Attach computer ID

FOLLOW-UP
SUPPLEMENT

Date of Follow-Up ____/____/____ DATE02
Mo. Day Year

Complete and attach to each copy of the Follow-Up form submitted.

Submit alone as an early notification of patient's death, dated with date of death. (Submit full Follow-Up form, dated with date of death with another copy of this form attached, with as much information as possible, when available.)

Submit alone if answer is yes to question 1.A., B., or C. STATUS02

1. A. Did the patient refuse follow-up?

   1. Yes, known to be alive at this time. []
   2. Yes, vital status unknown at this time. []
   3. No []

   B. Is the patient known to be alive, but is inaccessible for follow-up?

   1. Yes [] 2. No []

   C. Is the patient lost to follow-up (i.e., whereabouts and health unknown)?

   1. Yes [] 2. No []

   D. Did the patient die? 1. Yes [] 2. No [] DEATH02

   If yes, date of death ____/____/____ DVDTH02
   Mo. Day Year

2. A. Check which of the following best describes chest pain experienced by the patient during the follow-up period. (If more than one type of chest pain is present, this question should refer to that pain syndrome which most resembles angina pectoris.)

   1. Definite angina []
   2. Probable angina []
   3. Probably not angina [] ANGINA02
   4. Definitely not angina []

   B. Was this follow-up form completed by:

   1. phone call []
   2. in person []
   3. by mail [] INTERV02
   4. combination []

attach computer ID

Name_____

FOLLOW-UP QUESTIONNAIRE

Date of Follow-up____/____/____ DATE02
Mo. Day Year

HEALTH STATUS

1. Have you been told that you have had a new heart attack (myocardial infarction) in the past year without being hospitalized?
1. Yes ☐ 2. No ☐ MI02

If yes, date____/____/____ DVFMI02 by Dr._____
Mo. Day Year

Address_____

2. Have you had any symptoms in the past year? 1. Yes ☐ 2. No ☐ SYMPTM02

If yes,

HTFAIL02 Heart failure ☐ (Heart failure means an accumulation of extra fluids giving you swelling in both ankles, shortness of breath, and/or trouble sleeping without many pillows because of shortness of breath.)

CHPAIN02 Chest discomfort ☐ (Chest discomfort means any pain or discomfort in the arms, chest, throat or jaw for which you have consulted (or been followed by) a physician. The discomfort could be heaviness, tightness, burning, pressure, or any other sensation which your doctor calls angina or "heart pain." This discomfort may occur with exertion or at rest. It does not include the occasional aches and numbness felt around the chest incision after surgery.)

ARRHYT02 Rhythm disturbance ☐ (heart beat irregularity) (Rhythm disturbance means an irregular heart beat or very slow or very fast heart beat for which you required a physician's advice and treatment.)

FATIG02 General fatigue ☐ Other ☐ (please specify)_____
OTHSMP02

3. If you answered "yes" to heart failure above, complete the questions below.
PLEASE CHECK EACH ONE:

3.a. Do you have difficulty sleeping at night because of shortness of breath which is relieved by using several pillows?

ORTHOP02 1. Yes ☐ 2. No ☐

3.b. Do you frequently awake at night because of extreme shortness of breath which is relieved by sitting or standing up?

PND02 1. Yes ☐ 2. No ☐

3.c. Do you have inappropriate shortness of breath with mild exercise or with regular daily activity?

DOE02 1. Yes ☐ 2. No ☐

3.d. Do you have puffy swelling of both your ankles (edema)?

EDEMA02 1. Yes ☐ 2. No ☐

4. If you answered "yes" to chest discomfort above, complete the questions below.

4.a. Causes of chest discomfort. CHECK EACH ONE.

		1. Yes	2. No	3. Uncertain
LEGWRK02	Legwork (walking, bicycling, jogging, etc.)	☐	☐	☐
ARMWRK02	Armwork	☐	☐	☐
EATING02	Eating	☐	☐	☐
EMOTN02	Emotion, excitement, stress, tension, or anger	☐	☐	☐
SEXUAL02	Sexual activity	☐	☐	☐
REST02	Rest or during sleep (unrelated to exertion)	☐	☐	☐
OTHFCT02	Other (e.g., bending, wind, cold)	☐	☐	☐

4.b. Choose one of the following descriptions of the average or typical level of your chest discomfort over the past year:

CHECK ONE ONLY.

CHCLAS02

1. Only with strenuous or prolonged physical activity ☐
2. With rapid or moderate to extensive walking or stair climbing (more than 2 blocks or more than one flight); or in cold, in wind, or under emotional stress ☐
3. With minimal walking or stair climbing; such as walking 2 level blocks or less, or climbing one flight of stairs or less at normal pace under normal conditions ☐
4. With any physical activity or even at rest ☐
5. Unrelated to physical activity ☐
6. Only associated with a heart attack (myocardial infarction) ☐

4.c. Did you use nitroglycerin or other sublingual nitrates for chest discomfort during the past year?

NITRO02 1. Yes ☐ 2. No ☐

If yes, which of the following most typically occurred?

CHECK ONE ONLY.

RELIEF02

1. Relief of chest discomfort within 5 minutes ☐
2. Relief of chest discomfort within 5 to 15 minutes ☐
3. Relief of chest discomfort within 15 to 30 minutes ☐
4. Relief of chest discomfort after 30 minutes ☐
5. Rarely causes relief of chest discomfort ☐

5. When carrying out your normal daily activities (hobbies, recreation, job, yard-work, household routine), which of the following statements characterizes most of the past year?

CHECK ONE ONLY.

LIMIT02

1. There is no limitation of activities ☐
2. There is intermittent limitation of activities ☐
3. There is mild limitation of activities ☐
4. There is moderate limitation of activities ☐
5. There is severe limitation of activities ☐
6. Uncertain due to medical restrictions ☐
7. Uncertain--recovering from coronary bypass surgery ☐
8. Uncertain--recovering from other surgery ☐

If there was known limitation of activities, what was the main factor which caused it?

CHECK ONE ONLY.

FACTOR02

1. Chest pain ☐ 2. Stroke ☐ 3. Shortness of breath ☐
4. Leg cramps ☐ 5. General fatigue ☐ 6. Orthopedic problems ☐
7. Other ☐ (please specify)_____

6. Compared to a year ago, what is the amount of physical activity that you can do without developing chest discomfort? (IF YOU HAVE HAD CORONARY ARTERY BYPASS SURGERY WITHIN THE LAST 8 WEEKS, compare the amount of physical activity you could do without developing chest discomfort just before your surgery to what you could do a year ago.)

PHYACT02 1. More ☐ 2. Less ☐ 3. The same ☐ (Please check "3. The same" if you have never had chest discomfort.)

If the amount has changed, is the change

CHANGE02 1. Small? ☐ 2. Moderate? ☐ 3. Considerable? ☐

7. Have you developed in the past year, or do you continue to have:

CHECK EACH ONE.

		1. Yes	2. No	3. Uncertain
High blood pressure	HYPTEN02	☐	☐	☐
Diabetes	DIABET02	☐	☐	☐
Stroke	CERBRV02	☐	☐	☐
Poor circulation in your legs	PERART02	☐	☐	☐
Other (please specify)_____	OTHILL02	☐	☐	☐

DATE22

COUNT22

HOSPITALIZATIONS

1. Have you been hospitalized since _____?

(If hospitalized more than once, fill out ADDITIONAL HOSPITALIZATIONS on the next page.)

HOSPTL22 1. Yes ☐ 2. No ☐

If yes, name of hospital _____ Date ___/___/___ (Mo. Day Year) DVHOSP22

address _____

reason for admission _____ DAYS22 days (Number of days in hospital)

2. Check any of the following which occurred in association with the above hospitalization:

MIHOSP22 Heart attack ☐ Chest pain (not a heart attack) ☐ CPHOSP22 Stroke ☐ STROKH22

HFAILH22 Heart failure ☐ Rhythm disturbance ☐ RDISTH22 Cardiac catheterization or coronary arteriography ☐ CATHHP22

PTCA22 Balloon angioplasty (PTCA, balloon dilatation) ☐

3. Did you have any surgery during the above hospitalization?

SURGRY22 1. Yes ☐ 2. No ☐

If yes, indicate type (if known).

CORART22 Coronary artery surgery ☐ Valvular surgery ☐ Myocardial surgery (aneurysmectomy) ☐

Pacemaker surgery ☐ Pericardial surgery ☐ Peripheral vascular surgery ☐

Heart transplant ☐ Other ☐ OTHSRG22 (please specify) _____

AS STATED ABOVE, IF YOU WERE HOSPITALIZED MORE THAN ONCE, FILL OUT ADDITIONAL HOSPITALIZATIONS ON THE NEXT PAGE. PLEASE USE THE BACK OF THE NEXT PAGE TO DESCRIBE ANY FURTHER HOSPITALIZATIONS.

ADDITIONAL HOSPITALIZATIONS NHOSP02 - number of hospitalizations

1. First Additional Hospitalization

a. Name of hospital_____ Date___/___/___
Mo. Day Year

Address_____

Reason for admission_____ _____days
Number of days in hospital

b. Check any of the following which occurred in association with the above hospitalization:

Heart attack ☐ Chest pain (not a heart attack) ☐ Stroke ☐

Heart failure ☐ Rhythm disturbance ☐ Cardiac catheterization or coronary arteriography ☐

c. Did you have any surgery during the above hospitalization?

1. Yes ☐ 2. No ☐

If yes, indicate type (if known)

Coronary artery surgery ☐ Valvular surgery ☐ Myocardial surgery ☐

Pacemaker surgery ☐ Pericardial surgery ☐ Peripheral vascular surgery ☐

Heart transplant ☐ Other ☐ (please specify)_____

2. Second Additional Hospitalization

a. Name of hospital_____ Date___/___/___
Mo. Day Year

Address_____

Reason for admission_____ _____days
Number of days in Hospital

b. Check any of the following which occurred in association with the above hospitalization:

Heart attack ☐ Chest pain (not a heart attack) ☐ Stroke ☐

Heart failure ☐ Rhythm disturbance ☐ Cardiac catheterization or coronary arteriography ☐

c. Did you have any surgery during the above hospitalization?

1. Yes ☐ 2. No ☐

If yes, indicate type (if known)

Coronary artery surgery ☐ Valvular surgery ☐ Myocardial surgery ☐

Pacemaker surgery ☐ Pericardial surgery ☐ Peripheral vascular surgery ☐

Heart transplant ☐ Other ☐ (please specify)_____

TREATMENTS

Please check any treatments you have taken in the past two months.

1. Medication

If you take no medications, check box ☐ and skip to Diet section below.

If you do take medications, please list them here:

_____ _____

_____ _____

_____ _____

		1 Yes	2 No	
Nitroglycerin	NITROG02	☐	☐	
Long-acting nitrates	NITRAT02	☐	☐	specify _____
Antiarrhythmics	ANTIAR02	☐	☐	specify _____
Beta-blocking agent	BETABL02	☐	☐	specify _____
Calcium-blocking agent	CALCBL02	☐	☐	specify _____
Antiplatelet agents	ANTIPL02	☐	☐	
aspirin ☐	ASPRIN02			
dipyridamole ☐	DIPYRD02			
other ☐	OTHERA02	☐	☐	specify _____
Anticoagulation	ACOAG02	☐	☐	specify _____
Digitalis	DIGITL02	☐	☐	
Diuretic	DIURET02	☐	☐	
Furosemide ☐	FURO02			
Ethacrynic acid ☐				
Thiazides ☐	THIAZ02			
Aldactone ☐	ALDAC02			
Other ☐	OTHERD02	☐	☐	specify _____
Antihypertensive agent (except diuretics)	ANTHYP02	☐	☐	specify _____
Lipid-lowering agent	LIPID02	☐	☐	specify _____
Hypoglycemic agent	HYPOGL02	☐	☐	specify _____
Insulin ☐	INSULN02			
Oral ☐	ORAL02			
Tranquilizers/Sedatives	TRANQU02	☐	☐	
CNS Stimulant	CNSSTM02	☐	☐	

2. Diet

Weight reduction diet	WTDIET02	☐	☐
Triglyceride control diet	TRDIET02	☐	☐
Diabetic diet	DBDIET02	☐	☐
Low cholesterol diet	CHDIET02	☐	☐
Salt restriction diet	STDIET02	☐	☐

3. Other

Pacemaker	PACEMK02	☐	☐	
Oral contraceptives				
Supervised exercise program	EXERCS02	☐	☐	
Other	OTHERT02	☐	☐	specify _____

OCCUPATIONAL AND RECREATIONAL STATUS

1. Present employment (answer both a. and b.)

   a. 1. Full time ☐ 2. Part time ☐

   3. Retired ☐ (Retired means discontinued working upon reaching retirement age, as opposed to quitting either because of a doctor's advice or incapacitation.)

   EMPLOY02

   4. Quit ☐ (Quit means you were forced to quit working prior to retirement age because of your cardiac symptoms either by your choice or upon your physician's recommendation.)

   5. Other ☐ (please explain)_____

   b. 1. Laborer ☐ 2. Clerical ☐ 3. Professional ☐

   OCCUP02

   4. Homemaker ☐ 5. Other ☐

   Please list your present occupation and job title or the one you had prior to quitting or retiring _____

2. Typical daily recreation or physical activity level during the last six months. (This means activities in addition to regular employment/homemaking as answered in previous question. If you quit your job or are retired, this question refers to all of your daily activities.)

   1. Strenuous ☐ 2. Moderate ☐ 3. Mild ☐ 4. Sedentary ☐ RECRTN02

   Please give examples of present daily physical activity_____

SMOKING HISTORY

1. Did you smoke cigarettes during the past year? 1. Yes ☐ 2. No ☐ CIGRTS02

   If yes, average daily consumption during the past year CNSMPN02 cigarettes

2. Are you presently smoking a pipe? 1. Yes ☐ 2. No ☐ PIPE02

3. Are you presently smoking cigars? 1. Yes ☐ 2. No ☐ CIGARS02

OTHER

1. Your present weight _____ lbs. WEIGHT02.

2. Did you understand this questionnaire and think the information supplied is accurate?

   RELIAB02

   Yes, completely ☐

   Yes, but had difficulty with some sections ☐

   No, I am confused ☐

3. Please describe briefly any additional information you think is important (you may use the back of this page for more space):

CP: 1. ☐ 2. ☐ 3. ☐ 4. ☐ COM.B.. 1. ☐ 2. ☐ 3. ☐ 4. ☐