\geq 300$  mmHg after second reading?  
 ① Yes      ② No **F3BPYN**

**Sitting Blood Pressure**

**F3SYS**

- ⑥ Systolic    mmHg

*Comments (required for missing or unusual values):*

- ⑦ Diastolic    mmHg

**F3DIA**

**Standing Blood Pressure**

**F3SY2**

- ⑧ Systolic    mmHg

**Examiner Note:**

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

- ⑨ Diastolic    mmHg

**F3DIA2**

*b) Record these measurements on Long Distance Corridor Walk Eligibility Assessment Form (page 31, Question #4).*



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"/>

F3STFID5

## ABDOMINAL CIRCUMFERENCE

① Measurement 1    .  cm **F3AB1**

② Measurement 2    .  cm **F3AB2**

③ Difference between Measurement 1 & Measurement 2  .  cm **F3ABDF**

④ Is the difference between Measurement 1 and Measurement 2 greater than 1.0 cm?

① Yes

② No

**F3ABDFYN**

Complete Measurement 3 and Measurement 4 below.

Go to Question # 7 below.

⑤ Measurement 3    .  cm **F3AB3**

⑥ Measurement 4    .  cm **F3AB4**

⑦ Was maximal circumference at hip level? ① Yes ② No **F3THAYN**

⑧ Was largest circumference obstructed? ① Yes ② No **F3THAYN2**



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"/>

**F3STFID6**

## THIGH CIRCUMFERENCE

**F3THRLY1**

- ① Which thigh was measured at baseline (Year 1) clinic visit?      ① Right      ② Left  
*(Examiner Note: Refer to the Data from Prior Visits Report. If possible, measure same thigh as measured at baseline.)*

- ② Midpoint between inguinal crease and proximal border of the patella  
*(Examiner Note: Refer to the Data from Prior Visits Report for this midpoint measurement.)*

.  cm      **F3THMID**

- ③ Measurement 1        .  cm      **F3TH1**

- ④ Measurement 2        .  cm      **F3TH2**

- ⑤ Difference between Measurement 1 & Measurement 2       .  cm      **F3THDF**

- ⑥ Is the difference between Measurement 1 and Measurement 2 greater than 1.0 cm?

① Yes

② No

**F3THDFYN**

Complete Measurement 3 and Measurement 4 below.

Go to next page.

- ⑦ Measurement 3        .  cm      **F3TH3**

- ⑧ Measurement 4        .  cm      **F3TH4**



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"/>

**F3STFID7**

**SIT AND REACH FLEXIBILITY**

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

**1** Yes    **0** No    **8** Don't know    **7** Refused **F3SRHPRP**

STOP. Go to next test.

**2** Arm length measure:   .  **F3SRARM**  
cm

**3** Back length measure:   .  **F3SRBCK**  
cm

**4** Starting ruler position:   .  **F3SRST**  
cm

**Describe the test:** "This test is designed to see how flexible you are. Please sit comfortably with your arms straight and your fingers pointed at the metal plate. When I say 'go' I want you to slowly lean forward as far as you can, pushing this plate ahead of you. Don't jerk forward or bounce. Don't bend your knees. We're going to do this several times."

**5** Could the participant get into the required position (e.g., legs straight on the long sit)?

**1** Yes    **0** No    **8** Refused    **F3SRPOSI**

STOP.  
Go to next text.

**6** Practice Plate measure:   .  cm    **7** Refused **F3SRPRF**

**Ask participant:** "How did that feel? Did that hurt?"  
*(Examiner Note: If it hurts ask the participant if they would like to stop or are they willing to keep going.)*

**7** Did the participant have pain?

**F3SRPAIN** **1** Yes    **0** No    **8** Don't know    **7** Refused

Were they willing to try Trial 1?

**1** Yes    **0** No **F3SRPTR1**

Go to Trial 1.    STOP. Go to next test.

Go to Trial 1.



**SIT AND REACH FLEXIBILITY**

**8** Trial 1

**F3SRT1**  
Plate measure:   .  cm

**7** Refused **F3SRT1RF**

**9** Trial 2

**F3SRT2**  
Plate measure:   .  cm

**7** Refused **F3SRT2RF**

**10** Trial 3

**F3SRT3**  
Plate measure:   .  cm

**7** Refused **F3SRT3RF**

**11** Is the plate measure for Trial 3 greater than the plate measure for Trial 1 and Trial 2?

**1** Yes

**0** No **F3SRDIF1**

Complete Trial 4 below.

Go to Question #14 below.

**12** Trial 4

**F3SRT4**  
Plate measure:   .  cm

**7** Refused **F3SRT4RF**

**13** Is the plate measure for Trial 4 greater than the plate measure for Trial 1, 2, and 3?

**1** Yes

**0** No **F3SRDIF2**

Complete Trial 5 below.

Go to Question #14 below.

**14** Trial 5

**F3SRT5**  
Plate measure:   .  cm

**7** Refused **F3SRT5RF**

**15** Did the participant complain of any discomfort?

**1** Yes   **0** No   **8** Don't know   **7** Refused **F3SRCOMP**



HABC Enrollment ID #	Acrostic	Date Scan Completed	Staff ID #
H		/ / 2 0 0	
		Month Day Year	

F3DATE

F3STFID8

**BONE DENSITY (DXA) SCAN**

1 Do you have breast implants?

1 Yes 0 No 8 Don't know 7 Refused F3BI

- ◆ Flag scan for review by DXA Reading Center.
- ◆ Indicate in the table in Question #2 whether breast implant is in "Left ribs" or "Right ribs" subregion, or both.

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 F3MO

- 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-region	Hardware	Other Artifacts	None	
Head	1	2	9	F3HEAD
Left arm	1	2	9	F3LA
Right arm	1	2	9	F3RA
Left ribs	1	2	9	F3LR
Right ribs	1	2	9	F3RR
Thoracic spine	1	2	9	F3TS
Lumbar spine	1	2	9	F3LS
Pelvis	1	2	9	F3PEL
Left leg	1	2	9	F3LL
Right leg	1	2	9	F3RL

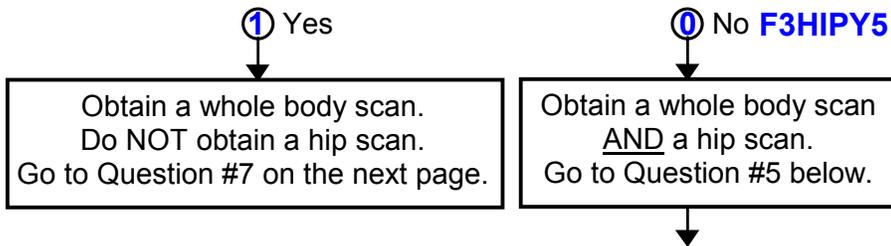
**BONE DENSITY (DXA) SCAN**

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

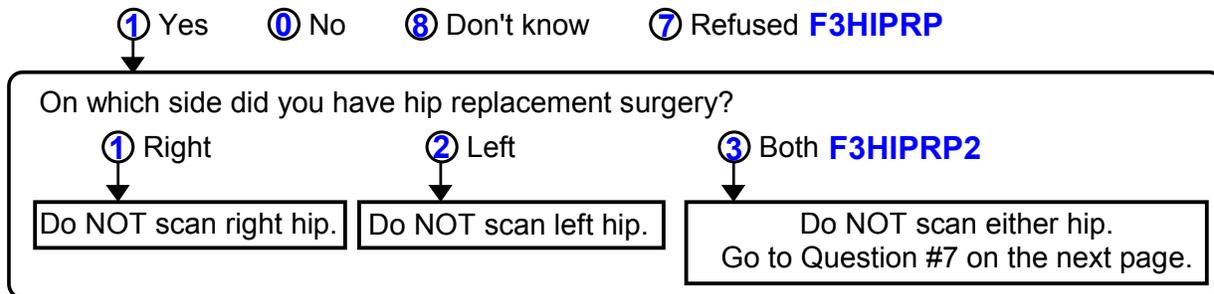
	Yes	No	Don't know	Refused
a. Barium enema	① *	①	⑧	⑦ F3BE
b. Upper GI X-ray series	① *	①	⑧	⑦ F3UGI
c. Lower GI X-ray series	① *	①	⑧	⑦ F3LGI
d. Nuclear medicine scan	① *	①	⑧	⑦ F3NUKE
e. Other tests using contrast ("dye") or radioactive materials	① *	①	⑧	⑦ F3OTH2

*(Examiner Note: If "Yes" to any, reschedule bone density measurement so that at least 10 days will have passed since the tests were performed.)*

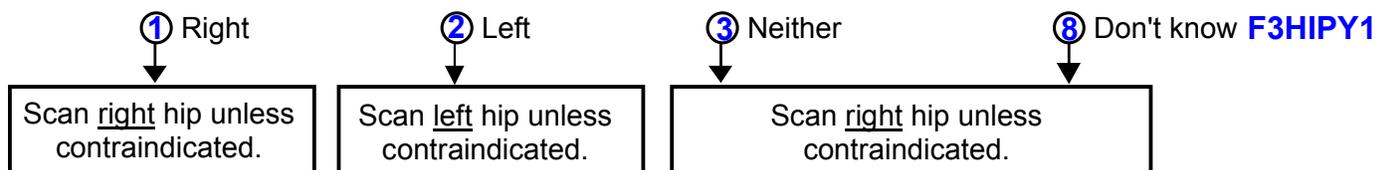
**4** Did the participant have a hip scan during Year 5?  
*(Examiner Note: Refer to Data from Prior Visits Report.)*



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



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



# BONE DENSITY (DXA) SCAN

7 Was a bone density measurement obtained for...?

**a. Whole body**

① Yes      ② No **F3WB**

Last 2 characters of scan ID #:   **F3SCAN1**

Date of scan:   /   /     **F3SCDTE1**

Month      Day      Year

**b. Hip**

① Yes      ② No **F3HIP**

Last 2 characters of scan ID #:   **F3SCAN2**

Date of scan:   /   /     **F3SCDTE2**

Month      Day      Year



HABC Enrollment ID #	Acrostic	Date Scan Completed	Staff ID #
H		/ / 2 0 0	
		Month Day Year	

F3DATE2 F3STFD9

## ISOKINETIC QUADRICEPS 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 9.)*

Yes     
  No     
  Don't know     
 F3BP2

Do NOT test. Go to Question #11.

- 2** Script: "First I need to ask you a few questions to see if you should try this test."

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

Yes     
  No     
  Don't know     
  Refused     
 F3ANEU

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?

Yes     
  No     
  Don't know     
  Refused     
 F3CERHEM

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?  
*(Examiner Note: If the isometric chair test has already been administered, do NOT ask participant this question. Refer to Question #1 on page 21 and record the answer below.)*

Yes     
  No     
  Don't know     
  Refused     
 F3KNRP

Which leg?		
<input type="radio"/> Right leg	<input type="radio"/> Left leg	<input type="radio"/> Both legs      F3KRLB1
↓	↓	↓
Do NOT test right leg.	Do NOT test left leg.	Do NOT test either leg. Go to Question #11.





**Manual Test**

- 8 Which leg was tested?
- 1 Right leg      2 Left leg      3 Manual Test not performed **F3RL2**

↓

*Please explain why:*

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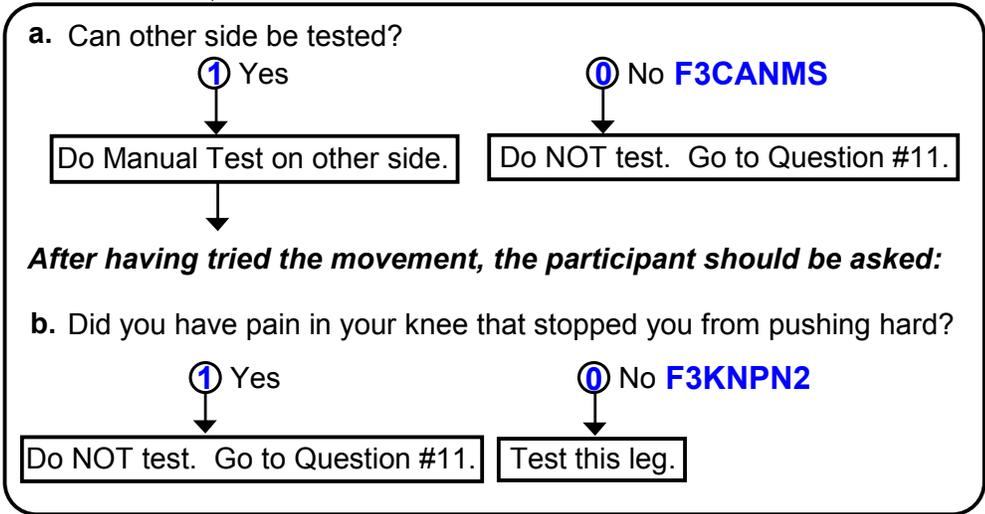
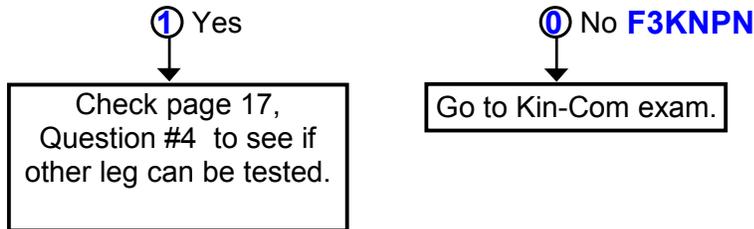


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**Examiner Note: Put hands above the participant's ankle and ask the participant to press against your hands. Keep your elbows extended and use the weight of your upper body to resist the push.**

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

- 9 Did you have pain in your knee that stopped you from pushing hard?



**Manual Positioning Settings**

**10** *Examiner Note: Refer to the Data from Prior Visits Report for dynamometer settings used at the Year 4 clinic visit. Position dynamometer exactly as before, unless a change in leg tested requires a change in settings. Enter Visit 6 settings below.*

- |   |                |                      |                      |                      |       |                      |                      |                      |                      |    |                                |
|---|----------------|----------------------|----------------------|----------------------|-------|----------------------|----------------------|----------------------|----------------------|----|--------------------------------|
| a. Dynamometer tilt                                     | <b>F3DTLT</b>  | <input type="text"/> | <input type="text"/> | <input type="text"/> | °     | e. Seat rotation     | <input type="text"/> | <input type="text"/> | <input type="text"/> | °  | <b>F3STROT</b>                 |
| b. Dynamometer rotation                                 | <b>F3DROT</b>  | <input type="text"/> | <input type="text"/> | <input type="text"/> | °     | f. Seat back angle   | <input type="text"/> | <input type="text"/> | <input type="text"/> | °  | <b>F3STBK</b>                  |
| c. Lever arm green C stop                               | <b>F3LEVGR</b> | <input type="text"/> | <input type="text"/> |                      |       | g. Seat bottom depth | <input type="text"/> | <input type="text"/> |                      | cm | <b>F3STBOT</b>                 |
| d. Lever arm red D stop                                 | <b>F3LEVRD</b> | <input type="text"/> | <input type="text"/> |                      |       | h. Seat bottom angle | <input type="text"/> | <input type="text"/> | <input type="text"/> | °  | <b>F3STBOTA</b>                |
|   |                |                      |                      |                      |       | i. Lever arm length  | <input type="text"/> | <input type="text"/> |                      | cm | <b>F3LENGTH</b>                |
| j. Maximum isometric effort to determine starting force | <b>F3MAXFC</b> | <input type="text"/> | <input type="text"/> | <input type="text"/> | ÷ 2 = | <b>F3STFOR</b>       | <input type="text"/> | <input type="text"/> | <input type="text"/> |    | → Enter as Start Forward Force |

**Kin Com Test**

**11** Which leg was tested?

① Right

② Left

③ Neither; test not done **F3RL3**

1. How many trials were attempted?

**F3TRAT**  
trials

2. Were three curves accepted?

① Yes      ② No **F3CURV**

a. Why not?

\_\_\_\_\_

\_\_\_\_\_

b. How many curves were accepted?

**F3TRAC**  
accepted

3. Peak Torque

**F3PKTORQ**  
Nm

4. Average Torque

**F3AVTORQ**  
Nm

Why wasn't the test done?

*(Examiner Note: Mark all that apply.)*

① Participant excluded based on eligibility criteria **F3EEC**

① Participant refused **F3KPRF**

① Other **F3OTEX**  
*(Please specify:*

\_\_\_\_\_, )

Was an extra record accidentally saved?

① Yes      ② No **F3EXREC**

How many accepted curves were saved in extra record?

**F3CURVS**  
curves

**12** What is the Kin-Com file name?

*(Examiner Note: Please refer to the top of the printout.)*

**F3KCFILE**  
.CHA



## ISOMETRIC STRENGTH (ISOMETRIC CHAIR)

- 1** Have you ever had knee surgery on either leg where all or part of the joint was replaced?  
*(Examiner Note: If the isokinetic quadriceps strength test has already been administered, do NOT ask participant this question. Refer to Question #4 on page 17 and record the answer below.)*

① Yes      ② No      ③ Don't know      ④ Refused **F3KNRP2**

Which leg?

① Right leg      ② Left leg      ③ Both legs **F3KRLB3**

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.)*

① Yes      ② No **F3ISOCH**

Which leg was tested during the most recent isometric chair measurement?  
*(Examiner Note: Refer to the Data from Prior Visits Report.)*

**F3ISORL** 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?  
**F3KC** ① Yes      ② No

Test right leg unless contraindicated.

Which leg was tested during today's Kin-Com exam?  
*(Examiner Note: See Question #11 on page 20 in Year 6 Clinic Visit Workbook.)*

**F3KCRL**

① Right leg → Test right leg unless contraindicated.

② Left leg → Test left leg unless contraindicated.

③ Neither; Test not done → Refer to the Data from Prior Visits Report to determine which leg to test.

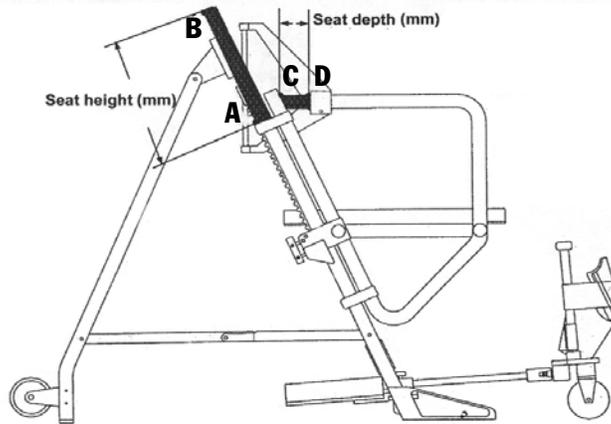
# ISOMETRIC STRENGTH (ISOMETRIC CHAIR)

**3** What is the seat height?  
*(Examiner Note: Refer to the Data from Prior Visits Report for previous seat height setting. Record seat height below. The seat height is the distance between point "A" and "B" as noted below. Use a ruler marked in millimeters.)*

**F3SEATHT**  
mm

**4** What is the seat depth?  
*(Examiner Note: Refer to the Data from Prior Visits Report for previous seat depth setting. Record seat depth below. The seat depth is 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.)*

**F3SEATDP**  
mm



**5** What is the length of the lower leg to be tested?  
*(Examiner Note: Refer to the Data from Prior Visits Report for previous lower leg length measurement. Record leg length measurement. If no previous measurement, measure lower leg.)*

.  **F3LEG1**  
meters

**6** Which leg was tested?  
 ① Right leg      ② Left leg      ③ Test not performed **F3RL4**

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"/> <b>F3MT1A</b>	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <b>F3MRT1A</b>	<input type="text"/> <input type="text"/> <input type="text"/> <b>F3RT1A</b>	<input type="text"/> <input type="text"/> <input type="text"/> <b>F3MVTD1A</b>	① Yes   ② No <b>F3KP1A</b> Test other leg. Go to Question #7.
2.	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <b>F3MT2A</b>	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <b>F3MRT2A</b>	<input type="text"/> <input type="text"/> <input type="text"/> <b>F3RT2A</b>	<input type="text"/> <input type="text"/> <input type="text"/> <b>F3MVTD2A</b>	① Yes   ② No <b>F3KP2A</b> Test other leg. Go to Question #7.
3.	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <b>F3MT3A</b>	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <b>F3MRT3A</b>	<input type="text"/> <input type="text"/> <input type="text"/> <b>F3RT3A</b>	<input type="text"/> <input type="text"/> <input type="text"/> <b>F3MVTD3A</b>	Test complete. Go to Question #9.



**ISOMETRIC STRENGTH (ISOMETRIC CHAIR)**

**7** What is the lower leg length of the second leg being tested?  
*(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.)*

.  **F3LEG2**  
meters

**8** Which other leg is being tested?  
 ① Right leg      ② Left leg      ③ Test not done **F3RL5**

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?
<b>1.</b>	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <b>F3MT1B</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <b>F3MRT1B</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>F3RT1B</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>F3MVTD1B</b>	① Yes    ② No <b>F3KP1B</b> STOP. Go to Question #9.
<b>2.</b>	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <b>F3MT2B</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <b>F3MRT2B</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>F3RT2B</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>F3MVTD2B</b>	① Yes    ② No <b>F3KP2B</b> STOP. Go to Question #9.
<b>3.</b>	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <b>F3MT3B</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <b>F3MRT3B</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>F3RT3B</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>F3MVTD3B</b>	Test complete. Go to Question #9.

**9** What size connecting rod was used?  
*(Examiner Note: Refer to the Data from Prior Visits Report. Use same size connecting rod as was used previously. If no previous measurement, choose appropriate size connecting rod.)*

① Small      ② Medium      ③ Large **F3ROD**

**10** Was the participant able to complete the isometric strength test?

① Yes      ② No **F3ISOTST**

Why not?

*(Examiner Note: Mark all that apply.)*

- F3KCBKR3**
- F3KCPN3**
- F3KCEQ3**
- F3KREF3**
- F3KCFAT3**
- F3KCOH3**

- ① Not eligible: bilateral knee replacement
- ① Knee pain
- ① Equipment problems
- ① Participant refused/didn't understand
- ① Participant fatigue
- ① Other *(Please specify: \_\_\_\_\_ )*



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F3STID11

## GRIP STRENGTH (Hand-Held Dynamometry)

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

1 Yes   0 No   8 Don't know   7 Refused   F3WRST1

Which hand?

1 Right   2 Left   3 Both right and left   F3WRTRL

Do NOT test right.	Do NOT test left.	Do NOT test either hand. Go to Questions #4 and #5 on next page and mark "Unable to test/exclusion/didn't understand."
--------------------	-------------------	---

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

1 Yes   0 No   8 Don't know   7 Refused   F3ARWRSR

Will the pain keep you from squeezing as hard as you can?

1 Yes   0 No   8 Don't know   F3PSQ1

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

1 Yes   0 No   8 Don't know   7 Refused   F3ARWRSR

Will the pain keep you from squeezing as hard as you can?

1 Yes   0 No   8 Don't know   F3PSQ2



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."

**F3NOTST**

**4 Right Hand**    ① Unable to test/exclusion/didn't understand

**F3RTR1**    Trial 1   kg    ⑦ Refused    ⑨ Unable to complete **F3RRUC1**

**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."

**F3RTR2**    Trial 2   kg    ⑦ Refused    ⑨ Unable to complete **F3RRUC2**

*Repeat the procedure on the left side.*

**F3LNTST**

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

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

**F3LTR1**  
Trial 1   kg    ⑦ Refused    ⑨ Unable to complete **F3LRUC1**

**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."

**F3LTR2**  
Trial 2   kg    ⑦ Refused    ⑨ Unable to complete **F3LRUC2**



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F4ID

F4ACROS

F4STFID1

## CHAIR STANDS

### SINGLE CHAIR STAND

Describe: "This is a test of strength in your legs where 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!"

F4SCS

- |                              |   |                                    |
|------------------------------|---|------------------------------------|
| ⑦ Participant refused        | → | Go to Standing Balance on page 27. |
| ⑨ Not attempted, unable      | → | Go to Standing Balance on page 27. |
| ⑩ Attempted, unable to stand | → | Go to Standing Balance on page 27. |
| ① Rises using arms           | → | Go to Standing Balance on page 27. |
| ② Stands without using arms  | → | Go to Repeated Chair Stands below. |

### 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'll demonstrate two chair stands to show you how it's done."

**Examiner Note:** Rise two times as quickly as you can, counting as you sit down each time.

Test: "When I say 'Go' stand up 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.

F4RCS

- |   |   |   |
|---|---|---|
| ⑦ Participant refused                                       |   |   |
| ⑨ Not attempted, unable                                     |   |   |
| ① Attempted, unable to complete 5 stands without using arms | → | <input type="text"/> Number completed without using arms  |
| ② Completes 5 stands without using arms                     | → | <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> Seconds to complete |
- F4COMP
- F4SEC

F4LINK

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**F4STFID2**

## 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.*

⑦ Participant refused → Go to Balance Walks on page 29.

⑨ Not attempted, unable → Go to Balance Walks on page 29.

① Unable to attain position or cannot hold for at least one second → Go to Balance Walks on page 29.

② Holds position between 1 and 29 seconds →   .   **F4STSTM** seconds. Go to Tandem Stand below.

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

F4STS

### 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:**

⑦ Participant refused → Go to One-Leg Stand on page 28.

⑨ Not attempted, unable → Go to One-Leg Stand on page 28.

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 →   .   **F4TSTM** seconds. Go to Trial 2.

③ Holds position for 30 seconds → Go to One-Leg Stand on page 28.

F4TS1

Draft



**TANDEM STAND**

Perform a second trial: "Now, let's do the same thing one more time. Hold onto my arm while you get into position. When you are ready, let go."

**Trial 2:**

- ⑦ Participant refused → Go to One-Leg Stand below.
- ⑨ Not attempted, unable → Go to One-Leg Stand below.
- F4TS2** ① Unable to attain position or cannot hold for at least one second → Go to One-Leg Stand below.
- ② Holds position between 1 and 29 seconds → 

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**F4TS2TM** seconds. Go to One-Leg Stand below.
- ③ Holds position for 30 seconds → Go to One-Leg Stand below.

**ONE-LEG STAND**

Describe: "For the last position, I would like you to try to stand on one leg for 30 seconds. You may stand on either leg, whichever is more comfortable. I'll demonstrate."

Demonstrate and say: "Try to hold your foot up until I say stop. If you lose your balance put your foot down."

**Examiner Note:** Allow the participant to hold onto your arm to get balanced.

Test: "Hold onto my arm while you get in position. When you are ready, let go."

**Trial 1:**

- ⑦ Participant refused → Go to Balance Walks on page 29.
- ⑨ Not attempted, unable → Go to Balance Walks on page 29.
- F4TR1** 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 → 

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**F4TR1TM** seconds. Go to Trial 2.
- ③ Holds position for 30 seconds → Go to Balance Walks on page 29.

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

**Trial 2:**

- ⑦ Participant refused → Go to Balance Walks on page 29.
- ⑨ Not attempted, unable → Go to Balance Walks on page 29.
- F4TR2** ① Unable to attain position or cannot hold for at least one second → Go to Balance Walks on page 29.
- ② Holds position between 1 and 29 seconds → 

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**F4TR2TM** seconds. Go to Balance Walks on page 29.
- ③ Holds position for 30 seconds → Go to Balance Walks on page 29.



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**BALANCE WALKS**

**F4STFD3**

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."

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

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

**Trial 1:** Time:   .   **F4UPTM1** seconds

Number of steps:   **F4UP1** steps

**F4UPRU1** ⑦ Participant refused →  Go to next test.  
 ⑨ Not attempted, unable to walk →  Go to next test.

**Trial 2:** Time:   .   **F4UPTM2** seconds

Number of steps:   **F4UP2** steps

**F4UPRU2** ⑦ Participant refused →  Go to next test.  
 ⑨ Not attempted, unable to walk →  Go to next test.

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

**F420CNA** ⑦ Participant refused →  Go to next test.  
 ⑨ Not attempted, unable to walk →  Go to next test.

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 three or more times. Perform up to 3 trials to obtain 2 valid times.)**

**Trial 1:** ① Yes →   .   **F420CT1** seconds      ① No **F420TR1**

**Trial 2:** ① Yes →   .   **F420CT2** seconds      ① No **F420TR2**

**Trial 3:** ① Yes →   .   **F420CT3** seconds      ① No **F420TR3**

Draft



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F4STFID4

## 20-METER WALK

1 Describe the 20-meter walk.

Script: Describe: "This is a two part walking test. For this first part of the test, please walk at your normal walking speed. Place your toes behind the start line. Then go past the orange cone and 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, "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:   **F420STP1** steps

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

**F420TM1A**  :   .   **F420TM1B**  
 Time on stop watch: Min Second Hundredths/Sec

- 7 Participant refused
  - 9 Not attempted, unable
  - 1 Attempted, unable to complete
- (Examiner Note: Do not record time.)**

F420MW1

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:   **F420STP2** steps

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

**F420TM2A**  :   .   **F420TM2B**  
 Time on stop watch: Min Second Hundredths/Sec

- 7 Participant refused
  - 9 Not attempted, unable
  - 1 Attempted, unable to complete
- (Examiner Note: Do not record time.)**

F420MW2

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

- 1 Yes      0 No **F4WLKAID**



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F4STFID5

**LONG-DISTANCE CORRIDOR WALK ELIGIBILITY ASSESSMENT**

Before Testing:

**1** Was participant able to complete the 20-meter walk (both the usual-pace and fast-pace)?  
*(Examiner Note: Refer to page 30.)*

Yes

No **F420MWC**

Do NOT test. Go to Question #3 on page 36, and Question #7 on page 38.

**2** Are there abnormal Marquette ECG hardcopy references?  
*(Examiner Note: Refer to Data from Prior Visits Report.)*

Yes

No **F4MARQ**

**Examiner Note: Mark all that apply.**

**F4HR1**  Heart rate <40 (bradycardia) or > 135 (tachycardia)

**F4WPW**  Wolff-Parkinson-White (WPW) or ventricular pre-excitation

**F4IR**  Idioventricular rhythm

**F4VT**  Ventricular tachycardia

**F4AV**  Third degree or complete A-V block

**F4TWAVE**  Any statement including reference to acute injury or ischemia, or marked T-wave abnormality

Do NOT test.  
Go to Question #3 on page 36 and Question #7 on page 38.

**3** What is the participant's heart rate (radial pulse)?  
*(Examiner Note: Refer to radial pulse recorded on page 8.)*

**F4HR2**  
bpm

Is heart rate greater than 110 or less than 40 bpm?

**F4HR40**  Yes

No

Do NOT test. Go to Question #3 on page 36 and Question #7 on page 38.

**4 a.** What is the systolic blood pressure?  
*(Examiner Note: Refer to standing systolic blood pressure recorded on page 9.)*

**F4SYSB2**  
mmHg

Is systolic blood pressure > 199 mmHg?

Yes

No **F4SYSYN**

Do NOT test. Go to Question #3 on page 36 and Question #7 on page 38.

**b.** What is the diastolic blood pressure?  
*(Examiner Note: Refer to standing diastolic blood pressure recorded on page 9.)*

**F4DIAB2**  
mmHg

Is diastolic blood pressure > 109 mmHg?

Yes

No **F4SYDIYN**

Do NOT test. Go to Question #3 on page 36 and Question #7 on page 38.



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

Yes     No **F4WKAID2**

Do NOT test. Go to Question #3 on page 36 and Question #7 on page 38.

**6 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?

**F4HA**  Yes →

Do NOT test.  
Go to Question #3 on page 36 and Question #7 on page 38.

No

Don't know

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

**F4ANG**  Yes →

Do NOT test.  
Go to Question #3 on page 36 and Question #7 on page 38.

No

Don't know

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

**F4HS**  Yes →

Do NOT test.  
Go to Question #3 on page 36 and Question #7 on page 38.

No

Don't know

**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 **F4CP**  Yes →

**Do 2-minute walk only,**  
and then go to Question #7  
on page 38.

No

Don't know

**b)** Angina **F4ANGI**  Yes →

**Do 2-minute walk only,**  
and then go to Question #7  
on page 38.

No

Don't know



## LONG-DISTANCE CORRIDOR WALK INSTRUCTIONS & SCRIPT

---

### 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 36 and Question #7 on page 38.*



**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. Please 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 on page 38.*

1 Heart rate:    **F4HR2MW**  
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 0 No **F4B2PL**

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 0 No **F4PLS2**

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, STOP the 2-minute walk.

e. Number of laps completed:  **F42LAP**  
laps

f. Meter mark:   **F42MTR**  
meters

g. Heart rate at end of 2-minute walk or at STOP:    bpm  
**F42BPM**

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.)

1 Yes 0 No **F42PLS**

If participant does not complete the 2-minute walk, record the time at STOP.

:   .   **F42MWTM1** **F42MWTM2**  
Min Second Hundredths/Sec

Do NOT do 400-m walk. Go to Question #3 below and Question #7 on page 38.

3 Did the participant complete the 2-minute walk?  
1 Yes 0 No **F4C2MW**

**(Examiner Note: Mark all that apply.)**

- F4PEX** 1 Participant excluded based on eligibility criteria
- F4PCP** 1 During the test the participant reported chest pain
- F4PSOB** 1 During the test the participant reported shortness of breath
- F4PF** 1 During the test the participant reported feeling faint
- F4PKP** 1 During the test the participant reported knee pain
- F4PHP** 1 During the test the participant reported hip pain
- F4PCF** 1 During the test the participant reported calf pain
- F4PBP** 1 During the test the participant reported back pain

Do NOT do 400-meter walk.  
Go to Question #7 on page 38.

- 7 Participant refused
- F4PRFOT** 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
---	---	---	---	---	---	---	---	---	---	----

b. Number of laps completed: 

--	--

**F44LAP**  
laps

c. Did participant complete all 10 laps?      ① Yes      ② No **F4CLAPS**

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

--	--

**F44DMS**  
meters

② Record time at 400-m or at stop: 

--	--

 : 

--	--

 . 

--	--

**F44TIMEB**  
**F44TIMEA** Min      Second      Hundredths/Sec

Restart stopwatch

③ Did the heart rate exceed 135 bpm at any time during the 400-m walk?  
① Yes      ② No **F4XCD**

④ Heart rate at 400-m or at stop: 

--	--	--

**F44BPM**  
bpm

⑤ Blood pressure at 400-m or at stop:

a. Systolic blood pressure: 

--	--	--

**F44SYS**  
mmHg

b. Diastolic blood pressure: 

--	--	--

**F44DIA**  
mmHg

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

--	--	--

**F44HR**  
bpm



- 7 Did the participant complete the 400-meter walk?  
 Yes  No **F4CM4MW**

**(Examiner Note: Mark all that apply.)**

- F44PEX**  Participant excluded based on eligibility criteria
- F44PNOT**  Participant began, but could not complete 2-minute walk, or completed the 2-minute walk with symptoms
- F44PHR**  Participant's heart rate exceeded 135 bpm during the 2-minute walk
- F44PCP**  During the test the participant reported chest pain
- F44PSOB**  During the test the participant reported shortness of breath
- F44PF**  During the test the participant reported feeling faint
- F44PKP**  During the test the participant reported knee pain
- F44PHP**  During the test the participant reported hip pain
- F44PCF**  During the test the participant reported calf pain
- F44PBP**  During the test the participant reported back pain
- F44PRF**  Participant refused
- F44OTH**  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..?

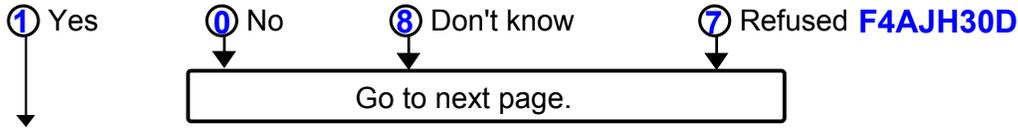
a. Chest pain	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know <input type="radio"/> Refused	<b>F4WC</b>
b. Shortness of breath	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know <input type="radio"/> Refused	<b>F4WSOB</b>
c. Knee pain	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know <input type="radio"/> Refused	<b>F4WK</b>
d. Hip pain	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know <input type="radio"/> Refused	<b>F4WH</b>
e. Calf pain	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know <input type="radio"/> Refused	<b>F4WC</b>
f. Foot pain	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know <input type="radio"/> Refused	<b>F4WF</b>
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	<b>F4WNUMB</b>
h. Leg cramps	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know <input type="radio"/> Refused	<b>F4WLC</b>
i. Back pain	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know <input type="radio"/> Refused	<b>F4WB</b>
j. Other <b>(Please specify: _____ )</b>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know <input type="radio"/> Refused	<b>F4WOTH</b>



HABC Enrollment ID #	Acrostic	Staff ID #
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F4STFID6

1 Now I am going to ask you a question about pain in your hip. In the past 12 months, have you had hip pain on most days for at least one month? This includes pain in the groin and either side of the upper thigh. Do not include pain that was only in your lower back or buttocks.  
(Examiner Note: **REQUIRED - Show card #1.**)



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

- F4AJH12M
- 2 Right hip only
  - 1 Left hip only
  - 3 Both right and left hip

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

- F4AJHPPN 1 Mild      2 Moderate      3 Severe      4 Extreme      8 Don't know

c. Now, please think about the past 30 days. In the past 30 days how much pain have you had in your hips during each situation I will describe? Would you say...  
(Examiner Note: **OPTIONAL - Show card #2. If pain is in both left and right hip, say: "again, answer for the worse hip."**)

	None	Mild	Moderate	Severe	Extreme	Don't know
a) Walking on a flat surface	0	1	2	3	4	8 F4AJHPFS
b) Going up or down stairs	0	1	2	3	4	8 F4AJHPST
c) At night while in bed	0	1	2	3	4	8 F4AJHPBD
d) Standing upright	0	1	2	3	4	8 F4AJHPUP
e) Putting on socks	0	1	2	3	4	8 F4AJHPSC
f) Getting in or out of a chair (Examiner Note: <b>Relatively hard, supportive chair</b> )	0	1	2	3	4	8 F4AJHPCH
g) Getting in or out of a car	0	1	2	3	4	8 F4AJHPIN



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**HIP INTERNAL ROTATION**

**F4STFD7**

**1** Have you ever had a hip replacement on your left hip?

Yes

No

Don't know

Refused **F4REPLH**

Do NOT examine left hip.  
Go to Question #4.

**Left Leg**

Align the stationary arm of the goniometer on a line between the patellae of the knees with the pivot over the left patella.

Hold the left leg at the shin with your right hand and put your left hand on the top of the left knee to stabilize the joint. Before the motion, say:

"I'm going to rotate your leg by pushing [pulling] your lower leg up and outward. As I move your leg, tell me if you feel any pain in your hip or groin."

Move the left leg (and the arm of the goniometer) counter-clockwise to the limit of motion or until the participant complains of pain. Buttocks should remain on the table and the stationary arm of the goniometer parallel to the table top.

**2** How many degrees was the limit of motion?

**F4HIPDGL**  
degrees

**3** After reading the limit of motion ask: "Did that hurt in your hip or groin?"

Yes

No

Don't know

Refused **F4HIPPNL**

**4** Have you ever had a hip replacement on your right hip?

Yes

No

Don't know

Refused **F4REPRH**

Do NOT examine right hip.

**Right Leg**

Reverse examiner hand and goniometer positions for the right leg.

Move the right leg (and the descending arm of the goniometer) clockwise to the limit of motion or until the participant complains of pain.

Script: "As I move your leg, tell me if you feel any pain in your hip or groin."

**5** How many degrees was the limit of motion?

**F4HIPDGR**  
degrees

**6** After reading the limit of motion ask: "Did that hurt in your hip or groin?"

Yes

No

Don't know

Refused **F4HIPPNR**



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"/>

F4STFID8

## ASSESSMENT OF ARTHRITIS and KNEE PAIN

**1** 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.

Yes   
  No   
  Don't know   
  Refused **F4AJARTH**

<b>a.</b> Did the doctor say it was...?	
<b>i.</b> Osteoarthritis or degenerative arthritis in your knee?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know <b>F4AJKNEE</b>
<b>ii.</b> Osteoarthritis or degenerative arthritis in your hip?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know <b>F4AJHIP</b>
<b>b.</b> Do you take any medicines for arthritis or joint pain?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know <b>F4AJMEDS</b>

Now I am going to ask you some questions regarding any pain or stiffness in your joints. I will also examine your knees.

These questions are about pain, aching or stiffness in or around your knee. This includes the front, back and sides of the knee.

First, I'll ask about your left knee.

**2** In the past 12 months, have you had any pain, aching or stiffness in your left knee?

Yes   
  No   
  Don't know   
  Refused **F4AJLK12**

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

Yes \*   
  No   
  Don't know **F4AJLK1M**

**\*Examiner Note: Refer to back to this question when completing Question #2a on page 45. Participant may be eligible for knee x-ray.**

3 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 **F4AJLK30**

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 **F4AJLKMS**

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...?

*(Examiner Note: Read each activity separately. Read response options. OPTIONAL-Show card #2.)*

	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 <b>F4AJLKFS</b>
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 <b>F4AJLKST</b>
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 <b>F4AJLKBD</b>
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 <b>F4AJLKUP</b>
e) Getting in or out of a chair <i>(Examiner 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 <b>F4AJLKCH</b>
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 <b>F4AJLKIN</b>

\* **Examiner Note: Refer back to this question when completing Question #2a on page 45. Participant may be eligible for knee x-ray.**



Now I am going to ask about your right knee.

- 4 In the past 12 months, have you had any pain, aching or stiffness in your right knee?  
 1 Yes     0 No     8 Don't know     7 Refused **F4AJRK12**

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

- 1 Yes \*     0 No     8 Don't know **F4AJRK1M**

**\* Examiner Note: Refer to back to this question when completing Question #2a on page 45. Participant may be eligible for knee x-ray.**

- 5 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 **F4AJRK30**

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 **F4AJRKMS**

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...?

**Examiner Note: Read each activity separately. Read response options. OPTIONAL-Show card #2.**

	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 <b>F4AJRKF5</b>
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 <b>F4AJRKST</b>
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 <b>F4AJRKB0</b>
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 <b>F4AJRKUP</b>
e) Getting in or out of a chair (Examiner Note: A relatively hard, supportive 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 <b>F4AJRKCH</b>
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 <b>F4AJRKIN</b>

**\* Examiner Note: Refer back to this question when completing Question #2a on page 45. Participant may be eligible for knee x-ray.**



## ASSESSMENT OF KNEE PAIN

---

⑥ In the past 30 days, have you limited your activities because of pain, aching or stiffness in your knees?

① Yes

② No

③ Don't know

⑦ Refused **F4AJACT**

↓  
On how many days did you limit your activities because of pain, aching or stiffness?  
If you are unsure, please make your best guess.

**F4AJLDAY**

days

③ Don't know **F4AJLDDK**

---

⑦ In the past 30 days, have you changed, cut back, or avoided any activities in order to avoid knee pain or reduce the amount of knee pain?

① Yes

② No

③ Don't know

⑦ Refused **F4AJCUT**

---





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<b>F5ID</b>	<b>F5ACROS</b>	<b>F5DATE</b>	<b>F5STFID1</b>

**PHLEBOTOMY**

Bar Code Label

**1** Do you bleed or bruise easily? **F5BRCD**  
**F5BLBR** ① Yes    ② No    ③ Don't know    ④ Refused

**2** Have you ever experienced fainting spells while having blood drawn?  
 ① Yes    ② No    ③ Don't know    ④ Refused **F5FNT**

**3** Have you ever had a radical mastectomy? **(Female Participants Only)**  
 ① Yes    ② No    ③ Don't know    ④ Refused **F5RADMAS**

Which side?

① Right	② Left	③ Both <b>F5RMSIDE</b>
↓	↓	↓
Draw blood on left side.	Draw blood on right side.	Do NOT draw blood. Go to Question #10 on page 48.

**4** Have you ever had a graft or shunt for kidney dialysis?  
 ① Yes    ② No    ③ Don't know    ④ Refused **F5KIDNEY**

Which side?

① Right	② Left	③ Both <b>F5KDSIDE</b>
↓	↓	↓
Draw blood on left side.	Draw blood on right side.	Do NOT draw blood. Go to Question #10 on page 48.

**F5LINK**

--



5 Time at start of venipuncture:

**F5VTM**

		:		
Hours			Minutes	

1 am 2 pm **F5AMP4**

6 Time blood draw completed:

**F5BLDRTM**

		:		
Hours			Minutes	

1 am 2 pm **F5AMP5**

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

		minutes
<b>F5TOUR</b>		

Comments on phlebotomy:

---



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---

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

a. Date of last food: 

	/		/				
Month		Day		Year			

**F5LMD**

**F5MHM**

b. Time of last food: 

		:		
Hours			Minutes	

 1 am 2 pm **F5LMAPM**

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

		hours (Question 6 minus Question 8b. Round to nearest hour.)
<b>F5FAST</b>		

9 Quality of venipuncture:

- Clean     
  Traumatic **F5QVEN**

**Please describe. Mark all that apply:**

- Vein collapse **F5PVC**  
 Hematoma **F5PH**  
 Vein hard to get **F5PVHTG**  
 Multiple sticks **F5PMS**  
 Excessive duration of draw **F5PEDD**  
 Leakage at venipuncture site **F5PLVS**  
 Other *(Please specify:)* **F5POTH**
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

10 Was any blood drawn?

- Yes     
  No **F5BLDR**

Please describe why not: \_\_\_\_\_

\_\_\_\_\_

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

Tube	Volume	Filled to Capacity?		Comment
		Yes	No	
1. EDTA	5 ml	<input checked="" type="radio"/>	<input checked="" type="radio"/> → <b>F5BV1</b>	_____
2. EDTA	10 ml	<input checked="" type="radio"/>	<input checked="" type="radio"/> → <b>F5BV2</b>	_____
3. Serum	10 ml	<input checked="" type="radio"/>	<input checked="" type="radio"/> → <b>F5BV3</b>	_____
4. Serum	10 ml	<input checked="" type="radio"/>	<input checked="" type="radio"/> → <b>F5BV4</b>	_____

\_\_\_\_\_



HABC Enrollment ID # H [ ] [ ] [ ] [ ] <b>F6ID</b>	Acrostic [ ] [ ] [ ] [ ] <b>F6ACROS</b>	Date Form Completed [ ] [ ] / [ ] [ ] / 2 0 0 Month Day Year <b>F6DATE</b>	Staff ID # [ ] [ ] [ ] <b>F6STFID1</b>
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**YEAR 6 RETURN VISIT PHLEBOTOMY**

Bar Code Label

**1** Do you bleed or bruise easily?  
**F6BLBR** ① Yes ② No ③ Don't know ④ Refused

**F6BRCD**

**2** Have you ever experienced fainting spells while having blood drawn?  
 ① Yes ② No ③ Don't know ④ Refused **F6FNT**

**3** Have you ever had a radical mastectomy? **(Female Participants Only)**  
 ① Yes ② No ③ Don't know ④ Refused **F6RADMAS**

Which side?

① Right ↓ Draw blood on left side.	② Left ↓ Draw blood on right side.	③ Both ↓ Do NOT draw blood. Go to Question #10 on page 48.
--	--	--

**F6RMSIDE**

**4** Have you ever had a graft or shunt for kidney dialysis?  
 ① Yes ② No ③ Don't know ④ Refused **F6KIDNEY**

Which side?

① Right ↓ Draw blood on left side.	② Left ↓ Draw blood on right side.	③ Both ↓ Do NOT draw blood. Go to Question #10 on page 48.
--	--	--

**F6KDSIDE**

**Examiner Note: If the participant is having a repeat blood draw only because they were not fasting during their Year 6 clinic visit, only draw a 3 to 5 ml serum tube. In Question #10.3, mark "Yes" when asked whether the serum tube was filled to capacity (even though the volume is less than 10 ml).**

**F6LINK**

[ ]



5 Time at start of venipuncture:

F6VTM [ ] [ ] : [ ] [ ] ① am ② pm F6AMPM4
Hours Minutes

6 Time blood draw completed:

[ ] [ ] : [ ] [ ] ① am ② pm F6AMPM5
Hours Minutes
F6BLDRTM

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

F6TOUR [ ] [ ] minutes

Comments on phlebotomy:
[ ]
[ ]
[ ]

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

a. Date of last food: [ ] [ ] / [ ] [ ] / [ ] [ ] [ ] [ ] F6LMD
Month Day Year
F6MHM

b. Time of last food: [ ] [ ] : [ ] [ ] ① am ② pm F6LMAPM
Hours Minutes

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

F6FAST [ ] [ ] hours (Question 6 minus Question 8b. Round to nearest hour.)

[ ]



9 Quality of venipuncture:

- ① Clean      ② Traumatic **F6QVEN**

*Please describe. Mark all that apply:*

- F6PVC** ① Vein collapse  
**F6PH** ① Hematoma  
**F6PVHTG** ① Vein hard to get  
**F6PMS** ① Multiple sticks  
**F6PEDD** ① Excessive duration of draw  
**F6PLVS** ① Leakage at venipuncture site  
**F6POTH** ① Other *(Please specify:)*

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

10 Was any blood drawn?

- ① Yes      ② No **F6BLDR**

Please describe why not: \_\_\_\_\_  
 \_\_\_\_\_

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

Tube	Volume	Filled to Capacity?		Comment
		Yes	No	
1. EDTA	5 ml	①	② → <b>F6BV1</b>	_____
2. EDTA	10 ml	①	② → <b>F6BV2</b>	_____
3. Serum*	10 ml	①	② → <b>F6BV3</b>	_____
4. Serum	10 ml	①	② → <b>F6BV4</b>	_____

**\*Examiner Note:** If the participant had a repeat blood draw only because they were not fasting during their Year 6 clinic visit, mark "Yes" to Question #10.3 when asked whether the serum tube was filled to capacity (even though the volume is less than 10 ml).

\_\_\_\_\_





HABC Enrollment ID # H <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Acrostic <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Date Scan Done <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	CT Tech ID # <input type="text"/> <input type="text"/> <input type="text"/>
<b>FCID</b>	<b>FCACROS</b>	Month      Day <b>FCDATE</b> Year	<b>FCSTFID</b>

**YEAR 6 CT TRACKING**

**1** On which side was the thigh length measured at baseline (Year 1)?

*(Examiner Note: Refer to Data from Prior Visits Report to see which thigh was measured at baseline.)*

**FCTHY1** ① Right      ② Left      ③ Neither      ④ Don't know

↓      ↓      ↓      ↓

Measure right thigh length.      Measure left thigh length.      Measure right thigh length.

**2** Was a thigh scan obtained this year (Year 6 clinic visit)?

**FCTHYN** ① Yes      ② No

↓      ↓

**a.** On which side was the thigh length measured?

**FCHLEN** ① Left      ② Right

**b.** Record the CT ID # below.

**FCTHSN**

Exam number

**FCTTS**   :

Time Stamp

Why wasn't a thigh scan obtained?  
*(Note: Mark all that apply.)*

**FCTHRE1** ① Cannot lie supine

**FCTHRE2** ① CT rescheduled

**FCTHRE3** ① Other *(Please specify: \_\_\_\_\_)*

**3** Was an abdominal scan obtained this year (Year 6 clinic visit)?

**FCABYN** ① Yes      ② No

↓      ↓

Record the CT ID # below.

**FCABEX**

Exam number

**FCATS**   :

Time Stamp

Why wasn't an abdominal scan obtained?  
*(Note: Mark all that apply.)*

**FCABRE1** ① Cannot lie supine

**FCABRE2** ① CT rescheduled

**FCABRE3** ① Other *(Please specify: \_\_\_\_\_)*



H					
---	--	--	--	--	--

--	--	--	--

## YEAR 6 CT TRACKING

**4** What facility performed the CT scan?

**1** Center Commons MRI and CT, Pittsburgh

**FCCTFAC 2** Diagnostic Imaging, Memphis

**3** UT Bowld Hospital, Memphis

**4** Methodist Central, Memphis

**5** Other (*Please specify:* \_\_\_\_\_  
\_\_\_\_\_ )

### PITTSBURGH ONLY:

**5** Was a spine scan obtained this year (Year 6 clinic visit)?

**FCSPYN 1** Yes

**0** No

**a.** What level was scanned?  
(*Note: Mark only one.*)

T12 **1**

**FCSPLY L1 2**

L2 **3**

L3 **4** (*Preferred*)

L4 **5**

**b.** Record the CT ID # below.

**FCSPSN**

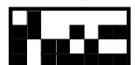
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Why wasn't a spine scan obtained?  
(*Note: Mark all that apply.*)

**FCSPRE1 1** Cannot lie supine

**FCSPRE2 1** CT rescheduled

**FCSPRE3 1** Other (*Please specify:* \_\_\_\_\_  
\_\_\_\_\_ )



--

HABC Enrollment ID #	Acrostic	Date Form Completed	Staff ID #
H [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ]	[ ] / [ ] / [ ] [ ] [ ] [ ]	[ ] [ ] [ ]
<b>ZBID</b>	<b>ZBACROS</b>	Month Day Year	<b>ZBSTFID</b>

## 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	<b>ZBHV</b>
2. Medication Inventory Update	29	<input type="radio"/> 1 Yes <input type="radio"/> 0 No	<b>ZBMI</b>
3. Weight	34	<input type="radio"/> 1 Yes <input type="radio"/> 0 No	<b>ZBWT</b>
4. Radial Pulse	34	<input type="radio"/> 1 Yes <input type="radio"/> 0 No	<b>ZBRP</b>
5. Blood Pressure	35	<input type="radio"/> 1 Yes <input type="radio"/> 0 No	<b>ZBBP</b>
6. Grip Strength	36	<input type="radio"/> 1 Yes <input type="radio"/> 0 No	<b>ZBGRIP</b>
7. Standing Balance	37	<input type="radio"/> 1 Yes <input type="radio"/> 0 No	<b>ZBSB</b>
8. Chair Stands	38	<input type="radio"/> 1 Yes <input type="radio"/> 0 No	<b>ZBCS</b>
9. 4-meter Walk	40	<input type="radio"/> 1 Yes <input type="radio"/> 0 No	<b>ZB4MW</b>
10. Knee Crepitus	41	<input type="radio"/> 1 Yes <input type="radio"/> 0 No	<b>ZBKNEE</b>
11. Isometric Strength (Isometric Chair)	42	<input type="radio"/> 1 Yes <input type="radio"/> 0 No	<b>ZBISO</b>
12. Ultrasound	45	<input type="radio"/> 1 Yes <input type="radio"/> 0 No	<b>ZBULTRA</b>
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	<b>ZBDXA</b>
14. Was blood collected?		<input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 5 Not applicable	<b>ZBBLOOD</b>
15. Was urine collected?		<input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 5 Not applicable	<b>ZBURINE</b>
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	<b>ZBHVWK</b>
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	<b>ZBSUB</b>
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	<b>ZBXR</b> <small>9 Not eligible</small>

Draft



HABC Enrollment ID #	Acrostic	Date Form Completed	Staff ID #
H <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
ZCID	ZCACROS	Month ZCDATE Year	ZCSTFID

**CORE HOME VISIT WORKBOOK**

Year of annual contact: **ZCTYPE**

Year 03       Year 06  
 Year 04       Year 07  
 Year 05       Other (Please specify) \_\_\_\_\_

Type of contact: **ZCCONTAC**

Home (face-to-face interview)  
 Telephone interview  
 Other (Please specify) \_\_\_\_\_

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

/  /

Month      Day      Year      ★ = Priority questions

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

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

★ 2. Since we last spoke to you about 6 months ago, did you stay in bed all or most of the day because of an illness or injury? Please include days that you were a patient in a hospital. **ZCBED12**

- Yes       No       Don't know       Refused

★ About how many days did you stay in bed all or most of the day because of an illness or injury? Please include days that you were a patient in a hospital.  
*(Interviewer Note: If necessary, probe - "If you are unsure, please make your best guess.")*

days      **ZCBEDDAY**

★ 3. Since we last spoke to you about 6 months ago, did you cut down on the things you usually do, such as going to work or working around the house, because of an illness or injury? Please include days in bed. **ZCCUT12**

- Yes       No       Don't know       Refused

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

days      **ZCCUTDAY**







★ 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

→

→

→

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

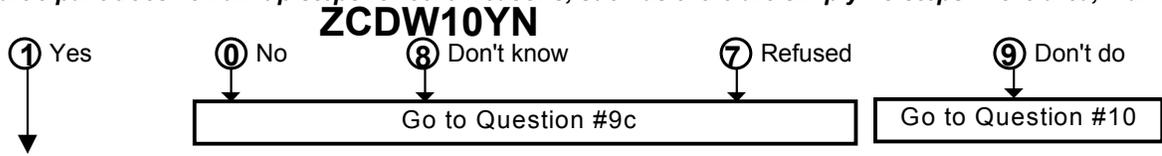
- ① Very easy
- ② Somewhat easy
- ③ Or not that easy
- ⑧ Don't know/Don't do

ZCDW1MEZ



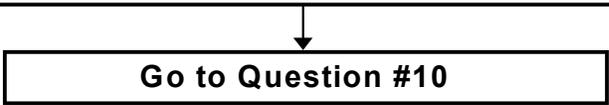
**CORE HOME VISIT WORKBOOK  
PHYSICAL FUNCTION**

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



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

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

ZCDW10EZ

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

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

ZCDW10WX

★ 9e. Because of a health or physical problem, do you have any difficulty walking up 20 steps, that is about 2 flights, without resting?

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

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

ZCDW20YN

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

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

ZCDW20EZ



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

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

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

**ZCDIODIF**

- A little difficulty
- Some difficulty
- A lot of difficulty
- Or are you unable to do it?
- Don't know

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

**ZCDIORHY**

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

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

**ZCBATHDF**

- A little difficulty
- Some difficulty
- A lot of difficulty
- Or are you unable to do it?
- Don't know

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

**ZCBATHRH**

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

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

**ZCDDIF**

- A little difficulty
- Some difficulty
- A lot of difficulty
- Or are you unable to do it?
- Don't know

★ Do you usually receive help from another person in dressing?  
 Yes     No     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**





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

/  /   
 Month / Day / Year

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

- Yes       No       Don't know       Refused

★ Were you hospitalized overnight for this problem?  
**ZCHOSMI**

Yes       No

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

**ZCREF23A** a.

**ZCREF23B** b.

**ZCREF23C** c.

Go to Question #24

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

- Yes       No       Don't know       Refused

**ZCHCCVA**

★ Were you hospitalized overnight for this problem?  
**ZCHOSMI2**

Yes       No

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

**ZCREF24A** a.

**ZCREF24B** b.

**ZCREF24C** c.

Go to Question #25

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

- Yes       No       Don't know       Refused

★ Were you hospitalized overnight for this problem?  
**ZCHOSMI3**

Yes       No

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

**ZCREF25A** a.

**ZCREF25B** b.

**ZCREF25C** c.

Go to Question #26



★ **26.** Since we last spoke to you about 6 months ago, has a doctor told you that you had cancer?  
We are specifically interested in hearing about a cancer that your doctor diagnosed for the first time since we last spoke to you.

**ZCCHMGMT**

- Yes     
  No     
  Don't know     
  Refused

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

a. 

--	--	--	--	--

b. 

--	--	--	--	--

c. 

--	--	--	--	--

**ZCREF26A**

**ZCREF26B**

**ZCREF26C**

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

**ZCLCPNEU**

- Yes     
  No     
  Don't know     
  Refused

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

a. 

--	--	--	--	--

b. 

--	--	--	--	--

c. 

--	--	--	--	--

**ZCREF27A**

**ZCREF27B**

**ZCREF27C**

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

**ZCOSBR45**

- Yes     
  No     
  Don't know     
  Refused

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

a. 

--	--	--	--	--

b. 

--	--	--	--	--

c. 

--	--	--	--	--

**ZCREF28A**

**ZCREF28B**

**ZCREF28C**



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

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

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

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

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



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

① Yes

② No

⑧ Don't know

⑦ Refused

Please go to Question #32

ZCOTILL

Please describe for what:

---

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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

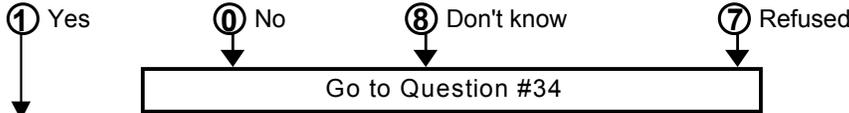
ZCELOFTN

---



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**

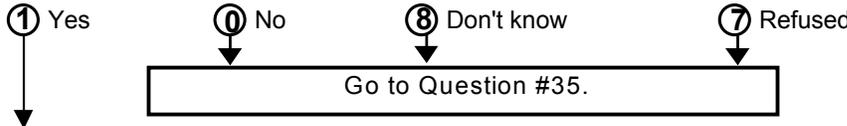
1 Yes \*       0 No       8 Don't know

↓

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 <b>ZCAJKFS</b>
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 <b>ZCAJKST</b>
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 <b>ZCAJKBD</b>
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 <b>ZCAJKUP</b>
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 <b>ZCAJKCH</b>
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 <b>ZCAJKIN</b>

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



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

**CORE HOME VISIT WORKBOOK  
LIFE EVENTS**

Year of annual contact:

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**





★ **45.** 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 **ZDMOVE**

**a.** Do you know what your new mailing address will be?

Yes ①      No ②      **ZDMOVE2**

What will be your new mailing address?

New address:

ZDMASTRT	
----------	--

Street Address

ZDMAAPT
---------

Apt/Room

ZDMACITY	ZDMASTAT
----------	----------

City

State

ZDMAZIP
---------

Zip Code

- ① Permanent address
- ② Winter address
- ④ Summer address
- ③ Other (Please describe: ZDADDRESS )

Telephone:

(				)	-					ZDMATELE
---	--	--	--	---	---	--	--	--	--	----------

Area Code

Number

Date new address/phone number effective:

	/		/		ZDMADATE
--	---	--	---	--	----------

Month

Day

Year





**46.**

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

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

a.

**ZDCIFNAM**

First Name

**ZDCILNAM**

Last Name

**ZDCISTR**

Street Address

**ZDCIAPT**

Apt/Room

**ZDCICITY**

City

State

-

**ZDCIZIP**

Zip Code

**ZDCISTAT**

Telephone:

(  )  -

Area Code

Number

**ZDCITELE**

b. How is this person related to you?

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

**ZDCIREL**

c. Is this person your next of kin?

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

**ZDCINOK**

d. Have you given this person power of attorney?

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

**ZDCIPOA**



★ **47.** You previously told us the name, address, and telephone number of two close friends or relatives who do not live with you and who would know how to reach you in case you move and we need to get in touch with you. These people did not have to be local people. Please tell me if the information I have is still correct.

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

**Contact #1**

**a.**

**ZDC1FNAM**

First Name

**ZDC1LNAM**

Last Name

**ZDC1STRT**

Street Address

**ZDC1APT**

Apt/Room

**ZDC1CITY**

City

State

**ZDC1ZIP**  -

Zip Code

**ZDC1STAT**

Telephone:

(    )  -

Area Code

Number

**ZDC1PHON**

**b.** How is this person related to you?

① My son or daughter

⑤ My mother or father

② My niece or nephew

⑥ Friend/neighbor

③ My grandchild

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

④ My brother or sister

**ZDC1REL**

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

① Yes

② No

③ Don't know

④ Refused

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

① Yes

② No

③ Don't know

④ Refused



47a.

Contact #2

a. **ZDC2FNAM**

First Name

**ZDC2LNAM**

Last Name

**ZDC2STRT**

Street Address

**ZDC2APT**

Apt/Room

**ZDC2CITY**

City

State

**ZDC2ZIP** -

Zip Code

**ZDC2STAT**

Telephone:

(    )  -

Area Code

Number

**ZDC2PHON**

b. How is this person related to you?

① My son or daughter

⑤ My mother or father

② My niece or nephew

⑥ Friend/neighbor

③ My grandchild

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

④ My brother or sister

**ZDC2REL**

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

① Yes

② No

③ Don't know

⑦ Refused

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

① Yes

② No

③ Don't know

⑦ Refused



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

① Yes      ② No      **ZDKNOK**



Who is your next of kin?

**ZDKFNAME** [Grid of 20 boxes]

First Name

**ZDKLNAME** [Grid of 20 boxes]

Last Name

**ZDKSTRT** [Grid of 20 boxes]

Street Address

**ZDKAPT** [Grid of 5 boxes]

Apt/Room

**ZDKSTATE**

**ZDKCITY** [Grid of 15 boxes] [Grid of 2 boxes]

City

State

[Grid of 5 boxes] - [Grid of 4 boxes]

Zip Code

**ZDKZIP**

Telephone:

( [Grid of 3 boxes] ) [Grid of 7 boxes] - [Grid of 4 boxes]

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

## 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 [ ] [ ]	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: [ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ]	[ ] [ ]	[ ] [ ] [ ] [ ]	<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: [ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ]	[ ] [ ]	[ ] [ ] [ ] [ ]	<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: [ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ]	[ ] [ ]	[ ] [ ] [ ] [ ]	<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: [ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ]	[ ] [ ]	[ ] [ ] [ ] [ ]	<input checked="" type="checkbox"/> Rx <input type="checkbox"/> Non Rx

# Health ABC HOME VISIT MEDICATION INVENTORY FORM--page b

## SectionB Prescription Medication -- Continued

Medication Name (Generic Name or Trade Name)      Strength      Units      Indicate Number Used & Circle Day, Week or Month      PRN? Check "X": Yes or No      Container Seen? Check "X": Yes or No

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

Continued on MIF Supplement

### Formulation Codes

0=unidentifiable, 1=oral tablet, 2=oral capsule, 3=oral liquid, 4=topical cream, lotion, or ointment, 5=other liquid, 6=ophthalmic, 7=missing, 8=rectal or vaginal, 9=inhaled or nasal, 10=injected, 11=transdermal patch, 12=powder, 99=other

# Health ABC HOME VISIT MEDICATION INVENTORY FORM--page c

## Section C Over-the-counter Medications and Supplements

Copy the name of the over-the-counter medicine, the strength in milligrams (mg) or other units, the total number of doses taken per day, week or month. Indicate whether the medication is taken on an "as needed" basis, and whether or not the container was actually seen. In addition, record reason for use, date started, and formulation code.

Medication Name (Generic Name or Trade Name)	Strength	Units	Indicate Number Used & Circle Day, Week or Month	PRN? Check "X": Yes or No	Container Seen? Check "X": Yes or No
1. <input type="text" value="MIFNAME"/>	<input type="text" value="MIF STREN"/>	<input type="text" value="MIF UNIT"/>	<input type="text" value="MIEDWM"/> <input type="text" value="1"/> D <input type="text" value="0"/> W <input type="text" value="N"/> M	<input type="text" value="1"/> Y <input type="text" value="0"/> N	<input type="text" value="1"/> Y <input type="text" value="0"/> N
Reason for use: <input type="text" value="MIFREAS"/>			Date Started: <input type="text" value="MIFMONTH"/> / <input type="text" value="MIFYEAR"/>	Formulation Code: <input type="text" value="MIFFORM"/>	<input type="checkbox"/> Rx <input checked="" type="checkbox"/> Non Rx
2. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> D <input type="text"/> W <input type="text"/> M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: <input type="text"/>			Date Started: <input type="text"/> / <input type="text"/>	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"/> D <input type="text"/> W <input type="text"/> M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: <input type="text"/>			Date Started: <input type="text"/> / <input type="text"/>	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"/> D <input type="text"/> W <input type="text"/> M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: <input type="text"/>			Date Started: <input type="text"/> / <input type="text"/>	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"/> D <input type="text"/> W <input type="text"/> M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: <input type="text"/>			Date Started: <input type="text"/> / <input type="text"/>	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"/> D <input type="text"/> W <input type="text"/> M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: <input type="text"/>			Date Started: <input type="text"/> / <input type="text"/>	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"/> D <input type="text"/> W <input type="text"/> M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: <input type="text"/>			Date Started: <input type="text"/> / <input type="text"/>	Formulation Code: <input type="text"/>	<input type="checkbox"/> Rx <input checked="" type="checkbox"/> Non Rx

# Health ABC HOME VISIT MEDICATION INVENTORY FORM--page d

## Section C Over-the-counter Medications and Supplements (continued)

Medication Name (Generic Name or Trade Name)      Strength      Units      Indicate Number Used & Circle Day, Week or Month      PRN? Check "X": Yes or No      Container Seen? Check "X": Yes or No

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

Continued on MIF Supplement

### Formulation Codes

0=unidentifiable, 1=oral tablet, 2=oral capsule, 3=oral liquid, 4=topical cream, lotion, or ointment, 5=other liquid, 6=ophthalmic, 7=missing, 8=rectal or vaginal, 9=inhaled or nasal, 10=injected, 11=transdermal patch, 12=powder, 99=other



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

## HOME VISIT MEDICATION INVENTORY FORM SUPPLEMENT

### Prescription and Over-the-counter Medications and Supplements

Copy the name of the prescription or over-the-counter medicine, the strength in milligrams (mg) or other units and the total number of doses taken per day, week or month.

Medication Name (Generic Name or Trade Name)	Strength	Units	Indicate Number Used & Circle Day, Week or Month	PRN? Check "X": Yes or No	Container Seen? Check "X": Yes or No
1S. MIFNAME	MIF STREN	MIF UNIT	MIFDWM D W M	1 Y 0 N MIFPRN	1 Y 0 N MIFSEEN Rx 1 MIFRX
Reason for use: MIFREAS Date Started: MIFMONTH / MIFYEAR Formulation Code: MIFFORM					
2S.			D W M	Y N	Y N
Reason for use: Date Started: Month / Year Formulation Code: Rx Non Rx					
3S.			D W M	Y N	Y N
Reason for use: Date Started: Month / Year Formulation Code: Rx Non Rx					
4S.			D W M	Y N	Y N
Reason for use: Date Started: Month / Year Formulation Code: Rx Non Rx					
5S.			D W M	Y N	Y N
Reason for use: Date Started: Month / Year Formulation Code: Rx Non Rx					
6S.			D W M	Y N	Y N
Reason for use: Date Started: Month / Year Formulation Code: Rx Non Rx					
7S.			D W M	Y N	Y N
Reason for use: Date Started: Month / Year Formulation Code: Rx Non Rx					

HABC Enrollment ID #	Acrostic
H <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

**CORE HOME VISIT WORKBOOK**

**Z4ID** **Z4ACROS**

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

**Z4TYPE**

**WEIGHT AND RADIAL PULSE**

**WEIGHT**

lbs **Z4WTLBS**

Staff ID#      
**Z4STFID1**

**RADIAL PULSE**

Staff ID#      
**Z4STFID2**

Measurement 1    beats per 30 seconds **x 2 =**    beats per minute  
**Z4PLSSM1** **Z4PULSE**

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

## 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** Trial 1 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** Trial 2 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** Trial 1 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** Trial 2 kg ① Refused **Z4LRF2**





**TANDEM STAND**

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

**Trial 2: Z4TS2**

- ⑦ Participant refused → Go to One-Leg Stand.
- ⑨ Not attempted, unable → Go to One-Leg Stand.  
(Please comment: \_\_\_\_\_ )
- 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 → 

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

**Z4TS2TM** 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: Z4TR1**

- ⑦ Participant refused → Go to Chair Stands.
- ⑨ Not attempted, unable → Go to Chair Stands.  
(Please comment: \_\_\_\_\_ )
- 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 → 

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

**Z4TR1TM** seconds. Go to Trial 2.
- ③ Holds position for 30 seconds → Go to Chair Stands.

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

**Trial 2: Z4TR2**

- ⑦ Participant refused → Go to Chair Stands.
- ⑨ Not attempted, unable → Go to Chair Stands.  
(Please comment: \_\_\_\_\_ )
- ① Unable to attain position or cannot hold for at least one second → Go to Chair Stands.
- ② Holds position between 1 and 29 seconds → 

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

**Z4TR2TM** seconds. Go to Chair Stands.
- ③ Holds position for 30 seconds → Go to Chair Stands.



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 <b>Z4SCS</b></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><b>Z4RCS</b></p> <p><b>Z4COMP</b> Number completed</p> <p><b>Z4SEC</b> Seconds to complete</p>	<p>→ <input type="text"/></p> <p>→ <input type="text"/></p> <p>→ <input type="text"/></p>
--	---	---

Unusual values?	<p>① Yes    ⑩ No</p>	<p><b>Z4UN</b></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 →

### 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 →

### Z44MW1

9 Not attempted, unable →

(Please comment: \_\_\_\_\_)

1 Attempted, but unable to complete →

(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:   .

Second    Hundredths/Sec

### Z44MWTM2

### 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:   .

Second    Hundredths/Sec

### Z44MWTM3

7 Participant refused →

### Z44MW3

9 Not attempted, unable →

(Please comment: \_\_\_\_\_)

1 Attempted, but unable to complete →

(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 #
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**ISOMETRIC STRENGTH (ISOMETRIC CHAIR) Z4STFD9**

**1** Have you ever had knee surgery on either leg where all or part of the joint was replaced? **Z4KNRP2**  
 ① Yes      ② No      ③ Don't know      ④ Refused

Which leg?

① Right leg      ② Left leg      ③ Both legs      **Z4KRLB3**

Do NOT test right leg.      Do NOT test left leg.      Do NOT test either leg. Go to Question #10.

**2** Has the participant ever had the isometric chair measurement? **Z4ISO**  
 (Examiner Note: Refer to the Health ABC Data from Prior Visits Report.)  
 ① Yes      ② No

Which leg was tested during the most recent isometric chair measurement?  
 (Examiner Note: Refer to the Health ABC Data from Prior Visits Report.) **Z4ISOLEG**

① Right leg      ② Left leg

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

Has the participant ever had the Kin-Com exam? **Z4KC**

① Yes      ② No

Test right leg unless contraindicated.

Which leg was tested during the most recent Kin-Com exam? (Examiner Note: Refer to the Health ABC Data from Prior Visits Report.)

① Right leg      ② Left leg

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

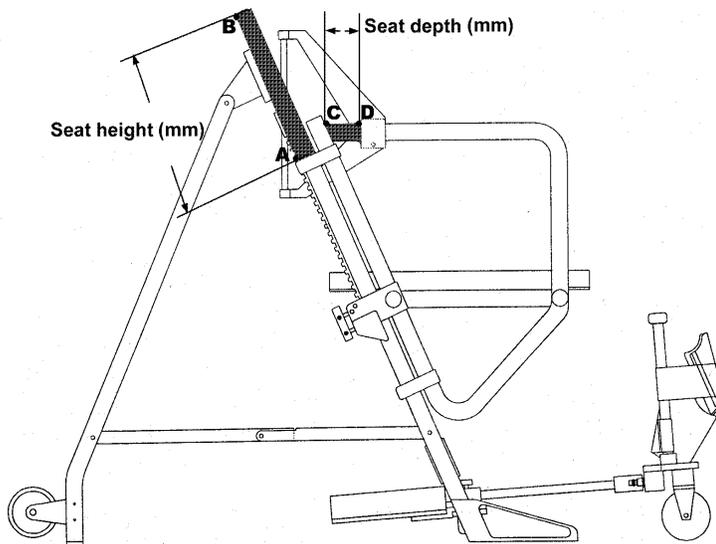
**Z4KCLEG**

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

mm **Z4SEATHT**

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

mm **Z4SEATDP**



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

**6** Which leg was tested?  
 ① Right leg      ② Left leg      ③ Test not performed **Z4RL4**  
 ↓                      ↓                      ↓  
 ↓                      ↓                      Go to Question #10.

Trial	Maximum Torque (Nm)	Max Rate Torque (Nm/sec)	Reaction Time (msec)	Time to 50% MVTD (msec)	Did participant have knee pain?
1.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>Z4MT1A</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>Z4MRT1A</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>Z4RT1A</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>Z4MVTD1A</b>	① Yes    ② No ↓ <b>Z4KP1A</b> 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"/> <b>Z4MT2A</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>Z4MRT2A</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>Z4RT2A</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>Z4MVTD2A</b>	① Yes    ② No ↓ <b>Z4KP2A</b> 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"/> <b>Z4MT3A</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>Z4MRT3A</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>Z4RT3A</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>Z4MVTD3A</b>	Test complete. Go to Question #9.

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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"/> <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

Scan left foot.                     
  Scan right foot.                     
  Go to question #2.

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

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

Scan left foot.

**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

Scan left foot; unless contraindicated in question #1 and #2 above.                     
  Scan right foot; unless contraindicated in question #1 and #2 above.                     
  Scan right foot.

**4** Sahara serial #:

**Z4SERIAL**



**5** Which foot was scanned? **Z4BUSCAN**

① Right

② Left

③ Scan not attempted

④ Scan not completed

2  
3

Why was the left foot scanned?

① Fracture **Z4BULEFT**

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

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

**Z4BUQUI1**

units

BUA

**Z4BUBUA1**

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

units

Did BUA result have an asterisk?

① Yes

② No

**Z4BUAST1**

SOS

**Z4BUSOS1**

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

m/s

Measurement #2:

QUI

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

**Z4BUQUI2**

units

BUA

**Z4BUBUA2**

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

units

Did BUA result have an asterisk?

① Yes

② No

**Z4BUAST2**

SOS

**Z4BUSOS2**

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

m/s

**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

**Z4BUQUI3**

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

units

BUA

**Z4BUBUA3**

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

units

Did BUA result have an asterisk?

① Yes

② No

**Z4BUAST3**

SOS

**Z4BUSOS3**

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

m/s

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

**Z4STID11**

**1** Do you have breast implants?

① Yes    ② No    **Z4BI**

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

**2** Do you have any metal objects in your body, such as a pacemaker, staples, screws, plates, etc.?

① Yes    ② No    **Z4MO**

- a. Flag scan for review by DXA Reading Center.
- b. Indicate in the table the location of joint replacement, hardware or other artifacts (sub regions are those defined by the whole body scan analysis.)

Sub	Hardware	Other Artifacts	
Head	①	②	<b>Z4HEAD</b>
Left arm	①	②	<b>Z4LA</b>
Right arm	①	②	<b>Z4RA</b>
Left ribs	①	②	<b>Z4LR</b>
Right ribs	①	②	<b>Z4RR</b>
Thoracic spine	①	②	<b>Z4TS</b>
Lumbar spine	①	②	<b>Z4LS</b>
Pelvis	①	②	<b>Z4PEL</b>
Left leg	①	②	<b>Z4LL</b>
Right leg	①	②	<b>Z4RL</b>

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

- |   | Yes | No |               |
|---|-----|----|---------------|
| <b>a.</b> Barium enema  | ① * | ①  | <b>Z4BE</b>   |
| <b>b.</b> Upper GI X-ray series                                       | ① * | ①  | <b>Z4UGI</b>  |
| <b>c.</b> Lower GI X-ray series                                       | ① * | ①  | <b>Z4LGI</b>  |
| <b>d.</b> Nuclear medicine scan                                       | ① * | ①  | <b>Z4NUKE</b> |
| <b>e.</b> Other tests using contrast ("dye") or radioactive materials | ① * | ①  | <b>Z4OTH2</b> |

*(\*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    ① No

Last 2 characters of scan ID #: **Z4SCAN1**

Date of scan:   /   /

Month                  Day                  Year

**Z4SCDTE1**

**b. Hip** **Z4HIP**  
 ① Yes    ① No

Last 2 characters of scan ID #: **Z4SCAN2**

Date of scan:   /   /

Month                  Day                  Year

**Z4SCDTE2**



HABC Enrollment ID # H [ ] [ ] [ ] [ ] <b>FEID</b>	Acrostic [ ] [ ] [ ] [ ] <b>FEACROS</b>	Date Form Completed [ ] [ ] / [ ] [ ] / 2 0 0 Month Day Year <b>FEDATE</b>	Staff ID # [ ] [ ] [ ] <b>FESTFID</b>
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## YEAR 6 VISIT-SPECIFIC HOME VISIT WORKBOOK PROCEDURE CHECKLIST

Measurement	Page #	Yes: Measurement fully completed	Yes: Measurement partially completed	No: Participant refused	No: Other reason/ Not applicable	Comments
1. Abdominal circumference	2	①	③	①	② <b>FEAB</b>	
2. Knee X-ray and MRI eligibility assessment	3	①	③	①	② <b>FEKNEE</b>	
3. Has a Return Visit Phlebotomy form been completed?		① Yes	① No	<b>FEPHLEB</b>		
4. Did the participant agree to schedule a CT?		① Yes		①	② <b>FECT</b>	
5. Did the participant agree to schedule a knee X-ray?		① Yes		①	② <b>FEKNXR</b>	
6. Did the participant agree to schedule a knee MRI?		① Yes		①	② <b>FEKNMRI</b>	

**FELINK**

Page Link #

Draft



HABC Enrollment ID #	Acrostic	Staff ID #
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**FESTFID1**

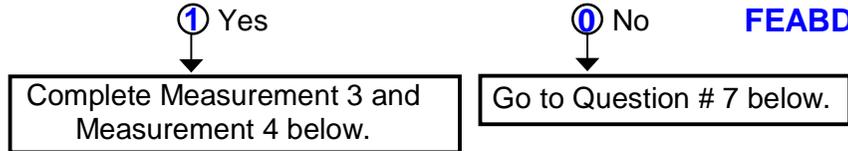
## ABDOMINAL CIRCUMFERENCE

① Measurement 1    .  cm **FEAB1**

② Measurement 2    .  cm **FEAB2**

③ Difference between Measurement 1 & Measurement 2  .  cm **FEABDF**

④ Is the difference between Measurement 1 and Measurement 2 greater than 1.0 cm?  
 Yes  No **FEABDFYN**



⑤ Measurement 3    .  cm **FEAB3**

⑥ Measurement 4    .  cm **FEAB4**

⑦ Was maximal circumference at hip level?  Yes  No **FETHAYN**

⑧ Was largest circumference obstructed?  Yes  No **FETHAYN2**

HABC Enrollment ID #	Acrostic	Date Form Completed	Staff ID #
H [ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] / [ ] [ ] / [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ]
		Month Day Year	

**YEAR 6 CORE HOME VISIT  
KNEE X-RAY AND MRI ELIGIBILITY ASSESSMENT**

**1** Is the participant eligible for a follow-up knee x-ray?  
(Examiner Note: Refer to Data from Prior Visits Report.)

**FEKNEIG**  Yes       No

Schedule knee x-ray.  
(Examiner Note: Explain knee OA substudy and schedule participant for a knee x-ray. Go to Question # 3.)

**2** Did the participant have knee symptoms that met eligibility criteria for a knee x-ray in Year 2, Year 3, Year 4, or Year 5?  
(Examiner Note: Refer to Data from Prior Visits Report.)

**FEKSYMP**  Yes

No

**a.** Does the participant have knee symptoms at this Year 6 visit?  
(Examiner Note: Review Questions #33 and #34 on page 16 in the Home Interview Workbook -- participant must have at least one asterisked "x" answer.)

**FEKSY6A**  Yes       No

Do NOT schedule knee x-ray.  
Go to Question #3.

**b.** Did the participant have a knee x-ray in Year 2, Year 3, Year 4, or Year 5?  
(Examiner Note: Refer to Data from Prior Visits Report.)

**FEKX2345**  Yes       No

Do NOT schedule x-ray.      Schedule knee x-ray.

**FEKSY6B**  Yes

No

Does the participant have knee symptoms at this Year 6 visit?  
(Examiner Note: Review Questions #33 and #34, on page 16 in the Home Interview Workbook -- participant must have at least one asterisked "x" answer.)

Schedule knee x-ray.      Do NOT schedule knee x-ray.

**3** Is the participant eligible for a follow-up knee MRI?  
(Examiner Note: Refer to Data from Prior Visits Report.)

**FEMRIFU**  Yes       No

Schedule knee MRI.  
(Examiner Note: Explain knee OA substudy and schedule participant for a knee MRI.)

Do NOT schedule MRI.

HABC Enrollment ID # H <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Acrostic <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Date Form Completed <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Staff ID # <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<b>F6ID</b>	<b>F6ACROS</b>	Month      Day      Year <b>F6DATE</b>	<b>F6STFID1</b>

**YEAR 6 RETURN VISIT PHLEBOTOMY**

Bar Code Label

**1** Do you bleed or bruise easily?  
**F6BLBR** ① Yes    ② No    ③ Don't know    ④ Refused

**F6BRCD**

**2** Have you ever experienced fainting spells while having blood drawn?  
 ① Yes    ② No    ③ Don't know    ④ Refused    **F6FNT**

**3** Have you ever had a radical mastectomy? **(Female Participants Only)**  
 ① Yes    ② No    ③ Don't know    ④ Refused    **F6RADMAS**

Which side?

① Right	② Left	③ Both <b>F6RMSIDE</b>
↓	↓	↓
Draw blood on left side.	Draw blood on right side.	Do NOT draw blood. Go to Question #10 on page 3.

**4** Have you ever had a graft or shunt for kidney dialysis?  
 ① Yes    ② No    ③ Don't know    ④ Refused    **F6KIDNEY**

Which side?

① Right	② Left	③ Both <b>F6KDSIDE</b>
↓	↓	↓
Draw blood on left side.	Draw blood on right side.	Do NOT draw blood. Go to Question #10 on page 3.

**Examiner Note: If the participant is having a repeat blood draw only because they were not fasting during their Year 6 clinic visit, only draw a 3 to 5 ml serum tube. In Question #10.3, mark "Yes" when asked whether the serum tube was filled to capacity (even though the volume is less than 10 ml).**

**F6LINK**



5 Time at start of venipuncture:

F6VTM   :   ① am ② pm F6AMPM4

Hours Minutes

6 Time blood draw completed:

:   ① am ② pm F6AMPM5

Hours Minutes

F6BLDRTM

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

F6TOUR   minutes

Comments on phlebotomy:

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

a. Date of last food:   /   /     F6LMD

Month Day Year

F6MHM

b. Time of last food:   :   ① am ② pm F6LMAPM

Hours Minutes

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

F6FAST   hours (Question 6 minus Question 8b. Round to nearest hour.)



**9** Quality of venipuncture:

- ① Clean      ② Traumatic **F6QVEN**

Please describe. Mark all that apply:

- F6PVC** ① Vein collapse  
**F6PH** ① Hematoma  
**F6PVHTG** ① Vein hard to get  
**F6PMS** ① Multiple sticks  
**F6PEDD** ① Excessive duration of draw  
**F6PLVS** ① Leakage at venipuncture site  
**F6POTH** ① Other (*Please specify:*)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**10** Was any blood drawn?

- ① Yes      ② No **F6BLDR**

Please describe why not: \_\_\_\_\_  
 \_\_\_\_\_

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

Tube	Volume	Filled to Capacity?		Comment
		Yes	No	
1. EDTA	5 ml	①	② → <b>F6BV1</b>	_____
2. EDTA	10 ml	①	② → <b>F6BV2</b>	_____
3. Serum*	10 ml	①	② → <b>F6BV3</b>	_____
4. Serum	10 ml	①	② → <b>F6BV4</b>	_____

**\*Examiner Note:** If the participant had a repeat blood draw only because they were not fasting during their Year 6 clinic visit, mark "Yes" to Question #10.3 when asked whether the serum tube was filled to capacity (even though the volume is less than 10 ml).

\_\_\_\_\_







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## YEAR 6 CT TRACKING

**4** What facility performed the CT scan?

**1** Center Commons MRI and CT, Pittsburgh

**FCCTFAC 2** Diagnostic Imaging, Memphis

**3** UT Bowld Hospital, Memphis

**4** Methodist Central, Memphis

**5** Other (*Please specify:* \_\_\_\_\_  
\_\_\_\_\_ )

### PITTSBURGH ONLY:

**5** Was a spine scan obtained this year (Year 6 clinic visit)?

**FCSPYN 1** Yes

**0** No

**a.** What level was scanned?  
(*Note: Mark only one.*)

**FCSPLY** T12 **1**

L1 **2**

L2 **3**

L3 **4** (*Preferred*)

L4 **5**

**b.** Record the CT ID # below.

**FCSPSN**

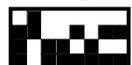
--	--	--	--

Why wasn't a spine scan obtained?  
(*Note: Mark all that apply.*)

**FCSPRE1 1** Cannot lie supine

**FCSPRE2 1** CT rescheduled

**FCSPRE3 1** Other (*Please specify:* \_\_\_\_\_  
\_\_\_\_\_ )



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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"/> / 2000	<input type="text"/> <input type="text"/> <input type="text"/>
Y A I D	Y A A C R O S	Month Day Year	Y A S T F I D

**PROXY INTERVIEW**

**Month or Year of Contact:**

- YAVISIT
- 3 Year 3 annual contact
  - 30 30-month semi-annual contact
  - 4 Year 4 annual contact
  - 42 42-month semi-annual contact
  - 5 Year 5 annual contact
  - 54 54-month semi-annual contact
  - 6 Year 6 annual contact
  - 66 66-month semi-annual contact
  - 7 Year 7 annual contact
  - 78 78-month semi-annual contact
  - 8 Other (Please specify) \_\_\_\_\_

**Type of Contact:**

- YACONTAC
- 1 Home (face-to-face interview)
  - 4 Clinic (face-to-face interview)
  - 5 Nursing home (face-to-face interview)
  - 2 Telephone interview
  - 3 Other (Please specify) \_\_\_\_\_
- YADATES

Date of last regularly scheduled contact:

/  /

Month Day Year

★ = Semi-annual telephone contact questions

**Interviewer Note: Ask all questions for annual contact. Ask only ★ questions during semi-annual telephone contact.**

- ★ 1. What is your relationship to (name of Health ABC participant)?
- 1 Spouse or partner
  - 2 Child
  - 3 Family member (other than spouse or child) (Please specify: \_\_\_\_\_)
  - YAREL  4 Close friend
  - 5 Health care provider YARELOTH
  - 6 Other (Please specify: )
  - 7 Refused

- ★ 2. How often do you have contact with (him/her)? (Interviewer Note: Please mark only one answer.)
- 1 Live together →
  - 2 Daily (but does not live together)
  - YACONFRQ  3 3 or more times a week
  - 4 Less than 3 times a week
  - 8 Don't know
  - 7 Refused

**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"/> <b>YAREF17A</b>	b. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>YAREF17B</b>	c. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>YAREF17C</b>
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"/> <b>YAREF17D</b>	e. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>YAREF17E</b>	f. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>YAREF17F</b>
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	→ <b>Complete a Health ABC Event Form, Section III. Record reference #:</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	② No		<b>YAREF18A</b>
	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;"> <b>Please specify the type of outpatient surgery.</b>                      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:

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**20.** Does (*name of Health ABC participant*) have any problems with (*his/her*) memory?

YAMEM  Yes       No       Don't know       Refused

Please go to Question #21

a. Did (*his/her*) trouble with memory begin suddenly or slowly?

Suddenly

YAMEMBEG  Slowly

Don't know

b. Has the course of memory problems been a steady downhill progression, an abrupt decline, stayed the same, or gotten better?

Steady downhill progression

Abrupt decline

YAMEMPRG  Stayed the same (no decline)

Gotten better

Don't know

c. Is a doctor aware of (*his/her*) memory problems?

YAMEMDR  Yes       No       Don't know

What does the doctor believe is causing (*his/her*) memory problems?  
*(Interviewer Note: Please mark only one answer.)*

Alzheimer's disease

Parkinson's disease

Confusion

Stroke

Delirium

Nothing wrong

YAMEMPRB

Dementia

Other (*Please specify*)

Depression

Don't know

Multiinfarct



★ **21.** Because of a health or physical problem, does (*name of Health ABC participant*) have any difficulty walking a quarter of a mile, that is about 2 or 3 blocks?  
*(Interviewer Note: If the proxy responds "Doesn't do," probe to determine whether this was because of a health or physical problem. If the participant doesn't walk because of a health or physical problem, mark "Yes." If the participant doesn't walk for other reasons, mark "Does not do.")*

YADWQMYN ① Yes      ② No      ⑧ Don't know      ⑦ Refused      ⑨ Does not do

↓ ↓ ↓ ↓ ↓

Go to Question #22

★ How much difficulty does (*he/she*) have?  
*(Interviewer Note: Read response options.)*

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

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

YADW10YN ① Yes      ② No      ⑧ Don't know      ⑦ Refused      ⑨ Does not do

↓ ↓ ↓ ↓ ↓

Go to Question #23

★ How much difficulty does (*he/she*) have?  
*(Interviewer Note: Read response options.)*

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



23. Does (name of Health ABC participant) have to use a cane, walker, crutches, or other special equipment to help (him/her) get around?

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

24. Because of a health or physical problem, does (name of Health ABC participant) have any difficulty getting in and out of bed or chairs?

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

a. How much difficulty does (he/she) have?  
(Interviewer Note: Read response options.)

① A little difficulty

② Some difficulty

YADIODIF ③ A lot of difficulty

④ Or are they unable to do it?

⑧ Don't know

b. Does (he/she) usually receive help from another person when (he/she) gets in and out of bed or chairs?

YADIORHY ① Yes      ① No      ⑧ Don't know

25. Does (name of Health ABC participant) have any difficulty bathing or showering?

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

a. How much difficulty does (he/she) have?  
(Interviewer Note: Read response options.)

① A little difficulty

② Some difficulty

YABATHDF ③ A lot of difficulty

④ Or are they unable to do it?

⑧ Don't know

b. Does (he/she) usually receive help from another person in bathing or showering?

YABATHRH ① Yes      ① No      ⑧ Don't know

**26.** Does (name of Health ABC participant) have any difficulty dressing?

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

a. How much difficulty does (he/she) have?  
*(Interviewer Note: Read response options.)*

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

b. Does (he/she) usually receive help from another person in dressing?

YADDRHYN ① Yes      ① No      ⑧ Don't know

★ **27.** In general, would you say that (name of Health ABC participant's) appetite or desire to eat has been. . . ?

*(Interviewer Note: Read response options.)*

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

★ **28.** Since we last spoke to (name of Health ABC participant) about 6 months ago, has (his/her) weight changed by 5 or more pounds?

*(Interviewer Note: We are interested in net gain or loss during the past 6 months. In other words, is the participant either 5 or more pounds heavier or lighter than they were 6 months ago?)*

YACHN5LB ① Yes              ① No              ⑧ Don't know              ⑦ Refused

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

YAGNLS ① Gain      ② Lose      ⑧ Don't know

★ b. How many pounds did (he/she) gain/lose in the past 6 months?  
*(Interviewer Note: If necessary, probe - "If you are unsure, please make your best guess.")*

YAHOW6   pounds      ⑧ Don't know YAHOW6DN









**32.** *Interviewer Note: Please answer the following question based on your judgment of the proxy's responses to the Proxy Interview.*

On the whole, how reliable do you think the proxy's responses to the Proxy Interview are?

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

**33.** What is the primary reason a proxy was contacted for the Semi-Annual Telephone Interview or Annual Contact? Please mark only one reason.

- ① Illness/health problem(s)
- ② Hearing difficulties
- ③ Cognitive difficulties
- ④ In nursing home/long-term care facility
- ⑤ Refused to give reason
- ⑥ Other (Please specify: )

**YAPROXY**

**YAPROXOT**

Thank you very much for answering these questions. Please remember to call us if (name of Health ABC participant) is admitted to a hospital or nursing home for any reason so that we can better understand changes in (his/her) health. We would also like to hear from you if (name of Health ABC participant) moves or if (his/her) mailing address changes. We will be calling you in about 6 months from now to find out how (name of Health ABC participant) has been doing.



HABC Enrollment ID # H	Acrostic	Date Form Completed / / 2000	Staff ID #
YBID	YBACROS	Month Day Year	YBSTFID

## PROXY CONTACT HOME VISIT WORKBOOK

**Year of Contact:**

Year 3 annual contact                       Year 6 annual contact  
**YBVISIT**  Year 4 annual contact                       Year 7 annual contact  
 Year 5 annual contact                       Other *(Please specify)*  
\_\_\_\_\_

### PROXY CONTACT HOME VISIT PROCEDURE CHECKLIST

Measurement	Page #	Yes: Measurement fully completed	Yes: Measurement partially completed	No: Participant/Proxy refused	No: Other reason/ Not Applicable
1. Was the Proxy Interview completed?		①	③	①	② YBPROXY
2. Medication inventory update	2	①	③	①	② YBMI
3. Weight	7	①	③	①	② YBWT
4. Radial pulse	7	①	③	①	② YBRP
5. Blood pressure	8	①	③	①	② YBBP
6. Grip strength	9	①	③	①	② YBGRIP
7. Chair stands	11	①	③	①	② YBCS
8. Standing balance	12	①	③	①	② YBSB
9. 4-meter walk	14	①	③	①	② YB4MW
10. Knee crepitus	16	①	③	①	② YBKNEE
11. Isometric strength (Isometric chair)	17	①	③	①	② YBISO
12. Ultrasound	20	①	③	①	② YBULTRA
13. Bone density (DXA) scan	22	①	③	①	② YBDXA
14. Was blood collected?		①	③	①	② YBBLOOD
15. Was urine collected?		①	③	①	② YBURINE
16. Was participant scheduled for an x-ray?		①	③	①	② YBXR

**YBLINK**

Page Link #

Draft





HABC Enrollment ID # H [ ] [ ] [ ] [ ] [ ] MAID/MIFIF	Acrostic [ ] [ ] [ ] [ ] [ ] MAACROS	Date Form Completed [ ] [ ] / [ ] [ ] / [ ] [ ] Month Day Year MIFDATE/MADATE	Staff ID # [ ] [ ] [ ] [ ] MASTAFF
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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	MIF STRE	MIF UNIT	MIFDWM ___ D W M	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: MIFREAS	"		MIFMONTH MIFYEAR ___/___/___	MIFPRN Formulation Code: MIFFORM	<input checked="" type="checkbox"/> Rx <input type="checkbox"/> Non Rx
2. 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
3. _____			___ 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

**PROXY CONTACT HOME VISIT  
MEDICATION INVENTORY FORM -- Page B**

**Section B Prescription Medication -- Continued**

<b>Medication Name</b> (Generic Name or Trade Name)	<b>Strength</b>	<b>Units</b>	<b>Indicate Number Used</b> & Circle Day, Week or Month	<b>PRN?</b> Check "X": Yes or No	<b>Container Seen?</b> Check "X": Yes or No
				<b>MIFPRN</b>	<b>MIFSEEN</b>

6. <b>MIFNAME</b>	<b>MIF</b> <b>STRE</b>	<b>MIF</b> <b>UNIT</b>	<b>MIFDWM</b> D W M	1 Y 0 N	1 Y 0 N
-------------------	---------------------------	---------------------------	------------------------	---------	---------

Reason for use: **MIFREAS** \_\_\_\_\_ Date Started: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Formulation Code: \_\_\_\_\_  Rx 1  Non Rx

7. _____	_____	_____	_____ D W M	Y N	Y N
----------	-------	-------	-------------	-----	-----

Reason for use: \_\_\_\_\_ Date Started: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Formulation Code: \_\_\_\_\_  Rx  Non Rx

8. _____	_____	_____	_____ D W M	Y N	Y N
----------	-------	-------	-------------	-----	-----

Reason for use: \_\_\_\_\_ Date Started: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Formulation Code: \_\_\_\_\_  Rx  Non Rx

9. _____	_____	_____	_____ D W M	Y N	Y N
----------	-------	-------	-------------	-----	-----

Reason for use: \_\_\_\_\_ Date Started: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Formulation Code: \_\_\_\_\_  Rx  Non Rx

10. _____	_____	_____	_____ D W M	Y N	Y N
-----------	-------	-------	-------------	-----	-----

Reason for use: \_\_\_\_\_ Date Started: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Formulation Code: \_\_\_\_\_  Rx  Non Rx

11. _____	_____	_____	_____ D W M	Y N	Y N
-----------	-------	-------	-------------	-----	-----

Reason for use: \_\_\_\_\_ Date Started: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Formulation Code: \_\_\_\_\_  Rx  Non Rx

12. _____	_____	_____	_____ D W M	Y N	Y N
-----------	-------	-------	-------------	-----	-----

Reason for use: \_\_\_\_\_ Date Started: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Formulation Code: \_\_\_\_\_  Rx  Non Rx

Continued on MIF Supplement

**Formulation Codes**  
 0=unidentifiable, 1=oral tablet, 2=oral capsule, 3=oral liquid, 4=topical cream, lotion, or ointment, 5=other liquid, 6=ophthalmic, 7=missing, 8=rectal or vaginal, 9=inhaled or nasal, 10=injectable, 11=transdermal patch, 12=powder, 99=other

**PROXY CONTACT HOME VISIT  
MEDICATION INVENTORY FORM -- Page C**

**Section C Over-the-counter Medications and Supplements**

Copy the name of the over-the-counter medicine, the strength in milligrams (mg) or other units, and the total number of doses taken per day, week or month. Indicate whether the medication is taken on an "as needed" basis, and whether or not the container was actually seen. In addition, record reason for use, date started, and formulation code.

Medication Name (Generic Name or Trade Name)	Strength	Units	Indicate Number Used & Circle Day, Week or Month	PRN? Check "X": Yes or No	Container Seen? Check "X": Yes or No
MIFNAME	MIF STRE	MIF UNIT	MIFDWM ___ D W M	MIFPRN 1 Y 0 N	MIFSEEN 1 Y 0 N
1. _____	_____	_____	___ D W M	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: _____	Date Started: _____ / _____		Formulation Code: _____	<input checked="" type="checkbox"/> Rx	<input checked="" type="checkbox"/> Non Rx
2. _____	_____	_____	___ D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: _____	Date Started: _____ / _____		Formulation Code: _____	<input type="checkbox"/> Rx	<input checked="" type="checkbox"/> Non Rx
3. _____	_____	_____	___ D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: _____	Date Started: _____ / _____		Formulation Code: _____	<input type="checkbox"/> Rx	<input checked="" type="checkbox"/> Non Rx
4. _____	_____	_____	___ D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: _____	Date Started: _____ / _____		Formulation Code: _____	<input type="checkbox"/> Rx	<input checked="" type="checkbox"/> Non Rx
5. _____	_____	_____	___ D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: _____	Date Started: _____ / _____		Formulation Code: _____	<input type="checkbox"/> Rx	<input checked="" type="checkbox"/> Non Rx
6. _____	_____	_____	___ D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: _____	Date Started: _____ / _____		Formulation Code: _____	<input type="checkbox"/> Rx	<input checked="" type="checkbox"/> Non Rx
7. _____	_____	_____	___ D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Reason for use: _____	Date Started: _____ / _____		Formulation Code: _____	<input type="checkbox"/> Rx	<input checked="" type="checkbox"/> Non Rx

**PROXY CONTACT HOME VISIT  
MEDICATION INVENTORY FORM -- Page D**

**Section C Over-the-counter Medications and Supplements -- Continued**

Medication Name (Generic Name or Trade Name)      Strength Units Indicate Number Used PRN?      Container Seen?

Circle      Check "X":      Check "X":  
Day, Week or Month      Yes or No      Yes or No  
**MIFPRN**      **MIFSEEN**

<b>8.</b> MIFNAME _____ Reason for use: <b>MIFREAS</b> _____	MIF STRE	MIF UNIT	MIFDWM ___ D W M	1 Y 0 N	1 Y 0 N
Date Started: _____ / _____ / _____ Formulation Code: _____			MIFMONTH MIFYEAR ___ / ___	1 Rx <input checked="" type="checkbox"/> Non Rx	
<b>9.</b> _____ Reason for use: _____			___ D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Date Started: _____ / _____ / _____ Formulation Code: _____			___ / ___	<input type="checkbox"/> Rx <input checked="" type="checkbox"/> Non Rx	
<b>10.</b> _____ Reason for use: _____			___ D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Date Started: _____ / _____ / _____ Formulation Code: _____			___ / ___	<input type="checkbox"/> Rx <input checked="" type="checkbox"/> Non Rx	
<b>11.</b> _____ Reason for use: _____			___ D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Date Started: _____ / _____ / _____ Formulation Code: _____			___ / ___	<input type="checkbox"/> Rx <input checked="" type="checkbox"/> Non Rx	
<b>12.</b> _____ Reason for use: _____			___ D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Date Started: _____ / _____ / _____ Formulation Code: _____			___ / ___	<input type="checkbox"/> Rx <input checked="" type="checkbox"/> Non Rx	
<b>13.</b> _____ Reason for use: _____			___ D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Date Started: _____ / _____ / _____ Formulation Code: _____			___ / ___	<input type="checkbox"/> Rx <input checked="" type="checkbox"/> Non Rx	
<b>14.</b> _____ Reason for use: _____			___ D W M	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Date Started: _____ / _____ / _____ Formulation Code: _____			___ / ___	<input type="checkbox"/> Rx <input checked="" type="checkbox"/> Non Rx	

Continued on MIF Supplement

**Formulation Codes**

0=unidentifiable, 1=oral tablet, 2=oral capsule, 3=oral liquid, 4=topical cream, lotion, or ointment, 5=other liquid, 6=ophthalmic, 7=missing, 8=rectal or vaginal, 9=inhaled or nasal, 10=injected, 11=transdermal patch, 12=powder, 99=other



HABC Enrollment ID # H [ ] [ ] [ ] [ ] [ ] MAID/MIFIF	Acrostic [ ] [ ] [ ] [ ] MAACROS	Date Form Completed [ ] [ ] / [ ] [ ] / [ ] [ ] Month Date Year MIFDATE/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.     D W M  Y  N  Y  N

Reason for use:  Date Started:  /  Formulation Code:  Rx Non Rx

3S.     D W M  Y  N  Y  N

Reason for use:  Date Started:  /  Formulation Code:  Rx Non Rx

4S.     D W M  Y  N  Y  N

Reason for use:  Date Started:  /  Formulation Code:  Rx Non Rx

5S.     D W M  Y  N  Y  N

Reason for use:  Date Started:  /  Formulation Code:  Rx Non Rx

6S.     D W M  Y  N  Y  N

Reason for use:  Date Started:  /  Formulation Code:  Rx Non Rx

7S.     D W M  Y  N  Y  N

Reason for use:  Date Started:  /  Formulation Code:  Rx Non Rx

HABC Enrollment ID #	Acrostic
H <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
YCID	YCACROS

**PROXY CONTACT HOME VISIT WORKBOOK**

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

**WEIGHT AND RADIAL PULSE**

**WEIGHT**

YCWT    .       ① lbs      ② kg YCLBSKG      YCSTFID1 Staff ID#

**RADIAL PULSE**

YCSTFID2 Staff ID#

Measurement 1 YCPLSSM     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?

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?

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



HABC Enrollment ID #	Acrostic	Staff ID #
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## 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

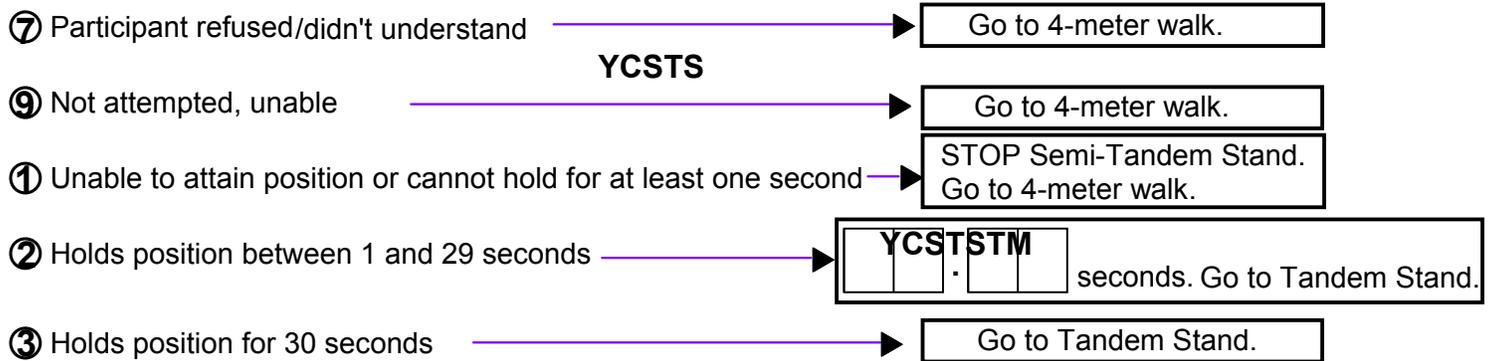
Describe: "First I would like you to try to stand with the side of the heel of one foot touching the big toe of the other foot for about 30 seconds. Please watch while I demonstrate."

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

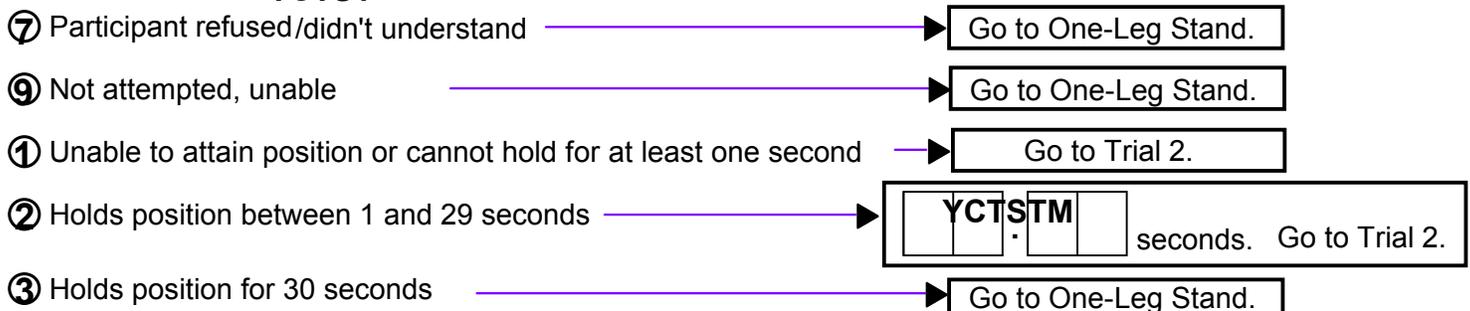
Describe: "Now I would like you to try to stand with the heel of one foot in front of and touching the toes of the other foot. I'll demonstrate."

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**



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### TANDEM STAND

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

**Trial 2:**

<b>YCTS2</b>	⑦	Participant refused/didn't understand	→	Go to One-Leg Stand.				
	⑨	Not attempted, unable	→	Go to One-Leg Stand.				
	①	Unable to attain position or cannot hold for at least one second	→	Go to One-Leg Stand.				
	②	Holds position between 1 and 29 seconds	→	<table border="1" style="display: inline-table; text-align: center; width: 100px;"> <tr> <td style="width: 20px;">YCTS2</td> <td style="width: 20px;">TM</td> </tr> <tr> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> </tr> </table> seconds. Go to One-Leg Stand.	YCTS2	TM		
YCTS2	TM							
	③	Holds position for 30 seconds	→	Go to One-Leg Stand.				

### ONE-LEG STAND

Describe: "For the last position, I would like you to try to stand on one leg for 30 seconds. You may stand on either leg, whichever is more comfortable. I'll demonstrate."

Demonstrate and say: "Try to hold your foot up until I say stop. If you lose your balance put your foot down."

**Examiner Note:** Allow the participant to hold onto your arm to get balanced.

Test: "Hold onto my arm while you get in position. When you are ready, let go."

**Trial 1:**

<b>YCTR1</b>	⑦	Participant refused/didn't understand	→	Go to 4-meter walk.				
	⑨	Not attempted, unable	→	Go to 4-meter walk.				
	①	Unable to attain position or cannot hold for at least one second	→	Go to Trial 2.				
	②	Holds position between 1 and 29 seconds	→	<table border="1" style="display: inline-table; text-align: center; width: 100px;"> <tr> <td style="width: 20px;">YCTR1</td> <td style="width: 20px;">TM</td> </tr> <tr> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> </tr> </table> seconds. Go to Trial 2.	YCTR1	TM		
YCTR1	TM							
	③	Holds position for 30 seconds	→	Go to 4-meter walk.				

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

**Trial 2:**

<b>YCTR2</b>	⑦	Participant refused/didn't understand	→	Go to 4-meter walk.				
	⑨	Not attempted, unable	→	Go to 4-meter walk.				
	①	Unable to attain position or cannot hold for at least one second	→	Go to 4-meter walk.				
	②	Holds position between 1 and 29 seconds	→	<table border="1" style="display: inline-table; text-align: center; width: 100px;"> <tr> <td style="width: 20px;">YCTR2</td> <td style="width: 20px;">TM</td> </tr> <tr> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> </tr> </table> seconds. Go to 4-meter walk.	YCTR2	TM		
YCTR2	TM							
	③	Holds position for 30 seconds	→	Go to 4-meter walk.				

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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    ③ 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.

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:   .   YC4MWTM3  
Second Hundredths/Sec

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

YC4MW3 9 Not attempted, unable → Go to Knee Crepitus.

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

7 Was the participant using a walking aid, such as a cane or walker?

1 Yes 0 No YCWLKAID

HABC Enrollment ID #	Acrostic	Staff ID #
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**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.

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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  

--	--	--	--

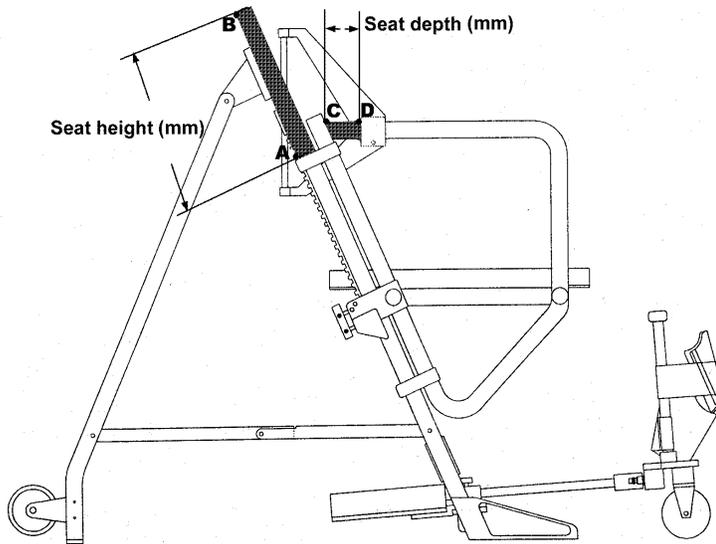
 mm

- 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?																		
<b>1.</b>	<table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> </tr> </table> YCMT1A						<table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> </tr> </table> YCMRT1A						<table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> </tr> </table> YCRT1A					<table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> </tr> </table> YCMVTD1A					YCKP1A <b>1</b> Yes <b>2</b> No Test other leg. Go to Question #7.
<b>2.</b>	<table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> </tr> </table> YCMT2A						<table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> </tr> </table> YCMRT2A						<table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> </tr> </table> YCRT2A					<table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> </tr> </table> YCMVTD2A					YCKP2A <b>1</b> Yes <b>2</b> No Test other leg. Go to Question #7.
<b>3.</b>	<table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> </tr> </table> YCMT3A						<table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> </tr> </table> YCMRT3A						<table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> </tr> </table> YCRT3A					<table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> </tr> </table> YCMVTD3A					Test complete. Go to Question #9.



**7** What is the length of the lower leg?  
(Examiner Note: Only test the other leg if three trials were not possible on the first leg. This should be the length of the other leg to be tested.)

YCLEG2 meters

**8** Which other leg is being tested?  
YCRL5 ① Right leg      ② Left leg      ③ Test not performed

Go to Question #10.

Trial	Maximum Torque (Nm)	Max Rate Torque (Nm/sec)	Reaction Time (msec)	Time to 50% MVTD (msec)	Did participant have knee pain?
1.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> YCMT1B	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <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"/> . <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"/> . <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 #
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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  $\geq$  10 units?

**YCBUDIF2**  Yes       No

Repeat scan and record results in section #6 below.

b. Did both BUA measurement #1 and BUA measurement #2 have an asterisk?

**YCBU2AST**  Yes       No

Repeat scan and record results in section #6 below.

**6**

QUI 

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

 .  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				<input type="text"/>	<input type="text"/>
Date of scan:	<input type="text"/>	/	<input type="text"/>	/	200
	Month		Day		Year
<b>YCSCDTE1</b>					

**b. Hip**

① Yes    ① No YCHIP  
↓

Last 2 characters of scan ID #: YCSCAN2				<input type="text"/>	<input type="text"/>
Date of scan:	<input type="text"/>	/	<input type="text"/>	/	200
	Month		Day		Year
<b>YCSCDTE2</b>					



HABC Enrollment ID # H [ ] [ ] [ ] [ ] <b>FEID</b>	Acrostic [ ] [ ] [ ] [ ] <b>FEACROS</b>	Date Form Completed [ ] [ ] / [ ] [ ] / 2 0 0 Month Day Year <b>FEDATE</b>	Staff ID # [ ] [ ] [ ] <b>FESTFID</b>
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## YEAR 6 VISIT-SPECIFIC HOME VISIT WORKBOOK PROCEDURE CHECKLIST

Measurement	Page #	Yes: Measurement fully completed	Yes: Measurement partially completed	No: Participant refused	No: Other reason/ Not applicable	Comments
1. Abdominal circumference	2	①	③	①	② <b>FEAB</b>	
2. Knee X-ray and MRI eligibility assessment	3	①	③	①	② <b>FEKNEE</b>	
3. Has a Return Visit Phlebotomy form been completed?		① Yes	① No	<b>FEPHLEB</b>		
4. Did the participant agree to schedule a CT?		① Yes		①	② <b>FECT</b>	
5. Did the participant agree to schedule a knee X-ray?		① Yes		①	② <b>FEKNXR</b>	
6. Did the participant agree to schedule a knee MRI?		① Yes		①	② <b>FEKNMRI</b>	

**FELINK**

Page Link #

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"/>

**FESTFID1**

## ABDOMINAL CIRCUMFERENCE

① Measurement 1    .  cm **FEAB1**

② Measurement 2    .  cm **FEAB2**

③ Difference between Measurement 1 & Measurement 2  .  cm **FEABDF**

④ Is the difference between Measurement 1 and Measurement 2 greater than 1.0 cm?  
 Yes  No **FEABDFYN**

Complete Measurement 3 and Measurement 4 below.

Go to Question # 7 below.

⑤ Measurement 3    .  cm **FEAB3**

⑥ Measurement 4    .  cm **FEAB4**

⑦ Was maximal circumference at hip level?  Yes  No **FETHAYN**

⑧ Was largest circumference obstructed?  Yes  No **FETHAYN2**

HABC Enrollment ID #	Acrostic	Date Form Completed	Staff ID #
H [ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] / [ ] [ ] / [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ]
		Month Day Year	

**YEAR 6 CORE HOME VISIT  
KNEE X-RAY AND MRI ELIGIBILITY ASSESSMENT**

**1** Is the participant eligible for a follow-up knee x-ray?  
(Examiner Note: Refer to Data from Prior Visits Report.)

**FEKNEIG**  Yes       No

Schedule knee x-ray.  
(Examiner Note: Explain knee OA substudy and schedule participant for a knee x-ray. Go to Question # 3.)

**2** Did the participant have knee symptoms that met eligibility criteria for a knee x-ray in Year 2, Year 3, Year 4, or Year 5?  
(Examiner Note: Refer to Data from Prior Visits Report.)

**FEKSYMP**  Yes

No

**a.** Does the participant have knee symptoms at this Year 6 visit?  
(Examiner Note: Review Questions #33 and #34 on page 16 in the Home Interview Workbook -- participant must have at least one asterisked "x" answer.)

**FEKSY6A**  Yes       No

Do NOT schedule knee x-ray.  
Go to Question #3.

**b.** Did the participant have a knee x-ray in Year 2, Year 3, Year 4, or Year 5?  
(Examiner Note: Refer to Data from Prior Visits Report.)

**FEKX2345**  Yes       No

Do NOT schedule x-ray.      Schedule knee x-ray.

Does the participant have knee symptoms at this Year 6 visit?  
(Examiner Note: Review Questions #33 and #34, on page 16 in the Home Interview Workbook -- participant must have at least one asterisked "x" answer.)

**FEKSY6B**  Yes       No

Schedule knee x-ray.      Do NOT schedule knee x-ray.

**3** Is the participant eligible for a follow-up knee MRI?  
(Examiner Note: Refer to Data from Prior Visits Report.)

**FEMRIFU**  Yes       No

Do NOT schedule MRI.

Schedule knee MRI.  
(Examiner Note: Explain knee OA substudy and schedule participant for a knee MRI.)

HABC Enrollment ID # H [ ] [ ] [ ] [ ] <b>F6ID</b>	Acrostic [ ] [ ] [ ] [ ] <b>F6ACROS</b>	Date Form Completed [ ] [ ] / [ ] [ ] / [ ] [ ] [ ] [ ] Month Day Year <b>F6DATE</b>	Staff ID # [ ] [ ] [ ] [ ] <b>F6STFID1</b>
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**YEAR 6 RETURN VISIT PHLEBOTOMY**

Bar Code Label

**1** Do you bleed or bruise easily?  
**F6BLBR** ① Yes ② No ③ Don't know ④ Refused

**F6BRCD**

**2** Have you ever experienced fainting spells while having blood drawn?  
 ① Yes ② No ③ Don't know ④ Refused **F6FNT**

**3** Have you ever had a radical mastectomy? **(Female Participants Only)**  
 ① Yes ② No ③ Don't know ④ Refused **F6RADMAS**

Which side?

① Right	② Left	③ Both <b>F6RMSIDE</b>
↓	↓	↓
Draw blood on left side.	Draw blood on right side.	Do NOT draw blood. Go to Question #10 on page 3.

**4** Have you ever had a graft or shunt for kidney dialysis?  
 ① Yes ② No ③ Don't know ④ Refused **F6KIDNEY**

Which side?

① Right	② Left	③ Both <b>F6KDSIDE</b>
↓	↓	↓
Draw blood on left side.	Draw blood on right side.	Do NOT draw blood. Go to Question #10 on page 3.

**Examiner Note: If the participant is having a repeat blood draw only because they were not fasting during their Year 6 clinic visit, only draw a 3 to 5 ml serum tube. In Question #10.3, mark "Yes" when asked whether the serum tube was filled to capacity (even though the volume is less than 10 ml).**

**F6LINK**

[ ]



5 Time at start of venipuncture:

F6VTM   :   ① am ② pm F6AMPM4  
Hours Minutes

6 Time blood draw completed:

:   ① am ② pm F6AMPM5  
Hours Minutes  
F6BLDRTM

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

F6TOUR   minutes

Comments on phlebotomy:

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

a. Date of last food:   /   /     F6LMD  
Month Day Year  
F6MHHM

b. Time of last food:   :   ① am ② pm F6LMAPM  
Hours Minutes

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

F6FAST   hours (Question 6 minus Question 8b. Round to nearest hour.)



**9** Quality of venipuncture:

- ① Clean      ② Traumatic **F6QVEN**

Please describe. Mark all that apply:

- F6PVC** ① Vein collapse  
**F6PH** ① Hematoma  
**F6PVHTG** ① Vein hard to get  
**F6PMS** ① Multiple sticks  
**F6PEDD** ① Excessive duration of draw  
**F6PLVS** ① Leakage at venipuncture site  
**F6POTH** ① Other *(Please specify:)*

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**10** Was any blood drawn?

- ① Yes      ② No **F6BLDR**

Please describe why not: \_\_\_\_\_  
 \_\_\_\_\_

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

Tube	Volume	Filled to Capacity?		Comment
		Yes	No	
1. EDTA	5 ml	①	② → <b>F6BV1</b>	_____
2. EDTA	10 ml	①	② → <b>F6BV2</b>	_____
3. Serum*	10 ml	①	② → <b>F6BV3</b>	_____
4. Serum	10 ml	①	② → <b>F6BV4</b>	_____

**\*Examiner Note:** If the participant had a repeat blood draw only because they were not fasting during their Year 6 clinic visit, mark "Yes" to Question #10.3 when asked whether the serum tube was filled to capacity (even though the volume is less than 10 ml).

\_\_\_\_\_







H					
---	--	--	--	--	--

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## YEAR 6 CT TRACKING

**4** What facility performed the CT scan?

**1** Center Commons MRI and CT, Pittsburgh

**FCCTFAC 2** Diagnostic Imaging, Memphis

**3** UT Bowld Hospital, Memphis

**4** Methodist Central, Memphis

**5** Other (*Please specify:* \_\_\_\_\_ )  
\_\_\_\_\_ )

### PITTSBURGH ONLY:

**5** Was a spine scan obtained this year (Year 6 clinic visit)?

**FCSPYN 1** Yes

**0** No

**a.** What level was scanned?  
(*Note: Mark only one.*)

**FCSPLY** T12 **1**

L1 **2**

L2 **3**

L3 **4** (*Preferred*)

L4 **5**

**b.** Record the CT ID # below.

**FCSPSN**

--	--	--	--

Why wasn't a spine scan obtained?  
(*Note: Mark all that apply.*)

**FCSPRE1 1** Cannot lie supine

**FCSPRE2 1** CT rescheduled

**FCSPRE3 1** Other (*Please specify:* \_\_\_\_\_ )  
\_\_\_\_\_ )



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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       0 No       8 Don't know       7 Refused **BLMCNH**

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       0 No       8 Don't know       7 Refused **BLMCVN**

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

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

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

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

Does someone usually help you get in and out of bed or chairs?

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

8. Do you have any difficulty bathing or showering?

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

Does someone usually help you bathe or shower?

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

9. Do you have any difficulty dressing?

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

Does someone usually help you to dress?

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

10. Because of a health or physical problem, do you have any difficulty walking a quarter of a mile, that is about 2 or 3 blocks?  
*(Interviewer Note: If the participant responds "Don't do," probe to determine whether this is because of a health or physical problem. If the participant doesn't walk because of a health or physical problem, mark "Yes." If the participant doesn't walk for other reasons, mark "Don't do.")*

**BLDWQMYN**

① Yes

② No

③ Don't know

④ Refused

⑤ Don't do

Go to Question #10d

Go to Question #11

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

① A little difficulty

② Some difficulty

③ A lot of difficulty

**BLDWQMDF**

④ Or are you unable to do it

⑤ 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: Do NOT read response options. If "some other reason," probe for response. Mark only ONE answer.)*

**BLMNRS**

① Arthritis

⑫ Hip fracture

② Back pain

⑬ Injury

③ Balance problems/unsteadiness on feet

⑭ Joint pain

④ Cancer

⑮ Lung disease

(asthma, chronic bronchitis, emphysema, etc)

⑤ Chest pain/discomfort

⑯ Old age

(no mention of a specific condition)

⑥ Circulatory problems

⑰ Osteoporosis

⑦ Diabetes

⑱ Shortness of breath

⑧ Fatigue/tiredness (no specific disease)

⑲ Stroke

⑨ Fall

① Other symptom

(Please specify: \_\_\_\_\_ )

⑩ Foot/ankle pain

**BLMNRS4**

② Multiple conditions/symptoms given; unable to determine MAIN reason

⑪ Heart disease (including angina, congestive heart failure, etc)

③ Don't know

⑫ High blood pressure/hypertension

c. Do you have any difficulty walking across a small room?

① Yes

② No

③ Don't know

④ Refused

**BLDWSMRM**

Go to Question #11



**10d.** 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**

**10e.** 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

→

→

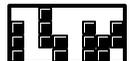
→

**BLDW1MYN**

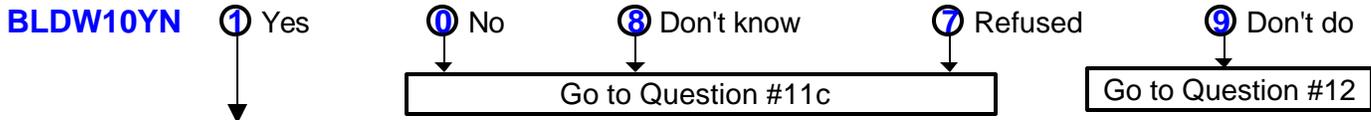
**10f.** How easy is it for you to walk one mile?  
*(Interviewer Note: Read response options.)*

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

**BLDW1MEZ**



11. 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.")*

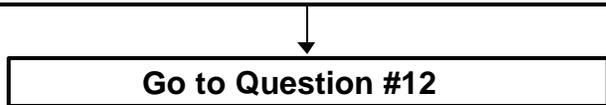


a. How much difficulty do you have?  
*(Interviewer Note: Read response options.)*

- 1 A little difficulty
- 2 Some difficulty
- 3 A lot of difficulty      **BLDIF**
- 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: Do NOT read response options. If "some other reason," probe for response. Mark only ONE answer.)*

- BLMNRS2**
- |   |  |
|---|--|
| <input type="radio"/> 1 Arthritis   | <input type="radio"/> 12 Hip fracture  |
| <input type="radio"/> 2 Back pain   | <input type="radio"/> 13 Injury  |
| <input type="radio"/> 3 Balance problems/unsteadiness on feet                               | <input type="radio"/> 14 Joint pain  |
| <input type="radio"/> 4 Cancer  | <input type="radio"/> 15 Lung disease<br>(asthma, chronic bronchitis, emphysema, etc)          |
| <input type="radio"/> 5 Chest pain/discomfort   | <input type="radio"/> 16 Old age<br>(no mention of a specific condition)                       |
| <input type="radio"/> 6 Circulatory problems  | <input type="radio"/> 17 Osteoporosis  |
| <input type="radio"/> 7 Diabetes  | <input type="radio"/> 18 Shortness of breath   |
| <input type="radio"/> 8 Fatigue/tiredness (no specific disease)                             | <input type="radio"/> 19 Stroke  |
| <input type="radio"/> 9 Fall  | <input type="radio"/> 1 Other symptom<br>(Please specify: _____ )                              |
| <input checked="" type="radio"/> 23 Foot/ankle pain <b>BLMNRS3</b>                          | <input type="radio"/> 2 Multiple conditions/symptoms given;<br>unable to determine MAIN reason |
| <input type="radio"/> 10 Heart disease<br>(including angina, congestive heart failure, etc) | <input type="radio"/> 8 Don't know   |
| <input type="radio"/> 11 High blood pressure/hypertension                                   |  |



11c. 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
- ④ Don't know/don't do

**BLDW10EZ**

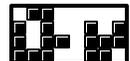
11d. Because of a health or physical problem, do you have any difficulty walking up 20 steps, that is about 2 flights, without resting?

- ① Yes →
- BLDW20YN** ② No →
- ④ Don't know/don't do →

11e. 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
- ④ Don't know/don't do

**BLDW20EZ**



12. 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 **BLAPPET**
- ⑤ Very poor
- ⑧ Don't know
- ⑦ Refused

13. 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**

14. 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 currently either 5 or more pounds heavier or lighter than they were 6 months ago.)*

- ① Yes
- ① No
- ⑧ Don't know
- ⑦ Refused **BLCHN5LB**

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/don't remember **BLGNLS**

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?

- ① Yes
- ① No
- ⑧ Don't know **BLTRGNLS**

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

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

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

16. 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?

- Yes     
  No     
  Don't know     
  Refused     
 BLHCHAMI

Were you hospitalized overnight for this problem?

Yes     
  No     
 BLHOSMI

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

a.       BLREF13A

b.       BLREF13B

c.       BLREF13C

Go to Question #17

17. 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     
 BLHCCVA

Were you hospitalized overnight for this problem?

Yes     
  No     
 BLHOSMI2

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

a.       BLREF14A

b.       BLREF14B

c.       BLREF14C

Go to Question #18

18. 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     
 BLCHF

Were you hospitalized overnight for this problem?

Yes     
  No     
 BLHOMI3

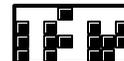
Complete a Health ABC Event Form, Section I, for each overnight hospitalization. Record reference #'s below:

a.       BLREF15A

b.       BLREF15B

c.       BLREF15C

Go to Question #19



19. 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.

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

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

- a. 

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

**BLREF16A**  
 b. 

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

**BLREF16B**  
 c. 

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

**BLREF16C**

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

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

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

- a. 

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

**BLREF17A**  
 b. 

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

**BLREF17B**  
 c. 

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

**BLREF17C**

21. 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)?

- 1 Yes     
  0 No     
  8 Don't know     
  7 Refused     
 BLOSBR45

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

- a. 

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

**BLREF18A**  
 b. 

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

**BLREF18B**  
 c. 

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

**BLREF18C**

22. 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     
 BLHOSP12

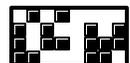
Complete a Health ABC Event Form, Section I, for each event.  
Record reference #'s and reason for hospitalization below.

a. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Reason for hospitalization: <b>BLREF19A</b>	b. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Reason for hospitalization: <b>BLREF19B</b>	c. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Reason for hospitalization: <b>BLREF19C</b>
d. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Reason for hospitalization: <b>BLREF19D</b>	e. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Reason for hospitalization: <b>BLREF19E</b>	f. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Reason for hospitalization: <b>BLREF19F</b>

23. 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     
 BLOUTPA

Was it for...?			Reference #:
a. A procedure to open a blocked artery	<input type="radio"/> 1 Yes → <input type="radio"/> 0 No <input type="radio"/> 8 Don't know	Complete a Health ABC Event Form, Section III. Record reference #: <b>BLBLART</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>BLREF20A</b>
b. Gallbladder surgery	<input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Don't know	<b>BLGALLBL</b>	
c. Cataract surgery	<input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Don't know	<b>BLCATAR</b>	
d. Hernia repair	<input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Don't know	<b>BLHERN</b>	
e. TURP (MEN ONLY) (transurethral resection of prostate)	<input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Don't know	<b>BLTURP</b>	
f. Other	<input type="radio"/> 1 Yes → <input type="radio"/> 0 No <input type="radio"/> 8 Don't know	<b>BLOTH</b>	Please specify the type of outpatient surgery. i. _____ ii. _____ iii. _____



24. Do you expect to move or have a different address in the next 6 months?

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



***Interviewer Note: Please record the new mailing address and telephone number, and date when the new address and telephone numbers are effective on the HABC Participant Contact Information report.***

***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 talking with you in about 6 months from now.***



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"/>
<b>BJID</b>	<b>BJACROS</b>	Month <b>BJDATE</b> Day Year	<b>BJSTFID</b>

**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<br>(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**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

