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

Circle Visit: [2]**Visit 1 Follow-Up** [5]**Visit 2 Follow-Up**

Form Version Date: **_13/03/2015__**

Medical History
Visit 2 Follow-Up

Section A. Please Mark the Appropriate Box Below:

☐[1].....This Form was Administered via a DFR/Proxy **(Go to Section B)**
☐[3].....This Form was Administered via Telephone by Study Personnel
☐[4].....This Form was Mailed and Self-Administered by Participant

Section B. Proxy Tracking. Denmark skip to B2.

B1. US sites:

Which contact person on the PCI form completed this form as the proxy? (Enter the corresponding number such as 6a, 6e, 6i, 8a, 8e, etc from the PCI form)

_____ **Go to B3**

B2. Denmark: What is proxy's relationship to the Study Participant?

☐[1].....Spouse
☐[2].....Child (Daughter/Son)
☐[3].....Sibling (Brother/Sister)
☐[4].....Niece/Nephew
☐[5].....Other (Please Specify): _____
☐[6].....Caregiver

B3. Please provide the reason that you are completing this form on behalf of or instead of the Study Participant (Please X All that Apply)

☐[1].....Physical Illness/Serious incapacitating illness
☐[1].....Hearing impairment
☐[1].....Nursing home or long-term care
☐[1].....Visual impairment
☐[1].....Self-doubt/Fearfulness about own limitations
☐[1].....Other: _____
☐[1].....Dementia/Cognitive impairment
☐[1].....Too Busy/Unavailable
☐[1].....Unable to be reached or located
☐[1].....Fatigue/Too overwhelmed
☐[1].....Uninterested/Unmotivated

***Q**2. "I'm going to read to you a list of conditions. Please respond 'yes' or 'no' if you have EVER been told by a doctor that you had this condition since we last interviewed you on *[insert date of last administration of medical history form]*."

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, write "D" in the appropriate box. If the Medical History is being administered for the first time since September 2014, ask if the participant has EVER had the starred conditions..***

Complete Medical History Questions on Page 3.

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						**Yes / No**
*Pacemaker						**Yes / No**
*Deep Vein Thrombosis (or blood clots in legs)						**Yes / No**
*Pulmonary Embolism (blood clot in lung)						**Yes / No**
*Rheumatic Fever						**Yes / No**
*Heart Valve Problems						**Yes / No**
If yes, circle type: [1]Aortic [2]Mitral [3]Both [4]Unknown [5]Other						
*Chest or Abdominal Surgery						**Yes / No**
If yes, circle one: [1]Aortic Valve [2]Mitral Valve [3]Chest Aorta [4]Abdominal Aorta [5]Other [6]Unknown						
High Blood Pressure or Hypertension						**Yes / No**
*Discomfort in calf while walking (Claudication)						**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**
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**

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

	Yes[1]	No[0]	Refused[R]	Don't Know[D]	Age you were first told	Current Condition?
f. Neurological						
Alzheimer's Disease or Dementia						
Parkinson's Disease						**Yes / No**
*Depression						**Yes / No**
*Anxiety						**Yes / No**
g. Cancer						
Breast Cancer						**Yes / No**
*Blood Cancer or Leukemia						**Yes / No**
*Lymphoma						**Yes / No**
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**

Q3a. Have you fallen since *[insert date*]?
Date: *date of last administration of MedHx form*

☐ 1.....Yes
☐ 0.....No **Go to Q3d**

Q3b. If yes, how many times? ____ ____

Q3c. Did any of these falls require medical attention?

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

Q3d. Have you fainted or lost consciousness since *[insert date*]?
Date: *date of last administration of MedHx form*

☐ 1.....Yes **Go to Q3e**
☐ 0.....No **Go to Q5**

Q3e. If yes, how many times? ____ ____ _____

Q5. How much do you currently weigh? If you are unsure, please make your best guess.

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

Q6a. Since this time last year, has your weight changed by 5 or more pounds *[or 2.27 or more kilograms]*?

☐ 1.....Yes
☐ 0.....No **End Here**

Q6b. Did you experience a gain or loss in your weight during this time?

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

Q6c. Were you trying to *[gain/lose]* weight?

☐ 1.....Yes
☐ 0.....No

Q6d. How many pounds (or kilograms) did you *[gain/lose]* overall since this time last year?

___ ___ ___ lbs **OR** ___ ___ ___kg **Follow-Up End Here**