



GenTAC

FORM 2
ENROLLMENT PATIENT
QUESTIONNAIRE

Short Version 2 – 3/15/2009

We are interested in learning more about people who are thought to have a genetic condition that may cause a problem with their thoracic aorta. As you complete this form, answer the questions as best as you can. If you don't know the answer or do not want to answer a question, you may leave it blank. If you are completing this form for a child or other dependent that is enrolled in this study, any references to "you" or "your" refer to that person.

Today's Date: |_|_|-|_|_|-|_|_|_|_|
 Month Day Year

SECTION A: DEMOGRAPHIC DATA

1. What is your date of birth?

|_|_|-|_|_|-|_|_|_|_|
 Month Day Year

2. What is your gender?

- Male
- Female

3. Which of the following groups describes your race?
(You may choose more than one.)

- White
- Black or African American
- Asian
- American Indian or Alaskan Native
- Native Hawaiian or Other Pacific Islander

4. Are you of Hispanic or Latino origin?

- No → **GO TO Q5**
- Yes → What is your country of origin?

5. What is the highest level of schooling you have completed? *(Choose only one.)*

- Not Applicable (subject is a child)
- 1-8 years
- Some high school
- High school graduate
- GED (high school equivalency)
- 1-3 years vocational education beyond high school
- Some college
- College graduate
- One or more years of graduate school or professional school
- Something else *(Please describe below)*

6. What is your current marital status?

- Not Applicable (subject is a child)
- Married or living as married (including living with a partner)
- Divorced or separated
- Widowed
- Never married

7. Are you covered by health insurance or some other kind of health care plan?

- No → **GO TO Q8**
- Yes

7a. What kind of health insurance or health care coverage do you have? *(Choose only one.)*

- Private health insurance plan from employer
- Medicare
- Medicaid
- Other, specify: _____

8. What is your approximate yearly household income? Include income from all sources.

- \$25,000 and under
- \$25,001 - \$50,000
- \$50,001 - \$75,000
- \$75,001 - \$100,000
- \$100,001 or more

9. What is your primary current employment status? *(Choose only one.)*

- Not Applicable (subject is a child)
- Employed full-time at a job or business
- Employed part-time at a job or business
- Self-employed
- Unable to work due to disability
- Student
- Homemaker
- Retired
- Unemployed
- Something else *(Please describe below)*

IF YOU ARE UNDER 18 YEARS OF AGE, CHECK THIS BOX AND GO TO SECTION E.

SECTION B: ALCOHOL USE

The next two questions ask about your general habits concerning alcoholic beverages. For these questions, a **drink is defined as one beer, a glass of wine, or a shot of hard liquor.**

1. During the past 12 months, how often did you usually drink any kind of alcoholic beverage?
 - Never → **GO TO SECTION C**
 - Less than one time a month
 - 1-3 times a month
 - 1 time a week
 - 2-4 times a week
 - Almost every day
 - Every day
2. During the past 12 months, about how many drinks would you have on a day when you drank?
 - 1 or 2 drinks
 - 3 or 4 drinks
 - 5-8 drinks
 - 9 or more drinks

SECTION C: SMOKING HISTORY

1. During your lifetime, have you smoked at least 100 cigarettes?
 - No → **GO TO SECTION D**
 - Yes
2. Do you smoke cigarettes now?
 - No
 - Yes
3. On average, how much do you or did you smoke each day? (**1 pack = 20 cigarettes**)
 - 10 cigarettes or less
 - 11-20 cigarettes
 - 21-40 cigarettes
 - More than 40 cigarettes
4. What is the total number of years you smoked cigarettes? (*Do not count years you did not smoke.*)

_____ Total number of years you smoked cigarettes
5. Other than cigarettes, which of the following tobacco products have you used on a regular basis for six months or longer? (**Choose all the tobacco products that you used.**)
 - Pipe
 - Cigars
 - Cigarillos
 - Chewing tobacco
 - Snuff
 - Never used any of these tobacco products for six months or longer

SECTION D: RECREATIONAL DRUG USE

The next questions are about certain drugs you might have used on a recreational basis. Place an X in Column A if you've used the drug in the past 12 months. Place an X in Column B if you've used it but not in the past 12 months. Give only 1 answer for each drug, and remember that your answers will be kept strictly confidential.

	<u>Column A</u>	<u>Column B</u>
	Yes, I've used this drug in the past 12 months	Yes, I've used this drug but not in the past 12 months
1. Crack cocaine	<input type="checkbox"/>	<input type="checkbox"/>
2. Other types of cocaine, like powder	<input type="checkbox"/>	<input type="checkbox"/>
3. Stimulants, like amphetamines, methamphetamines, or ecstasy	<input type="checkbox"/>	<input type="checkbox"/>
4. 2 or more drugs taken together, like cocaine and heroin, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>

SECTION E: HEALTH AND WELL-BEING

1. In general, would you say your health is...

- Excellent
- Very good
- Good
- Fair
- Poor

2. Compared to one year ago, how would you rate your health in general now?

- Much better now than one year ago
- Somewhat better now than one year ago
- About the same as one year ago
- Somewhat worse now than one year ago
- Much worse now than one year ago

3. In the following table, record the number of hours you spend doing each activity in an average week.

Activity	Number of hours per week
a. Strenuous activity such as aerobics, running, swimming, active sports, shoveling, lifting heavy objects, etc.	
b. Moderate activity such as walking for exercise, cleaning house, gardening, carpentry, etc.	
c. Slight activity , such as walking on level ground around the house, office, shopping, etc.	

4. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? **If your activities are limited a lot**, please indicate whether they are restricted on the advice of your doctor.

Activity	No, not limited at all	Yes, limited a little	Yes, limited a lot →	Due to a doctor's recommendation?	
				Yes	No
Example: riding a bike	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
a. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Lifting or carrying groceries.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Climbing several flights of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Climbing one flight of stairs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Bending, kneeling, or stooping.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Walking more than a mile.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Walking several hundred yards.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Walking one hundred yards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Bathing or dressing yourself.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Cut down on the <u>amount of time</u> you spent on work or other activities	<input type="checkbox"/>				
b. <u>Accomplished less</u> than you would like.....	<input type="checkbox"/>				
c. Were limited in the <u>kind</u> of work or other activities.....	<input type="checkbox"/>				
d. Had <u>difficulty</u> performing the work or other activities (for example, it took extra effort)	<input type="checkbox"/>				

6. How much bodily pain have you had during the past 4 weeks?

- None
- Very mild
- Mild
- Moderate
- Severe
- Very Severe

7. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

- Not at all
- Slightly
- Moderately
- Quite a bit
- A lot

8. How TRUE or FALSE is each of the following statements for you?

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
a. I seem to get sick a little easier than other people.....	<input type="checkbox"/>				
b. I am as healthy as anybody I know.....	<input type="checkbox"/>				
c. I expect my health to get worse	<input type="checkbox"/>				
d. My health is excellent.....	<input type="checkbox"/>				

SECTION F: HEARING/VISION

- Have you ever worn a hearing aid?
 - No
 - Yes
- Does a hearing problem cause you difficulty when listening to television or radio?
 - No
 - Yes
- Do you wear eyeglasses or contact lenses?
 - No
 - Yes
- How would you rate your vision, **without** eyeglasses or contact lenses if you wear them?
 - Excellent
 - Good
 - Fair
 - Poor
- Have you ever had any surgical procedure to correct or improve your vision? (**Check all of the procedures listed below that you have had.**)
 - No
 - Yes, LASIK or laser correction
 - Yes, lens extraction and replacement
 - Yes, implanted contact lens
 - Yes, cataract removal
 - Yes, other

SECTION G: SURGERY

- Have you ever had any of the vascular or heart surgeries or procedures listed below? This includes all types of heart surgeries, including those on your heart valves.
 - No → **GO TO SECTION H**
 - Yes

Please indicate the procedures you had by recording the year it was done. If you don't remember exactly when it was done, record your best guess.

Surgical Intervention	Year
Heart bypass or coronary bypass	
Aortic root replacement	
Aortic arch replacement	
Ascending aortic replacement	
Aortic valve repair (valve-replacing)	
Aortic valve repair (non-root)	
Valve-sparing aortic root replacemen	
Mitral valve repair or replacement	
Pulmonary valve replacement	
Pacemaker or defibrillator implantation	
Descending thoracic aortic replacement	
Thoracoabdominal aortic replacement	
Aorto-femoral bypass surgery	
Repair of pectus deformity	
Angioplasty	
Aorta to pulmonary shunt	
Tetralogy repair	
Coarctation repair	
Other heart surgery, specify:	

SECTION H: MEDICAL CONDITIONS

Has a doctor ever told you that you had any of the following conditions? Place a check in the appropriate column (No, Yes or Don't Know). For each **YES** answer, please provide your age at the time of diagnosis or procedure.

<u>Condition</u>	<u>No</u>	<u>Yes</u> →	<u>Age at Diagnosis</u>	<u>Don't Know</u>
1. Marfan syndrome.....	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
2. Turner syndrome	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
3. Ehlers-Danlos syndrome	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
4. Loeys-Dietz syndrome.....	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
5. FBN1,TGFBR1,TGFBR2, ACTA2 or MYH11 genetic mutations.....	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
6. Bicuspid aortic valve	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
6a. Coarctation	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
7. Shprintzen-Goldberg syndrome.....	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
7a. Thoracic aortic aneurysm or dissection	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
8. Heart murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
9. Heart rhythm palpitations.....	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
10. Angina.....	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
11. Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
12. Atherosclerosis, clogged arteries	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
13. Heart, blood vessel infection (endocarditis)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
14. Cardiomyopathy or heart failure	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
15. Congenital heart disease, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
16. Other heart disease, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
17. Hypertension, high blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
18. Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
19. Aneurysms outside the aorta.....	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
20. Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
23. Pneumothorax or collapsed lung.....	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
24. Other pulmonary or lung disease, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
25. Cancer, specify site: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
27. Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
28. Bleeding disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
29. Blood clotting disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
32. Raynaud's syndrome (fingers turn purple when cold)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
34. Problems with digestive system, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
37. Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
39. Scleroderma	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
40. Autoimmune disease, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
41. Joint dislocations, specify sites: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
45. Memory loss/problems.....	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
46. Learning problems.....	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
47. Depression.....	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>

SECTION I: PRESCRIPTION MEDICATIONS

1. These next questions are about prescription medications. Place an X in Column A if you've never taken the medication, Column B if you are currently taking the medication, or Column C if you've used it in the past but are not using it now. If you don't know if you've use it, place an X in the last column. Include only those medications that you usually take at home. **Do not include those you may have been given only during a recent hospitalization or emergency room visit.**

	<u>Column A</u>	<u>Column B</u>	<u>Column C</u>	<u>Column D</u>
	No, I've never taken this	Yes, I'm taking this now	Yes, I've taken this in the past but not now	I don't know if I've taken this

a. ACE-inhibitors

Such as: benazepril (Lotensin), captopril (Capoten), enalapril (Vasotec), fosinopril (Monopril), lisinopril (Prinivil, Zestril), moexipril (Univasc), perindopril (Aceon), quinapril (Accupril), ramipril (Altace), trandolapril (Mavik)

.....

b. Angiotensin Receptor Blockers

Such as: candesartan (Atacand), eprosartan (Tevetan), irbesartan (Avapro), losartan (Cozaar), telmisartan (Mycardis), valsartan (Diovan)

.....

c. Beta Blockers

Such as: acebutolol (Sectral), atenolol (Tenormin), betaxolol (Kerlone), bisoprolol fumarate (Zebeta), carteolol hydrochloride (Cartrol), carvedilol (Coreg), labetalol (Trandate), metoprolol tartrate (Lopressor), metoprolol succinate (Toprol-XL), nadolol (Corgard), penbutolol sulfate (Levator), pindolol (Visken), propranolol hydrochloride (Inderal, Inderal LA)

.....

d. Diuretics

Such as: bumetanide (Bumex), chlorothiazide or CTZ (Diuril), eplerone (Inspra), furosemide (Lasix), hydrochlorothiazide or HCTZ (Hydrodiuril), indapamide (Lozol), metolazone (Mykrox, Zaroxolyn), spironolactone (Aldactone), torsemide (Demadex)

.....

e. Calcium Channel Blockers

Such as: amlodipine (Norvasc), bepridil (Vascor), diltiazem (Cardizem), felodipine (Plendil), isradipine (Dynacirc), nefedipine (Adalat, Procardia), nicardipine (Cardene), nimodipine (Nimotop), nisoldipine (Sular), verapamil (Calan, Isoptin)

.....

f. Statins

Such as: atorvastatin (Lipitor), fluvastatin (Lescol), lovastatin (Mevacor), pravastatin (Pravachol), rosuvastatin (Crestor), simvastatin (Zocor)

.....

g. Alpha Blockers

Such as: alfuzosin (Uroxatral), doxazosin (Cardura), prazosin (Minipress), tamsulosin (Flomax), terazosin (Hytrin)

.....

h. Other Medications

Insulin

Warfarin (Coumadin)

2. Do you regularly take aspirin?

- No
- Yes

2a. On average, about how many aspirin tablets do you take each week?

_____ Number taken each week

IF YOU ARE A MALE, CHECK THIS BOX:

FORM COMPLETE.

SECTION J: PREGNANCIES

The next questions are about any pregnancies you have had.

1. Have you ever been pregnant?

- No → **FORM COMPLETE**
- Yes

2. Are you currently pregnant?

- No
- Yes

3. How many times have you been pregnant? Please be sure to include any pregnancies that ended in a live birth, miscarriage, stillbirth, or abortion, as well as a tubal or molar pregnancy.

_____ Number of times you have been pregnant

(Continued on next page)

As you answer the following questions, please think about each of your pregnancies. Start with your very first pregnancy, listing it in the column labeled "1st pregnancy". From there, work forward until you have provided information about all of your pregnancies, ending with the most recent. If you have been pregnant more than 6 times, please contact the coordinator for additional forms on which to record this information.

	1 st pregnancy	2 nd pregnancy	3 rd pregnancy						
4. In what month and year did this pregnancy end? <i>(If currently pregnant, enter your due date.)</i>	<table border="1"> <tr> <td>Month</td> <td>Year</td> </tr> </table>	Month	Year	<table border="1"> <tr> <td>Month</td> <td>Year</td> </tr> </table>	Month	Year	<table border="1"> <tr> <td>Month</td> <td>Year</td> </tr> </table>	Month	Year
Month	Year								
Month	Year								
Month	Year								
5. Was this a pregnancy with multiples?	<input type="checkbox"/> No <input type="checkbox"/> Yes → How many? _____	<input type="checkbox"/> No <input type="checkbox"/> Yes → How many? _____	<input type="checkbox"/> No <input type="checkbox"/> Yes → How many? _____						
6. What medicines or procedures did you have to help you get pregnant? <i>(Check all that apply.)</i>	<input type="checkbox"/> None <input type="checkbox"/> Pills or shots <input type="checkbox"/> Artificial insemination <input type="checkbox"/> In vitro fertilization <input type="checkbox"/> Donor egg <input type="checkbox"/> Donor sperm <input type="checkbox"/> Other	<input type="checkbox"/> None <input type="checkbox"/> Pills or shots <input type="checkbox"/> Artificial insemination <input type="checkbox"/> In vitro fertilization <input type="checkbox"/> Donor egg <input type="checkbox"/> Donor sperm <input type="checkbox"/> Other	<input type="checkbox"/> None <input type="checkbox"/> Pills or shots <input type="checkbox"/> Artificial insemination <input type="checkbox"/> In vitro fertilization <input type="checkbox"/> Donor egg <input type="checkbox"/> Donor sperm <input type="checkbox"/> Other						
7. <u>While you were pregnant</u> , did a doctor tell you the baby had a birth defect, chromosome abnormality, or other serious medical problem?	<input type="checkbox"/> No <input type="checkbox"/> Yes → What condition? _____ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes → What condition? _____ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes → What condition? _____ _____						
8. What was the outcome of this pregnancy? <i>(If you were pregnant with multiples, check all that apply and enter the number of babies with that outcome.)</i>	<input type="checkbox"/> Live birth..... # _____ <input type="checkbox"/> Still birth..... # _____ <input type="checkbox"/> Miscarriage..... # _____ <input type="checkbox"/> Abortion (elective, induced)..... # _____ <input type="checkbox"/> Tubal, ectopic..... # _____ <input type="checkbox"/> Other..... # _____ <input type="checkbox"/> Currently pregnant..... # _____	<input type="checkbox"/> Live birth..... # _____ <input type="checkbox"/> Still birth..... # _____ <input type="checkbox"/> Miscarriage..... # _____ <input type="checkbox"/> Abortion (elective, induced)..... # _____ <input type="checkbox"/> Tubal, ectopic..... # _____ <input type="checkbox"/> Other..... # _____ <input type="checkbox"/> Currently pregnant..... # _____	<input type="checkbox"/> Live birth..... # _____ <input type="checkbox"/> Still birth..... # _____ <input type="checkbox"/> Miscarriage..... # _____ <input type="checkbox"/> Abortion (elective, induced)..... # _____ <input type="checkbox"/> Tubal, ectopic..... # _____ <input type="checkbox"/> Other..... # _____ <input type="checkbox"/> Currently pregnant..... # _____						
9. <u>After this pregnancy was over</u> , did a doctor tell you the baby had a birth defect, chromosome abnormality, or other serious medical problem?	<input type="checkbox"/> No <input type="checkbox"/> Yes → What condition? _____ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes → What condition? _____ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes → What condition? _____ _____						

The following are questions about your health during and after each of your pregnancies.

	1 st pregnancy	2 nd pregnancy	3 rd pregnancy
10. <u>While you were pregnant</u> , which of these conditions did you have?	<input type="checkbox"/> None <input type="checkbox"/> High blood pressure, toxemia <input type="checkbox"/> Maternal diabetes <input type="checkbox"/> Premature rupture of membranes <input type="checkbox"/> Change in aortic dimension <input type="checkbox"/> Aortic dissection <input type="checkbox"/> Aortic rupture	<input type="checkbox"/> None <input type="checkbox"/> High blood pressure, toxemia <input type="checkbox"/> Maternal diabetes <input type="checkbox"/> Premature rupture of membranes <input type="checkbox"/> Change in aortic dimension <input type="checkbox"/> Aortic dissection <input type="checkbox"/> Aortic rupture	<input type="checkbox"/> None <input type="checkbox"/> High blood pressure, toxemia <input type="checkbox"/> Maternal diabetes <input type="checkbox"/> Premature rupture of membranes <input type="checkbox"/> Change in aortic dimension <input type="checkbox"/> Aortic dissection <input type="checkbox"/> Aortic rupture
11. Were you on bed rest during this pregnancy?	<input type="checkbox"/> No <input type="checkbox"/> Yes → Why? For how long? _____ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes → Why? For how long? _____ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes → Why? For how long? _____ _____
12. <u>After this pregnancy</u> , which of these conditions did you have?	<input type="checkbox"/> None <input type="checkbox"/> Change in aortic dimension <input type="checkbox"/> Aortic dissection <input type="checkbox"/> Aortic rupture	<input type="checkbox"/> None <input type="checkbox"/> Change in aortic dimension <input type="checkbox"/> Aortic dissection <input type="checkbox"/> Aortic rupture	<input type="checkbox"/> None <input type="checkbox"/> Change in aortic dimension <input type="checkbox"/> Aortic dissection <input type="checkbox"/> Aortic rupture

Thank you for completing this form.

You have made a valuable contribution to the GenTAC Registry.

Please return your completed form to the research staff.

This form will be mailed to the Data Coordinating Center for data entry.