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: [6]Visit 3 [7]Visit 3 (New Participant)

Form Version Date: _07/01/2021__

Medical History
Visit 3

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.** P l e ase respond 'yes' or 'no' if you have EVER been told by a doctor that you had this condition."

Note: ***If you respond "YES", then answer what age you were first told you had the condition and whether or not you currently have the condition, before moving on to next condition. If you don't know or refuse to answer, please mark the appropriate box. If you don't know the age you were first told, write "D" in the appropriate box.*** **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						**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 ***within the last year?

☐ 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 ***within the last year?

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

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

Q**3f. Were you told by a doctor that you had a heart attack, angina, or chest pain due to heart disease ***within the last year?

☐ 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 ***within the last year?

☐ 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 ***within the last year?

☐ 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 ***within the last year?

☐ 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 a congestive heart failure ***within the last year?

☐ 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 ***within the last year?

☐ 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 ***within the last year? We are specifically interested in hearing about a cancer that was diagnosed for the first time ***within the last year***? [***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 ***within the last year?

☐ 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 ***within the last year?

☐ 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 ***within the last year?

☐ 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) ***within the last year?

☐ 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 ***within the last year?

☐ 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> ***within the last year?

☐ 1	.....Yes	**Go to Q4b**
☐ 0	.....No	**Go to Q4d**
☐ D	.....Don't Know	**Go to Q4d**
☐ R	.....Refused	**Go to Q4d**

Q**4b. How many times were you hospitalized overnight for any other reason ***within the last year?
___ ___ times

***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.

Q4d. Have you ever seen a neurologist or other specialist for problems with memory or thinking?

☐ 1 .....Yes **Go to Q4d1**
☐ 0 .....No **Go to Q4e**

Q4d1. Date of Neurologist/specialist Visit: ___ ___ / ___ ___ / ___ ___ ___ ____ (dd/mm/yyyy)

Type of Visit: _____

Location / Provider: _____

Q4e. Has the participant/you ever had a brain scan?

☐ 1 .....Yes **Go to Q4e1**
☐ 0 .....No **Go to Q4f**

Q4e1. Date of Scan ___ ___ / ___ ___ / ___ ___ ___ ___ (dd/mm/yyyy)

Type of Scan (CT, MRI, PET, etc): _____

Location of Scan: _____

Q4f. Has the participant/you ever had hallucinations (seen or heard things that are not present)?

☐ 1 .....Yes
☐ 0 .....No

Q4g. Has the participant/you ever had delusions (incorrect thoughts, such as thinking someone was stealing from you)?

☐ 1 .....Yes
☐ 0 .....No

Q4h. Have the participant/you ever been told, that you seem to 'act out your dreams' while asleep (for example, punching, flailing your arms in the air, making running movements, etc. while asleep)?"

☐ 1 .....Yes
☐ 0 .....No

***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

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 Q9**
☐[D] .....Don't Know **Go to Q9**
☐[R] .....Refused **Go to Q9**

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**

Q8c. How old were you when your first child was born? Do not include adopted children.

____ ____ years old **Go to Q8d**

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

Q9. How old were you when you first started getting your period? If you are unsure, please make your best guess.

____ ____ years old

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 when menopause began, please take 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 ***ever*** had a hysterectomy (surgery to remove your uterus or womb)?

☐ 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 **If No, End Questionnaire**
☐ D .....Don't Know
☐ R .....Refused
☐ N .....Not Applicable **If Not Applicable, End Questionnaire**

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