LONG LIFE FAMILY STUDY

(Affix Label Here)

Participant ID: _____

Participant Name Code: _____

Date Form Filled Out:

☐☐☐☐☐☐☐☐☐☐

d d M M M y y y y
(e.g., 10JUN2005)

Interviewer Code: ☐☐☐

Circle Field Center Location:

BU CU DK UP

LLFS Participant Contact Information
(Phase II Follow-Up)

Interviewer Note: ***This form is to be kept in a confidential file, separate from data entry forms. This form should be available for verification and updating during Phase II Follow-Up.)***

1. What is your name? _____
   PREFIX FIRST NAME MI LAST NAME

2. What is your home address? (Street, City, State, Zip) _____

   _____

   _____

3a. What is your home telephone number? _____

3b. What is an alternate telephone number? _____

4a. **US:** What is your Social Security Number? (*Check this box if refused to provide* ☐)

SSN: ___ ___ ___ -- ___ ___ -- ___ ___ ___ ___

4b. **DK:** What is your CPR (Civil Public Registry) Number? (*Check this box if refused to provide* ☐)

CPR: ___ ___ ___ ___ ___ ___ -- ___ ___ ___ ___

5. **US:** What is your Medicare Number? (*Check this box if refused to provide* ☐)

Medicare ID: ___ ___ ___ ___ ___ -- ___ ___ ___ ___ ___ ___ ___

6a. Please provide the name of the person who you would want us to ask to provide information and answer questions for you in the event that you are unable to answer for yourself.

Name: _____
PREFIX FIRST NAME MI LAST NAME

6b. Is this person a family member enrolled in LLFS?

☐[1] .....Yes **Go to 7a**
☐[0] .....No

6c. Address (Street, City, State, Zip) _____

_____

_____

Phone: _____ (□ Home □Work) Best day/time to call: _____

E-Mail Address: _____

6d. Relationship to You (i.e. spouse, friend, etc.): _____

7a. Do you have a primary care physician or a specific location that you ***usually*** go to for health care or for advice about your health care?

☐ 1 .....Yes
☐ 0 .....No

<u>Interviewer Note</u>: Please read response options for 7b and check only one.

7b. Where do you ***usually*** go for health care or advice about health care?

☐ 1 .....Private Doctor's Office (individual or group practice)
☐ 2 .....Public Clinic, such as a neighborhood health center
☐ 3 .....Health Maintenance Organization (HMO)
☐ 4 .....Hospital Outpatient Clinic
☐ 5 .....Emergency Room
☐ 6 .....Other (Please Specify)_____
☐ D .....Don't Know
☐ R .....Refused

7c. Please tell me the name, address and telephone number of the doctor or health care provider that you usually visit for health care needs.

Organization Name: _____

Physician Name: _____
PREFIX **FIRST NAME** **MI** **LAST NAME**

Address (Street, City, State, Zip): _____

_____

_____

Office Phone: _____ Office Fax: _____

E-Mail Address: _____
