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

Circle Visit: [1]Visit 1 [3]Visit 2 [4]Visit 2 (New Participant)

Form Version Date: _13/03/2015__

Medical History
Visit 2

Section A: Please Mark the Appropriate Box Below:

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

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

***Q1.** In general, how would you describe your health over the course of your lifetime?

- ☐ 5 .....Excellent
- ☐ 4 .....Very Good
- ☐ 3 .....Good
- ☐ 2 .....Fair
- ☐ 1 .....Poor
- ☐ D .....Don't Know
- ☐ R .....Refused

Note: Q2 will be asked by your interviewer during your visit. Please skip to Q3a on page 5.

Q2.** "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 asked you these conditions 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 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						**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						**Yes / No**
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 of last administration of medical history 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 of last administration of medical history form]?

☐[1].....Yes **Go to Q3e**
☐[0].....No **Go to Q3f**

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

Note: *Now I'm going to ask about some medical problems you may have had since their last medical history update on* ***[insert date of last telephone follow-up]***?

Q**3f. Were you told by a doctor that you had a heart attack, angina, or chest pain due to heart disease since ***[insert date of last telephone follow-up]?

☐[1].....Yes **Go to Q3f1**
☐[0].....No **Go to Q3g**
☐[D].....Don't Know **Go to Q3g**
☐[R].....Refused **Go to Q3g**

***Q**3f1. Were you hospitalized overnight for this problem?

☐[1].....Yes **Go to Q3f2**
☐[0].....No **Go to Q3g**

***Q**3f2. Date of Admission: ___ ___ / ___ ___ / ___ ___ ___ ___ **(DD/MM/YYYY)**

Date of Discharge: ___ ___ / ___ ___ / ___ ___ ___ ___

Name of Hospital: _____

City, State: _____

Q**3g. Were you told by a doctor that you had a stroke, mini-stroke or TIA since ***[insert date of last telephone follow-up]?

☐ 1	.....Yes	**Go to Q3g1**
☐ 0	.....No	**Go to Q3h**
☐ D	.....Don't Know	**Go to Q3h**
☐ R	.....Refused	**Go to Q3h**

***Q**3g1. Were you hospitalized overnight for this problem?

☐ 1	.....Yes	**Go to Q3g2**
☐ 0	.....No	**Go to Q3h**

***Q**3g2. Date of Admission: ___ ___ / ___ ___ / ___ ___ ___ ___ **(DD/MM/YYYY)**

Date of Discharge: ___ ___ / ___ ___ / ___ ___ ___ ___

Name of Hospital: _____

City, State: _____

Q**3h. Were you told by a doctor that you had congestive heart failure since ***[insert date of last telephone follow-up]?

☐ 1	.....Yes	**Go to Q3h1**
☐ 0	.....No	**Go to Q3i**
☐ D	.....Don't Know	**Go to Q3i**
☐ R	.....Refused	**Go to Q3i**

***Q**3h1. Were you hospitalized overnight for this problem?

☐ 1	.....Yes	**Go to Q3h2**
☐ 0	.....No	**Go to Q3i**

***Q**3h2. Date of Admission: ___ ___ / ___ ___ / ___ ___ ___ ___ **(DD/MM/YYYY)**

Date of Discharge: ___ ___ / ___ ___ / ___ ___ ___ ___

Name of Hospital: _____

City, State: _____

Q**3i. Were you told by a doctor that you had cancer? We are specifically interested in hearing about a cancer that was diagnosed for the first time since ***[insert date of last telephone follow-up]?
[***Interviewer Note:*** *A cancer recurrence is not considered a new cancer.]*

☐ 1	.....Yes	**Go to Q3i1**
☐ 0	.....No	**Go to Q3j**
☐ D	.....Don't Know	**Go to Q3j**
☐ R	.....Refused	**Go to Q3j**

***Q**3i1. Were you hospitalized overnight for this problem?

☐ 1	.....Yes	**Go to Q3i2**
☐ 0	.....No	**Go to Q3j**

***Q**3i2. Date of Admission: ___ ___ / ___ ___ / ___ ___ ___ ___ **(DD/MM/YYYY)**

Date of Discharge: ___ ___ / ___ ___ / ___ ___ ___ ___

Name of Hospital: _____

City, State: _____

Q**3j. Were you told by a doctor that you had pneumonia since ***[insert date of last telephone follow-up]?

☐ 1	.....Yes	**Go to Q3j1**
☐ 0	.....No	**Go to Q3k**
☐ D	.....Don't Know	**Go to Q3k**
☐ R	.....Refused	**Go to Q3k**

***Q**3j1. Were you hospitalized overnight for this problem?

☐ 1	.....Yes	**Go to Q3j2**
☐ 0	.....No	**Go to Q3k**

***Q**3j2. Date of Admission: ___ ___ / ___ ___ / ___ ___ ___ ___ **(DD/MM/YYYY)**

Date of Discharge: ___ ___ / ___ ___ / ___ ___ ___ ___

Name of Hospital: _____

City, State: _____

Q**3k. Were you told by a doctor that you broke or fractured a bone(s) since ***[insert date of last telephone follow-up]?

☐ 1	.....Yes	**Go to Q3k1**
☐ 0	.....No	**Go to Q4a**
☐ D	.....Don't Know	**Go to Q4a**
☐ R	.....Refused	**Go to Q4a**

***Q**3k1. Were you hospitalized overnight for this problem?

☐ 1	.....Yes	**Go to Q3k2**
☐ 0	.....No	**Go to Q4a**

***Q**3k2. Date of Admission: ___ ___ / ___ ___ / ___ ___ ___ ___ **(DD/MM/YYYY)**

Date of Discharge: ___ ___ / ___ ___ / ___ ___ ___ ___

Name of Hospital: _____

City, State: _____

Q**4a. Were you hospitalized overnight <u>for any other reasons</u> since ***[insert date of last telephone follow-up]?

☐ 1	.....Yes	**Go to Q4b**
☐ 0	.....No	**Go to Q5**
☐ D	.....Don't Know	**Go to Q5**
☐ R	.....Refused	**Go to Q5**

Q**4b. How many times were you hospitalized for any other reason since ***[insert date of last telephone follow-up]? ____

***Q**4c. For each hospitalization indicated in **Q4b**, please provide the following:

(1)Date of hospital admission: ___ ___ / ___ ___ / ___ ___ ___ ___ **(DD/MM/YYYY)**

Date of discharge: ___ ___ / ___ ___ / ___ ___ ___ ___

Diagnosis at Discharge: _____

Name of Hospital: _____

City, State: _____

(2)Date of hospital admission: ___ ___ / ___ ___ / ___ ___ ___ ___ **(DD/MM/YYYY)**

Date of discharge: ___ ___ / ___ ___ / ___ ___ ___ ___

Diagnosis at Discharge: _____

Name of Hospital: _____

City, State: _____

(3)Date of hospital admission: ___ ___ / ___ ___ / ___ ___ ___ ___ **(DD/MM/YYYY)**

Date of discharge: ___ ___ / ___ ___ / ___ ___ ___ ___

Diagnosis at Discharge: _____

Name of Hospital: _____

City, State: _____

For more than three (3) hospitalizations, please list on a separate sheet.

***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 **Go to Q7**

***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

Only answer Q7 if highlighted, otherwise go to Q8a

Q7. What was your usual weight at about age 50? If you don't remember exactly, please make your best guess.

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

☐ D .....Don't Know
☐ R .....Refused
☐ N .....Participant has not yet turned 50

Note: The following section is to be asked of female participants only; if you are male, end this questionnaire.

Q8a. Have you ever been pregnant?

☐ 1	.....Yes	
☐ 0	.....No	**Go to Q10a**
☐ D	.....Don't Know	**Go to Q10a**
☐ R	.....Refused	**Go to Q10a**

Q8a1. How many times have you been pregnant?

____ ____ pregnancies

Q8b. How many of your pregnancies resulted in the birth of a live child?

____ ____ pregnancies **if 0 Go to Q9**

Q8c1. Have you been pregnant since ***[date of first in person visit]***?

Note: If you have already reached menopause, enter no/menopausal.

☐ 1	.....Yes	**Go to Q8d**
☐ 0	.....No/Menopausal	**Go to Q8e**
☐ D	.....Don't Know	**Go to Q8e**
☐ R	.....Refused	**Go to Q8e**

Q8d. How old were you when your last child was born? Do not include adopted children.

____ ____ years old

Q8e. During any of your pregnancies, were you told you had high blood pressure or hypertension?

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

Q8f. During any of your pregnancies, were you told you had eclampsia or pre-eclampsia (toxemia)?

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

Q8g. During any of your pregnancies, were you told you had high blood sugar or diabetes?

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

If Q10a-Q13c are highlighted, please complete; otherwise go to Q14.

Q10a. Have you reached menopause?

☐[1].....Yes
☐[0].....No **Go to Q11**
☐[D].....Don't Know **Go to Q11**
☐[R].....Refused **Go to Q11**

Q10b. In what year, or how old were you, when you reached menopause (complete cessation of period for one year)?

____ ____ ____ ____ Year OR ____ ____ ____ Age OR

Note: If you cannot remember the exact age or year in which menopause began, please enter your best guess by choosing one of the categories below for age at which menopause was reached.

Please choose one:
☐[1].....≤ 45 years
☐[2].....46-47 years
☐[3].....48-49 years
☐[4].....50-51 years
☐[5].....≥ 52 years

Q10c. Was the onset of your menopause a result of:

☐[1].....Natural Causes
☐[2].....Surgery
☐[3].....Radiation Treatment
☐[4].....Chemotherapy
☐[5].....Other (Please Specify)_____

Q11. Have you had an operation to remove one or both of your ovaries?

☐[1].....Yes
☐[0].....No **Go to Q12a**
☐[D].....Don't Know **Go to Q12a**
☐[R].....Refused **Go to Q12a**

Q11a. How old were you when your ovaries were removed? *If more than one surgery, use age at last surgery.*

____ ____ years old

Q11b. Number of ovaries removed?

☐ 1 .....One ovary
☐ 2 .....Two ovaries
☐ 3 .....Part of an ovary
☐ D .....Don't Know

Q11c. Have you taken estrogen or female hormone pills after you had an ovary removed?

☐ 1 .....Yes
☐ 0 .....No **Go to Q12a**
☐ D .....Don't Know **Go to Q12a**
☐ R .....Refused **Go to Q12a**

Q11d. If you took estrogen or female hormone pills, for how many years did you take estrogen or female hormone pills every day or nearly everyday? If you are unsure, please make your best guess.

____ ____Years

Q11e. When did you start taking estrogen or female hormone pills? If you are unsure, please make your best guess.

____ ____ ____Age **OR** ___ ___ ___ ___ Year

Q12a. Have you had a hysterectomy (surgery to remove your uterus or womb) since *[**date of first in person visit**]*?

☐ 1 .....Yes
☐ 0 .....No **Go to Q13a**
☐ D .....Don't Know **Go to Q13a**
☐ R .....Refused **Go to Q13a**

Q12b. When did you have this surgery?

____ ____ ____ Age OR ___ ___ ___ ___ Year

Q13a. Since menopause, have you taken estrogen or female hormone pills?

☐ 1 .....Yes
☐ 0 .....No **Go to Q14**
☐ D .....Don't Know
☐ R .....Refused
☐ N .....Not Applicable **Go to Q14**

Q13b. When did you start taking estrogen or female hormone pills? If you are unsure, please make your best guess.

____ ____ ____ Age **OR** ___ ___ ___ ___ Year

Q13c. If you took estrogen or female hormone pills, for how many years did you take estrogen or female hormone pills every day or nearly everyday? If you are unsure, please make your best guess.

____ ____ Years

Q14. Since ***[insert date of first in person visit]*** have you taken estrogen or female hormone pills?

☐ 2 .....Yes, now
☐ 1 .....Yes, not now
☐ 0 .....No
☐ D .....Don't Know
☐ R .....Refused
