LONG LIFE FAMILY STUDY

(Affix Label Here)

Participant ID: _____

Participant Name Code: _____

Date Form Filled Out:

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(e.g., 10JUN2005)

Interviewer Code: ☐☐☐

Circle Field Center Location:

BU CU DK UP

Medical History
(Phase II Follow-Up)

Please Mark the Appropriate Box Below:

☐[1] .....This Form was Administered via a DFR/Proxy
☐[2] .....This Form was Administered via Telephone by Study Personnel
☐[3] .....This Form was Mailed and Self-Administered by Participant

***P**1. "I'm going to read to you a list of conditions. Please respond 'yes' or 'no' if you have been told by a doctor that you had this condition since we last interviewed you on *[insert date of last contact]*."

***Interviewer:** If participant responds "YES", ask at what age they were first told they had the condition and whether or not they currently have the condition, before moving on to next condition. If they don't know if they ever had the condition or refused to answer, please mark the appropriate box. If they don't know the age they were first told, please mark the appropriate box.*

Complete Medical History Questions on Page 2.

Participant ID: _____ **Participant Name Code:** _____

	Yes[1]	No[0]	Refused[R]	Don't Know[D]	Age you were first told	Current Condition?
a. Cardiac Conditions						
Myocardial Infarction or Heart Attack						**Yes / No**
Coronary Angioplasty or Coronary Artery Bypass Grafting (CABG)						**Yes / No**
Heart Failure or Congestive Heart Failure						**Yes / No**
Atrial Fibrillation/Pacemaker						**Yes / No**
Deep Vein Thrombosis (or blood clots in legs) or Pulmonary Embolism (blood clot in lung)						**Yes / No**
Rheumatic Fever or Heart Valve Problems						**Yes / No**
High Blood Pressure						**Yes / No**
b. Stroke						
Stroke or Cerebrovascular Accident						**Yes / No**
Transient Ischemic Attack (TIA) or Mini-Stroke						**Yes / No**
c. Lung Disease						
Asthma						**Yes / No**
Chronic Bronchitis						**Yes / No**
Emphysema or Chronic Obstructive Pulmonary Disease (COPD)						**Yes / No**
Pneumonia						**Yes / No**
Pulmonary Fibrosis						**Yes / No**
Chest Surgery If yes, specify: _____						**Yes / No**
d. Arthritis						
Arthritis of the Knees, Hips or Spine						**Yes / No**
e. Endocrine/GI/Kidney						
Diabetes						**Yes / No**
Thyroid Disease						**Yes / No**
Osteoporosis						**Yes / No**
Chronic Liver Disease, Cirrhosis, or Hepatitis						**Yes / No**
Kidney (Renal) Disease or Failure						**Yes / No**
f. Neurological						
Alzheimer's Disease or Dementia						**Yes / No**
Parkinson's Disease						**Yes / No**
Depression or Anxiety						**Yes / No**
g. Cancer						
Breast Cancer						**Yes / No**
Blood Cancer, Leukemia, or Lymphoma						**Yes / No**

Participant ID: _____ **Participant Name Code:** _____

	Yes[1]	No[0]	Refused[R]	Don't Know[D]	Age you were first told	Current Condition?
Colon (Bowel) or Rectal Cancer						**Yes / No**
Lung Cancer						**Yes / No**
Malignant Melanoma						**Yes / No**
Other Skin Cancer						**Yes / No**
Esophageal Cancer						**Yes / No**
Pancreatic Cancer						**Yes / No**
Other Cancer, specify: _____						**Yes / No**
For Men Only:						
Prostate Cancer						**Yes / No**
Enlarged Prostate, not cancer						**Yes / No**
h. Hearing						
Use Hearing Aid(s)						**Yes / No**
i. Vision						
Cataract Surgery Both Eyes						**Yes / No**
Cataract Surgery One Eye						**Yes / No**
Macular Degeneration						**Yes / No**
Glaucoma						**Yes / No**
j. Fractures						
Hip						**Yes / No**
Wrist or Forearm						**Yes / No**
Spine						**Yes / No**
Other: Specify: _____						**Yes / No**
k. Other Illnesses						
Specify: _____						**Yes / No**
Specify: _____						**Yes / No**
Specify: _____						**Yes / No**
Specify: _____						**Yes / No**
Specify: _____						**Yes / No**

2a. Have you fallen within the last year?

☐[1].....Yes
☐[0].....No **Go to Q4a**

2b. If yes, how many times? ____ ____

2c. Did any of these falls require medical attention?

☐[1].....Yes
☐[0].....No
☐[D].....Don't Know
☐[R].....Refused

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3. How much do you currently weigh? If you are unsure, please make your best guess.

___ ___ ___ lbs **OR** ___ ___ ___ kg

4a. Since this time last year, has your weight changed by 5 or more pounds *[or 2.27 or more kilograms]*?

☐[1].....Yes
☐[0].....No **Go to Q7**

4b. Did you experience a gain or loss in your weight during this time?

☐[1].....Gain
☐[2].....Loss
☐[3].....Both

4c. Were you trying to *[gain/lose]* weight?

☐[1].....Yes
☐[0].....No

4d. How many pounds (or kilograms) did you *[gain/lose]* overall since this time last year?

___ ___ ___ lbs **OR** ___ ___ ___kg
