

This Space for Clinic Use Only

Name: _____

SHEP ID: - -

Date of next Clinic Visit: at : a.m. 1 p.m. 2

Acrostic: _____

DEAR PARTICIPANT:

PLEASE FILL OUT THIS FORM AS COMPLETELY AS POSSIBLE AND BRING IT WITH YOU TO THE CLINIC VISIT SCHEDULED ABOVE. IF YOU DO NOT UNDERSTAND SOME OF THE QUESTIONS, LEAVE THEM BLANK UNTIL YOUR CLINIC VISIT. WE WILL REVIEW THE WHOLE FORM WITH YOU AT THAT TIME.

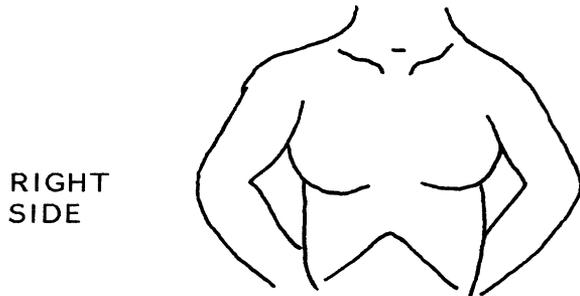
IN THE PAST YEAR, HAS A DOCTOR TOLD YOU THAT YOU HAD ANY OF THE FOLLOWING?

- 1. High blood pressure severe enough to lead to hospitalization? 52 11 Yes 1 No 2 Don't know 3
- 2. Heart attack (myocardial infarction, coronary occlusion or coronary thrombosis) 53 12 Yes 1 No 2 Don't know 3
- 3. Angina (chest pain) 54 13 Yes 1 No 2 Don't know 3
- 4. Other heart problems 55 14 Yes 1 No 2 Don't know 3
- 5. Stroke (cerebrovascular accident, CVA) 56 15 Yes 1 No 2 Don't know 3
- 6. Memory problems or other problems of the brain 57 16 Yes 1 No 2 Don't know 3
- 7. Diabetes (high blood or urine sugar) 58 17 Yes 1 No 2 Don't know 3
- 8. Gout 59 18 Yes 1 No 2 Don't know 3
- 9. Cancer 60 19 Yes 1 No 2 Don't know 3
- 10. Other major diseases (specify): 61 20 Yes 1 No 2 Don't know 3

(PLEASE TURN OVER)

11. a. How many days in the past two weeks have you had to substantially reduce your social activities outside the home (meetings, shopping) because you did not feel well? (21) 62,63
- b. How many days in the past two weeks have you had to substantially reduce your major work activities at home (house cleaning, laundry) because you did not feel well? (22) 64,65
- c. How many days in the past two weeks have you had to substantially reduce your ordinary activities at home (cooking, dressing) because you did not feel well? (23) 66,67
- d. How many days in the past two weeks did you spend most of the day in bed because you did not feel well? (24) 68,69
12. a. In the past year, have you had any pain or discomfort in your chest? (25) 70 Yes 1 No 2
↓
Skip to 12c
- b. In the past year, have you had any pressure or heaviness in your chest? (26) 71 Yes 1 No 2
↓
Skip to 13
(next page)
- c. Do you get this pain, discomfort, pressure or heaviness when you walk uphill or hurry? (27) 72 Yes 1 No 2
↓
Skip to 13
(next page)
- d. Do you get it when you walk at an ordinary pace on the level ground? (28) 73 Yes 1 No 2
- e. What do you do when you get this pain while you are walking? 74 (29) Stop or slow down 1
Continue at same pace 2
- f. Does it go away when you stand still? 75 (30) Yes 1 No 2
↓
Skip to 12h
(next page)
- g. How soon? 76 (31) 10 minutes or less 1
More than 10 minutes 2

h. Where do you get this pain or discomfort?
(Mark the places with an "X" on the diagram.)



Do not use--clinic use only.

77	32	(1) Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 2	78
		(2) Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 2	33
79	34	(3) Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 2	

13. In the past year, have you had a severe pain across the front of your chest lasting for half an hour or more?

80 35 Yes 1 No 2

14. a. Have you had a heart attack (myocardial infarction, coronary thrombosis) in the past year?

36 81 Yes 1 No 2 Don't know 3

Skip to 15
(next page)

b. Were you hospitalized for any heart attacks in the past year?

37 82 Yes 1 No 2

c. How many such attacks have you had?

38 83,84

d. What were the dates of these heart attacks? (month/year)

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(PLEASE TURN OVER)

15. a. Do you get a pain in either leg on walking? 85 (39) Yes 1 No 2
↓
Skip to 16
- b. Does this pain ever begin when you are standing still or sitting? 86 (40) Yes 1 No 2
- c. Do you get this pain in your calf? (or calves?) 87 (41) Yes 1 No 2
- d. Do you get it when you walk uphill or hurry? 88 (42) Yes 1 No 2
↓
Skip to 16
- e. Do you get it when you walk at an ordinary pace on the level ground? 89 (43) Yes 1 No 2
- f. Does this pain ever disappear while you are still walking? 90 (44) Yes 1 No 2
- g. What do you do if you get it when you are walking? 91 (45) Stop or slow down 1
Continue at same pace 2
- h. Does it go away when you stand still? 92 (46) Yes 1 No 2
↓
Skip to 16
- i. How soon? 93 (47) 10 minutes or less 1
More than 10 minutes 2

16. a. Do you usually cough first thing in the morning in the winter? (If you cough with your first smoke or when first going outside, you should mark "yes." Do not respond "yes" for clearing of throat or a single cough.) 94 (48) Yes 1 No 2
↓
Skip to 16c
- b. Do you usually cough during the day or at night in the winter? (Do not respond "yes" for a single cough.) 95 (49) Yes 1 No 2
↓
Skip to 17 (next page)
- c. Do you cough like this on most days for as much as 3 months each year? 96 (50) Yes 1 No 2
- d. Do you usually bring up any phlegm (mucus) from your chest first thing in the morning in the winter? 97 (51) Yes 1 No 2

e. Do you usually bring up any phlegm from your chest during the day or at night in the winter?

98 (52) Yes 1 No 2
↓

Skip to 17

f. Do you bring up phlegm like this on most days for as much as 3 months each year?

99 (53) Yes 1 No 2

g. In the past year, have you had a period of increased cough and phlegm lasting for 3 weeks or more?

100 (54) Yes, once 1
Yes, more than once 2
No 3

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

101 (55) Yes 1 No 2

b. Do you get short of breath walking with other people of your own age on level ground?

102 (56) Yes 1 No 2

c. Do you ever wake up at night gasping for breath?

103 (57) Yes 1 No 2

d. Do you get short of breath at night unless you sleep on two or more pillows?

104 (58) Yes 1 No 2

e. Have you ever had asthma?

105 (59) Yes 1 No 2
↓

Skip to 18 (next page)

f. Have you had any asthma attacks in the past year?

106 (60) Yes 1 No 2

g. Do you take medication to control or treat asthma?

107 (61) Yes 1 No 2

Clinic Use Only

SHEP ID: [] - [] - [] Acrostic: []

(PLEASE TURN OVER)

18. a. In the past year, have you had any sudden feeling of numbness, tingling or loss of feeling in either arm, hand, leg, foot or face?

108 (62) Yes 1 No 2
↓

Skip to 19

b. How many attacks of such numbness or tingling have you had in the past year? (Check one.)

109 (63) { Only one 1
Two 2
Three to five 3
More than five 4

c. How long did each of the attack(s) usually last?

110 (64) { Less than 5 minutes 1
From 5 minutes to one hour 2
From 1-6 hours 3
From 6-24 hours 4
More than 24 hours 5

d. Did you see a doctor for the numbness, tingling, or loss of feeling?

111 (65) Yes 1 No 2

19. a. In the past year, have you had any sudden attacks of paralysis or loss of use of either arm, hand, leg or foot?

112 (66) Yes 1 No 2
↓

Skip to 20
(next page)

b. How many attacks of such paralysis have you had in the past year? (Check one.)

113 (67) { Only one 1
Two 2
Three to five 3
More than five 4

c. How long did the attack(s) usually last?

114 (68) { Less than 5 minutes 1
From 5 minutes to one hour 2
From 1-6 hours 3
From 6-24 hours 4
More than 24 hours 5

d. Did you see a doctor for this paralysis?

115 (69) Yes 1 No 2

20. a. In the past year, have you had any sudden loss of eyesight or blurring of vision for a short period of time? 116 (70) Yes 1 No 2
↓
- Skip to 21
- b. What part of your vision was affected? 117 (71) {
- Right eye only 1
 - Left eye only 2
 - Both eyes 3
 - Vision to the right side 4
 - Vision to the left side 5
- c. How many attacks of loss of eyesight or blurring of vision have you had in the past year? 118 (72) {
- Only one 1
 - Two 2
 - Three-five 3
 - More than five 4
- d. How long did the attack(s) usually last? 119 (73) {
- Less than 5 minutes 1
 - From 5 minutes to one hour 2
 - From 1-6 hours 3
 - From 6-24 hours 4
 - More than 24 hours 5
- e. Did you see a doctor for this vision problem? 120 (74) Yes 1 No 2

21. a. In the past year, have you had any sudden attacks of changes in speech, loss of speech or inability to say words? 121 (75) Yes 1 No 2
↓
- Skip to 22
(next page)
- b. How many attacks of loss of speech have you had in the past year? 122 (76) {
- Only one 1
 - Two 2
 - Three-five 3
 - More than five 4
- c. How long did the attack(s) usually last? 123 (77) {
- Usually less than 5 minutes 1
 - From 5 minutes to one hour 2
 - From 1-6 hours 3
 - From 6-24 hours 4
 - More than 24 hours 5
- d. Did you see a doctor for your speech problem? 124 (78) Yes 1 No 2

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(PLEASE TURN OVER)

22. In the past year, have you had any of the following:

- a. Dizziness
- b. Spinning sensation (vertigo)
- c. Loss of balance
- d. Difficulty walking
- e. Blackouts or fainting
- f. Frequent falls

- 125 (79) Yes 1 No 2
 126 (80) Yes 1 No 2
 127 (81) Yes 1 No 2
 128 (82) Yes 1 No 2
 129 (83) Yes 1 No 2
 130 (84) Yes 1 No 2
 131 (85) Yes 1 No 2

23. a. Did you answer "yes" to any of the problems in Question 22?

Skip to 24

b. About how many total attacks of all conditions checked do you think you had in the past year?

- 132 (86) { Only one 1
 Two 2
 Three-five 3
 More than five 4

c. How long did the attack(s) usually last?

- 133 (87) { Usually less than 5 minutes 1
 From 5 minutes to one hour 2
 From 1-6 hours 3
 From 6-24 hours 4
 More than 24 hours 5

d. Did you see a doctor for any of these spells?

- 134 (88) Yes 1 No 2

24. a. In the past year, have you had surgery to improve the blood flow in your arteries or vessels (endarterectomy, by-pass surgery)? (Do not include surgery for varicose veins.)

- 135 (89) Yes 1 No 2

Skip to 25 (next page)

b. Did you have surgery on your neck vessels (carotid artery)?

- 136 (90) Yes 1 No 2

Date(s) of surgery _____

c. Did you have surgery on your heart (coronary by-pass)?

- 137 (91) Yes 1 No 2

Date(s) of surgery _____

d. Did you have surgery on the aorta or leg arteries?

- 138 (92) Yes 1 No 2

Date(s) of surgery _____

25. a. Have you been hospitalized for any reason within the past year?

139 **93** Yes 1 No 2
↓

Skip to 26

b. List the reason, the name and address of the hospital, and the month and year of the hospitalization.

Reason	Month/Year	Name of Hospital, City and State
(1)	_____	_____
(2)	_____	_____
(3)	_____	_____
(4)	_____	_____
(5)	_____	_____

(If more than 5 hospitalizations, list rest on a blank sheet of paper.)

26. In the past year, have you had a fracture of the:

a. Hip? _____
When? _____

140 **94** Yes 1 No 2

b. Spine? _____
When? _____

141 **95** Yes 1 No 2

c. Forearm? _____
When? _____

142 **96** Yes 1 No 2

Clinic Use Only

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(PLEASE TURN OVER)

27. a. About how many times would you say that you have fallen to the floor or ground for no obvious reason in the past three months?

143

97

- None 1
- Once 2
- Twice 3
- Three times 4
- Four or five times 5
- More than five times 6
- Don't know 7

If "None," skip to 28

b. Did you have any injury from those falls that required a doctor's attention?

98

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

Describe injury: _____

144

28. Has any medicine you may be taking, or have taken in the past year, ever caused you to have a skin rash or other kind of allergic reaction?

145

99

- Yes 1
- No 2

Describe medicine, reaction and circumstances:

PERSONAL INFORMATION:

29. a. Which of the following most closely describes your current employment status?

146

100

- Employed full time 1
- Employed part time 2
- Retired or not employed 3

b. If retired, in what month and year did you retire from your last paid employment (20 hours per week or more)?

101

147-148

Month

149-150

Year

102

30. What is your current marital status?

151

103

- Married 1
- Widowed 2
- Separated 3
- Divorced 4
- Never married 5

31. a. Do you currently smoke cigarettes?

152

104

- Yes 1
- No 2

Skip to 32 (next page)

b. How many do you now smoke per day?

105

153-155

32. a. Which answer best describes how often you drink wine, beer, whiskey or liquor? (Check one.)

156

106

- Never drank 1
- I used to drink, but don't drink now 2
- 1 or 2 times a year or very occasionally 3
- Less than one per week or only at parties 4
- 1 to 2 times a week 5
- 3 to 4 times a week 6
- Nearly every day 7
- Every day 8

b. When you drink alcoholic beverages, how many do you usually drink in a day? (One drink = 1 can of beer, or a glass of wine or 1 shot of whiskey or liquor)

157-158

107

33. a. Are you taking any medicines that require a prescription from a doctor?

159

108

Yes 1 No 2
↓

Skip to 34
(next page)

Name all of the medicines that are being prescribed for you by a doctor or a clinic.

Medicine Name	What illness is medicine for?
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____

160-161

b. Total number of prescription medicines being taken

109

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(PLEASE TURN OVER)

34. Have you stopped taking any prescription medications in the past two weeks?

162 **110** Yes 1 No 2
↓

Skip to 35
(next page)

Please list them below

Medicine Name	What illness is medicine for?
1. _____	_____
2. _____	_____
3. _____	_____

Why did you stop taking the medicines?

Medicine No. 1

	Check if Yes	
1. The doctor advised me to stop	163 111 <input checked="" type="checkbox"/> 1	164 112
2. The prescription ran out	<input type="checkbox"/> 1	
3. I felt better	165 113 <input type="checkbox"/> 1	
4. I couldn't remember to take them	<input type="checkbox"/> 1	166 114
5. I couldn't be bothered	<input type="checkbox"/> 1	
6. They made me feel sick	167 115 <input type="checkbox"/> 1	168 116
7. I didn't think they were working	<input type="checkbox"/> 1	
8. A friend told me to stop	169 117 <input type="checkbox"/> 1	170 118
9. Don't know	<input type="checkbox"/> 1	
10. Other:	171 119 <input type="checkbox"/> 1	172 120

Medicine No. 2

	Check if Yes	
1. The doctor advised me to stop	173 121 <input type="checkbox"/> 1	174 122
2. The prescription ran out	<input type="checkbox"/> 1	
3. I felt better	175 123 <input type="checkbox"/> 1	176 124
4. I couldn't remember to take them	<input type="checkbox"/> 1	
5. I couldn't be bothered	177 125 <input type="checkbox"/> 1	178 126
6. They made me feel sick	<input type="checkbox"/> 1	
7. I didn't think they were working	<input type="checkbox"/> 1	180 128
8. A friend told me to stop	179 127 <input type="checkbox"/> 1	
9. Don't know	<input type="checkbox"/> 1	
10. Other:	181 129 <input type="checkbox"/> 1	182 130

Medicine No. 3

- | | | | |
|-------------------------------------|-----|---|----------------------------------|
| | | Check if Yes | |
| 1. The doctor advised me to stop | 183 | <input checked="" type="checkbox"/> 131 | <input type="checkbox"/> 132 184 |
| 2. The prescription ran out | | <input type="checkbox"/> 133 | <input type="checkbox"/> 134 186 |
| 3. I felt better | 185 | <input type="checkbox"/> 135 | <input type="checkbox"/> 136 188 |
| 4. I couldn't remember to take them | | <input type="checkbox"/> 137 | <input type="checkbox"/> 138 190 |
| 5. I couldn't be bothered | 187 | <input type="checkbox"/> 139 | <input type="checkbox"/> 140 192 |
| 6. They made me feel sick | | | |
| 7. I didn't think they were working | | | |
| 8. A friend told me to stop | 189 | | |
| 9. Don't know | | | |
| 10. Other: | 191 | | |

35.

a. Are you presently taking any medicines or diet supplements that you buy in a drugstore, supermarket or health food store without a prescription? For example, aspirin, laxatives, vitamins, antacids.

193 141 Yes 1 No 2

Skip to 36 (next page)

What kind?

Brand Name	What illness do take it for?
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

(If more than 5, list on a blank sheet of paper.)

b. Total number of non-prescription medicines being taken

194-195 142

Clinic Use Only

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(PLEASE TURN OVER)

36. a. In the past year, have you changed where you go for medical care? 196 (143) Yes 1 No 2
- b. If yes, would you object to us sending your blood pressure results to the person or clinic that usually supplies your health care? (144) 1
197 Yes 1
No 2
Don't know 3
I do not have a personal physician or clinic that supplies health care 4

New Clinic Name or Doctor: _____
Address: _____ _____
Telephone: _____

Thank you for completing this form. Please remember to bring this form and any prescription medications that you are now taking with you for your clinic visit which is scheduled on the date shown on the front page.

- | | | |
|---------|-------|---------------------|
| 198 | (145) | RECORD TYPE |
| 199-204 | (146) | DATE RECEIVED |
| 205-207 | (147) | UPDATE NUMBER |
| 208-213 | (148) | DATE LAST PROCESSED |
| 214 | (149) | PAPER COPY |
| 215 | (150) | EDIT STATUS CODE |
| 3-8 | (514) | BATCH DATE |
| 11-16 | (515) | DATE MODIFIED |
| 17-20 | (516) | TIME MODIFIED |
| 21 | (517) | EDIT STATUS |

30-32 (1) FORM NUMBER

40 (518) SEQUENCE NUMBER

SHEP ANNUAL MEDICAL, MEDICATION AND HABITS HISTORY

33 (2) VERSION NUMBER

This Space for Clinic Use Only

Name: _____

SHEP ID: (3) [22,23] - (4) [24,25,26,27] - (5) [28,29] Acrostic: (6) [41-46] _____ 51

Date of next Clinic Visit: (7) [36,37] [38,39] [34,35] at (8) [47,48] : (9) [49,50] a.m. 1 p.m. 2

Month Day Year Hour Minute

DEAR PARTICIPANT:

PLEASE FILL OUT THIS FORM AS COMPLETELY AS POSSIBLE AND BRING IT WITH YOU TO THE CLINIC VISIT SCHEDULED ABOVE. IF YOU DO NOT UNDERSTAND SOME OF THE QUESTIONS, LEAVE THEM BLANK UNTIL YOUR CLINIC VISIT. WE WILL REVIEW THE WHOLE FORM WITH YOU AT THAT TIME.

IN THE PAST YEAR, HAS A DOCTOR TOLD YOU THAT YOU HAD ANY OF THE FOLLOWING?

- 52 (11) 1. High blood pressure severe enough to lead to hospitalization? Yes 1 No 2 Don't know 3
- 53 (12) 2. Heart attack (myocardial infarction, coronary occlusion or coronary thrombosis) Yes 1 No 2 Don't know 3
- 54 (13) 3. Angina (chest pain) Yes 1 No 2 Don't know 3
- 55 (14) 4. Other heart problems Yes 1 No 2 Don't know 3
- 56 (15) 5. Stroke (cerebrovascular accident, CVA) Yes 1 No 2 Don't know 3
- 57 (16) 6. Memory problems or other problems of the brain Yes 1 No 2 Don't know 3
- 58 (17) 7. Diabetes (high blood or urine sugar) Yes 1 No 2 Don't know 3
- 59 (18) 8. Gout Yes 1 No 2 Don't know 3
- 60 (19) 9. Cancer Yes 1 No 2 Don't know 3
- 61 (20) 10. Other major diseases (specify): Yes 1 No 2 Don't know 3

(PLEASE TURN OVER)

11. a. How many days in the past two weeks have you had to substantially reduce your social activities outside the home (meetings, shopping) because you did not feel well?

21 62,63

b. How many days in the past two weeks have you had to substantially reduce your major work activities at home (house cleaning, laundry) because you did not feel well?

22 64,65

c. How many days in the past two weeks have you had to substantially reduce your ordinary activities at home (cooking, dressing) because you did not feel well?

23 66,67

d. How many days in the past two weeks did you spend most of the day in bed because you did not feel well?

24 68,69

12. a. 25 In the past year, have you had any pain or discomfort in your chest?

70

Yes 1 No 2

↓

Skip to 12c

71

b. 26 In the past year, have you had any pressure or heaviness in your chest?

Yes 1 No 2

↓

Skip to 13 (next page)

c. 27 Do you get this pain, discomfort, pressure or heaviness when you walk uphill or hurry?

72

Yes 1 No 2

↓

Skip to 13 (next page)

d. 28 Do you get it when you walk at an ordinary pace on the level ground?

73

Yes 1 No 2

e. 29 What do you do when you get this pain while you are walking?

74

Stop or slow down 1

Continue at same pace 2

f. 30 Does it go away when you stand still?

75

Yes 1 No 2

↓

Skip to 12h (next page)

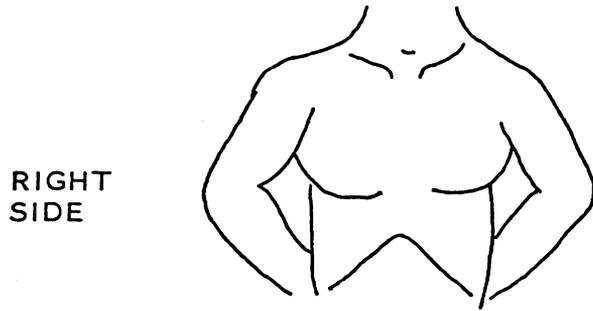
g. 31 How soon?

76

10 minutes or less 1

More than 10 minutes 2

h. Where do you get this pain or discomfort?
(Mark the places with an "X" on the diagram.)



77 (32) Do not use--clinic use only.
 78 (33) (1) Yes 1 No 2
 (2) Yes 1 No 2
 79 (34) (3) Yes 1 No 2

13. In the past year, have you had a severe pain
 80 (35) across the front of your chest lasting
 for half an hour or more? Yes 1 No 2

14. a. Have you had a heart attack (myocardial
 81 (36) infarction, coronary thrombosis)
 in the past year? Yes 1 No 2 Don't know 3

Skip to 15
(next page)

b. Were you hospitalized for any heart attacks
 82 (37) in the past year? Yes 1 No 2

c. How many such attacks have you had?

(38) 83 84

d. What were the dates of these heart attacks?
(month/year)

Clinic Use Only

SHEP ID: - - Acrostic:

(PLEASE TURN OVER)

85

15. a. ³⁹ Do you get a pain in either leg on walking?

Yes 1 No 2

↓

Skip to 16

86

b. ⁴⁰ Does this pain ever begin when you are standing still or sitting?

Yes 1 No 2

87. c. ⁴¹ Do you get this pain in your calf? (or calves?)

Yes 1 No 2

d. ⁴² Do you get it when you walk uphill or hurry?

Yes 1 No 2

↓

Skip to 16

88

89. e. ⁴³ Do you get it when you walk at an ordinary pace on the level ground?

Yes 1 No 2

90. f. ⁴⁴ Does this pain ever disappear while you are still walking?

Yes 1 No 2

91. g. ⁴⁵ What do you do if you get it when you are walking?

Stop or slow down 1
Continue at same pace 2

92. h. ⁴⁶ Does it go away when you stand still?

Yes 1 No 2

↓

Skip to 16

93

94. i. ⁴⁷ How soon?

10 minutes or less 1
More than 10 minutes 2

16. a. ⁴⁸ Do you usually cough first thing in the morning in the winter? (If you cough with your first smoke or when first going outside, you should mark "yes." Do not respond "yes" for clearing of throat or a single cough.)

Yes 1 No 2

↓

Skip to 16c

95

b. ⁴⁹ Do you usually cough during the day or at night in the winter? (Do not respond "yes" for a single cough.)

Yes 1 No 2

↓

Skip to 17
(next page)

96

c. ⁵⁰ Do you cough like this on most days for as much as 3 months each year?

Yes 1 No 2

97. d. ⁵¹ Do you usually bring up any phlegm (mucus) from your chest first thing in the morning in the winter?

Yes 1 No 2

e. Do you usually bring up any phlegm
98 (52) from your chest during the day or at night
in the winter?

Yes 1 No 2
↓

Skip to 17

f. Do you bring up phlegm like this
99 (53) on most days for as much as 3 months
each year?

Yes 1 No 2

g. In the past year, have you
100 (54) had a period of increased cough
and phlegm lasting for 3 weeks or more?

Yes, once 1
Yes, more than once 2
No 3

17. a. Are you troubled by shortness of breath
101 (55) when hurrying on level ground or walking
up a slight hill?

Yes 1 No 2

b. Do you get short of breath walking
102 (56) with other people of your own age
on level ground?

Yes 1 No 2

c. Do you ever wake up at night
103 (57) gasping for breath?

Yes 1 No 2

d. Do you get short of breath at night
104 (58) unless you sleep on two or more pillows?

Yes 1 No 2

e. Have you ever had asthma?
105 (59)

Yes 1 No 2
↓

Skip to 18
(next page)

f. Have you had any asthma attacks
106 (60) in the past year?

Yes 1 No 2

g. Do you take medication to control
107 (61) or treat asthma?

Yes 1 No 2

Clinic Use Only

SHEP ID: - -

Acrostic:

(PLEASE TURN OVER)

18.

a. (62) In the past year, have you had any sudden feeling of numbness, tingling or loss of feeling in either arm, hand, leg, foot or face?

108

Yes 1 No 2
↓

Skip to 19

b. (63) How many attacks of such numbness or tingling have you had in the past year? (Check one.)

109

Only one 1
Two 2
Three to five 3
More than five 4

c. (64) How long did each of the attack(s) usually last?

110

Less than 5 minutes 1
From 5 minutes to one hour 2
From 1-6 hours 3
From 6-24 hours 4
More than 24 hours 5

d. (65) Did you see a doctor for the numbness, tingling, or loss of feeling?

111

Yes 1 No 2

19.

a. (66) In the past year, have you had any sudden attacks of paralysis or loss of use of either arm, hand, leg or foot?

112

Yes 1 No 2
↓

Skip to 20
(next page)

b. (67) How many attacks of such paralysis have you had in the past year? (Check one.)

113

Only one 1
Two 2
Three to five 3
More than five 4

c. (68) How long did the attack(s) usually last?

114

Less than 5 minutes 1
From 5 minutes to one hour 2
From 1-6 hours 3
From 6-24 hours 4
More than 24 hours 5

d. (69) Did you see a doctor for this paralysis?

115

Yes 1 No 2

20.

a. (70) In the past year, have you had any sudden loss of eyesight or blurring of vision for a short period of time?

116

Yes 1 No 2



Skip to 21

b. (71) What part of your vision was affected?

117

- Right eye only 1
- Left eye only 2
- Both eyes 3
- Vision to the right side 4
- Vision to the left side 5

c. (72) How many attacks of loss of eyesight or blurring of vision have you had in the past year?

118

- Only one 1
- Two 2
- Three-five 3
- More than five 4

d. (73) How long did the attack(s) usually last?

119

- Less than 5 minutes 1
- From 5 minutes to one hour 2
- From 1-6 hours 3
- From 6-24 hours 4
- More than 24 hours 5

120

e. (74) Did you see a doctor for this vision problem?

Yes 1 No 2

21.

a. (75) In the past year, have you had any sudden attacks of changes in speech, loss of speech or inability to say words?

121

Yes 1 No 2



Skip to 22 (next page)

b. (76) How many attacks of loss of speech have you had in the past year?

122

- Only one 1
- Two 2
- Three-five 3
- More than five 4

c. (77) How long did the attack(s) usually last?

123

- Usually less than 5 minutes 1
- From 5 minutes to one hour 2
- From 1-6 hours 3
- From 6-24 hours 4
- More than 24 hours 5

124

d. (78) Did you see a doctor for your speech problem?

Yes 1 No 2

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22. In the past year, have you had any of the following:

- a. Dizziness
- b. Spinning sensation (vertigo)
- c. Loss of balance
- d. Difficulty walking
- e. Blackouts or fainting
- f. Frequent falls

126 (80) 125 (79) Yes 1 No 2
 127 (81) Yes 1 No 2
 128 (83) 128 (82) Yes 1 No 2
 129 (84) Yes 1 No 2
 130

23. a. Did you answer "yes" to any of the problems in Question 22?

131 (85) Yes 1 No 2
 ↓

Skip to 24

b. (86) About how many total attacks of all conditions checked do you think you had in the past year?

- Only one 1
- Two 2
- Three-five 3
- More than five 4

132

c. (87) How long did the attack(s) usually last?

- Usually less than 5 minutes 1
- From 5 minutes to one hour 2
- From 1-6 hours 3
- From 6-24 hours 4
- More than 24 hours 5

133

d. (88) Did you see a doctor for any of these spells?

- Yes 1 No 2

24. a. In the past year, have you had surgery to improve the blood flow in your arteries or vessels (endarterectomy, by-pass surgery)? (Do not include surgery for varicose veins.)

- Yes 1 No 2
 ↓

Skip to 25 (next page)

b. (90) Did you have surgery on your neck vessels (carotid artery)?

- Yes 1 No 2

136 Date(s) of surgery _____

c. (91) Did you have surgery on your heart (coronary by-pass)?

- Yes 1 No 2

137 Date(s) of surgery _____

d. (92) Did you have surgery on the aorta or leg arteries?

- Yes 1 No 2

138 Date(s) of surgery _____

25.

a. **93** Have you been hospitalized for any reason within the past year?

Yes 1 No 2
↓

139

Skip to 26

b. List the reason, the name and address of the hospital, and the month and year of the hospitalization.

Reason	Month/Year	Name of Hospital, City and State
(1)	_____	_____
(2)	_____	_____
(3)	_____	_____
(4)	_____	_____
(5)	_____	_____

(If more than 5 hospitalizations, list rest on a blank sheet of paper.)

26. In the past year, have you had a fracture of the:

a. **94** Hip? When? _____
140

Yes 1 No 2

b. **95** Spine? When? _____
141

Yes 1 No 2

c. **96** Forearm? When? _____
142

Yes 1 No 2

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27. a. ⁽⁹⁷⁾ About how many times would you say that you have fallen to the floor or ground for no obvious reason in the past three months?
143

- None 1
- Once 2
- Twice 3
- Three times 4
- Four or five times 5
- More than five times 6
- Don't know 7

If "None," skip to 28

b. ⁽⁹⁸⁾ Did you have any injury from those falls that required a doctor's attention?
144 Describe injury: _____

- Yes 1 No 2 Don't know 3

28. ⁽⁹⁹⁾ Has any medicine you may be taking, or have taken in the past year, ever caused you to have a skin rash or other kind of allergic reaction?
145

- Yes 1 No 2

Describe medicine, reaction and circumstances:

PERSONAL INFORMATION:

29. a. ⁽¹⁰⁰⁾ Which of the following most closely describes your current employment status?
146

- Employed full time 1
- Employed part time 2
- Retired or not employed 3

b. If retired, in what month and year did you retire from your last paid employment (20 hours per week or more)?

⁽¹⁰¹⁾ 147-148 ⁽¹⁰²⁾ 149-150
Month Year

30. ⁽¹⁰³⁾ What is your current marital status?
151

- Married 1
- Widowed 2
- Separated 3
- Divorced 4
- Never married 5

31. a. ⁽¹⁰⁴⁾ Do you currently smoke cigarettes?
152

- Yes 1 No 2

Skip to 32
(next page)

b. How many do you now smoke per day?

⁽¹⁰⁵⁾ 153-155

32. a. 106 Which answer best describes how often you drink wine, beer, whiskey or liquor? (Check one.)

156

- Never drank 1
- I used to drink, but don't drink now 2
- 1 or 2 times a year or very occasionally 3
- Less than one per week or only at parties 4
- 1 to 2 times a week 5
- 3 to 4 times a week 6
- Nearly every day 7
- Every day 8

b. When you drink alcoholic beverages, how many do you usually drink in a day? (One drink = 1 can of beer, or a glass of wine or 1 shot of whiskey or liquor)

157-158

107

33. a. 108 Are you taking any medicines that require a prescription from a doctor?

159

Yes 1 No 2
↓

Skip to 34 (next page)

Name all of the medicines that are being prescribed for you by a doctor or a clinic.

Medicine Name	What illness is medicine for?
1. _____	
2. _____	
3. _____	
4. _____	
5. _____	
6. _____	
7. _____	
8. _____	
9. _____	
10. _____	

160-161

b. Total number of prescription medicines being taken

109

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(PLEASE TURN OVER)

34 Have you stopped taking any prescription medications
 in the past two weeks?

Yes 1 No 2
 ↓

Skip to 35
 (next page)

162 _____

Please list them below

	Medicine Name	What illness is medicine for?
1.	_____	_____
2.	_____	_____
3.	_____	_____

163 Why did you stop taking the medicines?

165	Medicine No. 1	Check if Yes
113	1. The doctor advised me to stop	<input type="checkbox"/> 1
112	2. The prescription ran out	<input type="checkbox"/> 1
164	3. I felt better	<input type="checkbox"/> 1
115	4. I couldn't remember to take them	<input type="checkbox"/> 1
114	5. I couldn't be bothered	<input type="checkbox"/> 1
166	6. They made me feel sick	<input type="checkbox"/> 1
167	7. I didn't think they were working	<input type="checkbox"/> 1
116	8. A friend told me to stop	<input type="checkbox"/> 1
117	9. Don't know	<input type="checkbox"/> 1
168	10. Other:	<input type="checkbox"/> 1
118	_____	
119	_____	
170	_____	
120	_____	
172	_____	

173	Medicine No. 2	Check if Yes
123	1. The doctor advised me to stop	<input type="checkbox"/> 1
122	2. The prescription ran out	<input type="checkbox"/> 1
174	3. I felt better	<input type="checkbox"/> 1
125	4. I couldn't remember to take them	<input type="checkbox"/> 1
124	5. I couldn't be bothered	<input type="checkbox"/> 1
176	6. They made me feel sick	<input type="checkbox"/> 1
126	7. I didn't think they were working	<input type="checkbox"/> 1
127	8. A friend told me to stop	<input type="checkbox"/> 1
178	9. Don't know	<input type="checkbox"/> 1
128	10. Other:	<input type="checkbox"/> 1
129	_____	
180	_____	
130	_____	
181	_____	
182	_____	

183

131 Medicine No. 3

Check if Yes

- 185 133 132 1. The doctor advised me to stop 1
- 184 2. The prescription ran out 1
- 186 3. I felt better 1
- 187 135 134 4. I couldn't remember to take them 1
- 5. I couldn't be bothered 1
- 6. They made me feel sick 1
- 188 137 138 7. I didn't think they were working 1
- 189 8. A friend told me to stop 1
- 190 139 140 9. Don't know 1
- 10. Other: 1

191

192

35.

a. Are you presently taking any medicines or diet supplements that you buy in a drugstore, supermarket or health food store without a prescription? For example, aspirin, laxatives, vitamins, antacids.

193

Yes 1 No 2
↓

Skip to 36
(next page)

What kind?

Brand Name

What illness do take it for?

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

(If more than 5, list on a blank sheet of paper.)

b. Total number of non-prescription medicines being taken

194-195
142

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36. What are your current living arrangements?
(Check all that apply.)
- 216 (151) a. Living alone (skip to 37) 1
 - (152) 217 b. Living with spouse 1
 - (153) c. Living with other related individuals 1
 - 218 d. Living with non-related friends 1
 - 219 (154) (155) 220 e. Living with non-related paid help 1

37. a. (143) In the past year, have you changed where you go
for medical care? Yes 1 No 2
196

b. (144) If yes, would you object to us sending your
blood pressure results to the person or clinic
that usually supplies your health care? Yes 1
No 2
Don't know 3
I do not have a personal
physician or clinic that
supplies health care 4
197

New Clinic Name or Doctor: _____
Address: _____ _____
Telephone: _____

Thank you for completing this form. Please remember to bring this form and any prescription medications that you are now taking with you for your clinic visit which is scheduled on the date shown on the front page.

- | | |
|---|---|
| <p>3-8 (514) BATCH DATE</p> <p>11-16 (515) DATE MODIFIED</p> <p>17-20 (516) TIME MODIFIED</p> <p>21 (517) Edit Status</p> | <p>198 (145) RECORD TYPE</p> <p>199-204 (146) DATE RECEIVED</p> <p>205-207 (147) UPDATE NUMBER</p> <p>208-213 (148) DATE LAST PROCESSED</p> <p>214 (149) PAPER COPY</p> <p>215 (150) Cross Forms Edit</p> |
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