ACCA

Annual Clinic Check-Up Form

Subject ID Number: ☐☐☐☐☐☐☐☐☐

Contact Year: ☐☐

Instructions: This form is completed at each annual visit. See specific instructions for completing the Annual Clinic Check-up Form.

1. Date of Visit: ☐☐ / ☐☐ / ☐☐ (Month / Day / Year)

2. Last Name: ☐☐☐☐☐☐☐☐☐☐☐☐

Initials: ☐☐ (1st 2nd)

I. CLINIC WORKUP RECORD

3. Weight (to nearest 0.1 kg with outdoor garments and shoes removed). 3. ☐☐☐.☐

4. Pulse at rest (record subject's heart rate for 15 seconds, not 60 seconds). 4. ☐☐

Record subject's blood pressure. (Take using right arm after subject has been sitting quietly for at least 5 minutes.)

Readings		Systolic	Diastolic
5.1 Reading 1 (std)	i.	☐☐☐	ii. ☐☐☐
5.2 Reading 2 (R-Z)	i.	☐☐☐	ii. ☐☐☐
5.3 Zero Reading 2		☐☐☐	
5.4 Net 2 (Reading 2- Zero Reading 2)	i.	☐☐☐	ii. ☐☐☐
5.5 Reading 3 (std)	i.	☐☐☐	ii. ☐☐☐
5.6 Reading 4 (R-Z)	i.	☐☐☐	ii. ☐☐☐
5.7 Zero 4		☐☐☐	
5.8 Net 4 (Reading 4- Zero Reading 4)	i.	☐☐☐	ii. ☐☐☐

6. Initials and code number of person completing question 5.

a. Initials: _____ 6. Code Number ☐☐

7. Was bloo wn for complete blood count? 7.

1) No..... ☐ 1

2) Yes..... ☐ 2

Initials and code number of person performing Fecal Occult Blood Test readings in question 9. 10. Number

a. Initials _____ b. ☐☐

II. URINALYSIS

Check the one appropriate result for each test.

		Neg.	Trace	30 mg or +	100 mg or ++	300 mg or +++	1000 mg or ++++
8.1	Protein	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
8.2	Glucose	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
8.3	Occult Blood	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

III. FECAL OCCULT BLOOD TEST

TEST RESULTS

	Test #	Date (Month/Day/Year)	Results Neg.	Pos.
9.1	1	☐☐/☐☐/☐☐	☐ 1	☐ 2
9.2	2		☐ 1	☐ 2
9.3	3	☐☐/☐☐/☐☐	☐ 1	☐ 2
9.4	4		☐ 1	☐ 2
9.5	5	☐☐/☐☐/☐☐	☐ 1	☐ 2
9.6	6		☐ 1	☐ 2

HEMATOLOGY DATA FORM

C B C A

Subject ID Number: | | | | | | | | | |

Contact Year: | | |

Instructions: This form is to be completed each annual visit where blood was drawn. See General Instructions, Section III.A for numeric information.

1. Date of Visit: | | | / | | | / | | |
   Month Day Year

2. Last Name: | | | | | | | | | | | | | |

   Initials: | | |
   1st 2nd

3. White Blood Count, x 10^3/cmm.....	3.			.	
4. Red Blood Count, x 10^6/cmm.....	4.		.	
5. Hemoglobin, g/100 ml.....	5.			.	
6. Hematocrit (%).....	6.		

7. Initials and code number of person completing this form.

   a. Initials: _____

7. Code Number

   b. | | |

CSUA

ANNUAL CONTACT SUMMARY FORM

Subject ID Number: | | | | | | | | | |

Contact Year: | | |

Instructions: This form should be filled out for all eligible participants (alive at date of last contact). For contact year 85, all participants alive as of CVI are eligible. See specific instructions for completing the Annual Contact Summary Form.

1. Subject Status As Of: | | | / | | | / | | | (Month / Day / Year)

2. Last Name: | | | | | | | | | | | | | | |

Initials: | | | (1st 2nd)

3. Initials and code number of individual completing this form.

a. Initials: _____

3. Code Number

b. | | |

4. Date of Last Subject Status: | | | / | | | / | | | (Month / Day / Year)

Subject Status

Select status and check one mode of contact (if applicable).

5.1 Status		5.2 Mode of Contact	
☐ 1	Contacted and Alive.....	☐ 1	Letter
		☐ 2	Phone
		☐ 3	Clinic Visit or Personal Interview
☐ 2	Indirect Contact and Alive.....	☐ 4	Relative, Spouse, Acquaintance
		☐ 5	Employer Information
		☐ 6	Other
☐ 3	Reported Deceased....	☐ 7	Relative, Spouse, Acquaintance
		☐ 8	Registry (National Death Index)
		☐ 9	Other
☐ 4	Unknown, Reported Alive on Date of Last Subject Status as shown in question 4.		

6. Since Date of Last Subject Status, has the participant been hospitalized or had any major illnesses?

6.

1) No..... ☐ 1

2) Yes..... ☐ 2

9) Unknown..... ☐ 9

D E C A (1-4)

DEFINITIVE EVENT CODING FORM

Subject ID Number: (5-13)

Contact Year: (14-15)

Event Identifier: (16-17) M.F.# For CPR Use Only (18-23)

Instructions: This form must be sent to the CPR within 60 days of sending the Provisional Event Notification form. A copy of the hospital record must be obtained and kept in the participant's clinic file. Another copy of the hospital record must be sent to the CPR with a Cover Sheet for a hospital record. Use this form to document all events. The event identifier number and event date must match those on the Linking Form (SEL).

1. Today's Date: Month / Day / Year (24-29)

2. Last Name: (30-41)

Initials: (42-43)

3. Date of Event: Month / Day / Year (44-49)

I. HOSPITALIZATION INFORMATION

4. Dates of Hospitalization: 1) From: Month / Day / Year (50-55)

2) To: Month / Day / Year (56-61)

Code "00-00-00" as ending date of hospitalization for subjects who are still hospitalized; from and to date can be the same. If not hospitalized draw a line through both dates.

Comments:

II. DIAGNOSES

5. FATAL EVENTS *(Check appropriate box)*

1) Cardiovascular death..... 1

2) Cancer death..... 2

3) Other death..... 3 (62)

If Q5.3, specify cause: (63-92)

6. NON-FATAL EVENTS

Enter the diagnoses listed on face sheet of the hospital record. If the face sheet is not obtainable, enter the discharge diagnosis. Additional diagnoses should be entered as required. Do not enter historical diagnoses.

6.1 Primary Diagnosis

Specify: _____

6.2 Additional Diagnoses

1) Specify: _____

2) Specify: _____

6. CPR USE ONLY

6.1 . (93-96)

6.2

1) . (97-100)

2) . (101-104)

6. NON-FATAL EVENTS (continued)

6.2

3) Specify: _____

_____

_____

4) Specify: _____

_____

_____

5) Specify: _____

_____

_____

CPR USE ONLY

6.2

3) [ ][ ][ ][.] (105-108)

4) [ ][ ][ ][.] (109-112)

5) [ ][ ][ ][.] (113-116)

III. OPERATIVE PROCEDURES

Enter below the procedures listed on the face sheet of the subject's hospital record. If a face sheet is not obtainable, list the operative procedures performed as indicated in the hospital record.

7. Procedures

1) Specify: _____

_____

_____

2) Specify: _____

_____

_____

3) Specify: _____

_____

_____

4) Specify: _____

_____

CPR USE ONLY

7.

1) [ ][ ][.] (117-119)

2) [ ][ ][.] (120-122)

3) [ ][ ][.] (123-125)

4) [ ][ ][.] (126-128)

8. Source of Diagnoses:

Code LRC criteria if LRC event has occurred and face sheet diagnosis is different.

8.

1) Face Sheet..... [ ]1

2) Discharge Diagnoses..... [ ]2

3) LRC Criteria..... [ ]3

4) Death Certificate..... [ ]4 (129)

9. Initials and code number of person completing this form.

1) Initials: _____

9. Code Number

1) [ ][ ] (130-131)

10.

1) Initials of CPR coder: ..... 1) [ ][ ] (132-133)

2) Initials of CPR reviewer: ..... 2) [ ][ ] (134-135)

LLDA

Lipid Laboratory Data Form

Subject ID Number: | | | | | | | | | |

Contact Year: | | |

Instructions: This form should be completed at each annual visit where blood was drawn for lipid determinations. See specific instructions for completing the Lipid Laboratory Data Form.

1. Date of Visit: | | |/| | |/| | | (Month / Day / Year)

2. Last Name: | | | | | | | | | | | | |

Initials: | | (1st 2nd)

Standing Plasma Test

3.1 Chylomicron layer: 3.1

1) Present..... |_|1
2) Absent..... |_|2
9) Not done..... |_|9

3.2 Appearance of plasma: 3.2

1) Clear..... |_|1
2) Turbid..... |_|2
9) Not done..... |_|9

4.1 Cholesterol (*Record in mg%*): | | | | | mg%

4.2 Date of cholesterol determination: | | |/| | |/| | | (Month / Day / Year)

5.1 Triglycerides (*Record in mg%*): | | | | | mg%

5.2 Triglyceride blank: | |

5.3 Triglyceride less blank: (*Net triglycerides*) | | | | | mg%

5.4 Date of triglyceride determination: | | |/| | |/| | | (Month / Day / Year)

6.1 HDL cholesterol: | | | mg%

6.2 Date of HDL cholesterol determination: | | |/| | |/| | | (Month / Day / Year)

7. Estimated LDL cholesterol: (*LDL=CHOL-HDL-TG/5*) | | | mg%

Check the following lipid determinations made with a frozen sample. *If a fresh sample was used, leave blank.*

	Check if frozen
8.1 Cholesterol.....	8.1 |_|1
8.2 Triglycerides.....	8.2 |_|2
8.3 HDL cholesterol.....	8.3 |_|3

9. Code number and initials of person completing this form.

a. Initials _____

9. Code Number

b. | |

MHQA

ANNUAL MEDICAL HISTORY QUESTIONNAIRE

Subject ID Number: ☐☐☐☐☐☐☐☐☐

Contact Year: ☐☐

Instructions: This form is to be completed by the participant (beginning at question 3.1) before his annual visit (if possible) and brought to the annual visit. It should be reviewed by the LRC staff in the presence of the participant.

1. Date of Visit: ☐☐/☐☐/☐☐ (Month / Day / Year)

2. Last Name: ☐☐☐☐☐☐☐☐☐☐☐☐

Initials: ☐☐ (1st 2nd)

3.1 Are you currently retired? — 3.1

1) No..... ☐1

2) Yes..... ☐2

If "No", go to question 4.

3.2 If Yes, enter date of retirement: ☐☐/☐☐ (Month / Year)

3.3 Are you currently employed? — 3.3

1) No..... ☐1

2) Yes..... ☐2

If "No", go to question 5.

3.4 If Yes, what is your occupation?

_____

3.4 Clinic Use Only

☐☐ Occupation Code

3.5 How many hours per week do you work? — 3.5 ☐☐

Go to question 5.

4. What is your usual occupation?

_____

4. Clinic Use Only

☐☐ Occupation Code

5. What is your present marital status? — 5.

1) Never Married..... ☐1

2) Married..... ☐2

3) Separated..... ☐3

4) Divorced..... ☐4

5) Widowed..... ☐5

6.1 Do you regularly engage in strenuous exercise or hard physical labor? — 6.1

1) No..... ☐1

2) Yes..... ☐2

6.2 If "Yes", do you engage three or more times weekly? — 6.2

1) No..... ☐1

2) Yes..... ☐2

7.1 Do you presently smoke cigarettes? — 7.1

1) No..... ☐1

2) Yes..... ☐2

7.2 If "Yes", what is the average number of cigarettes smoked per day?..... — 7.2 ☐☐

How many servings of the following alcoholic beverages do you consume in an average week?

8.1)	12 oz. cans or bottles of regular beer.....	8.1 ☐☐☐
8.2)	12 oz. cans or bottles of light beer.....	8.2 ☐☐☐
8.3)	4.5 oz. glasses of wine.....	8.3 ☐☐☐
8.4)	1.5 oz. shots of whiskey, gin, vodka, rum, tequila (straight or mixed drinks).....	8.4 ☐☐☐
8.5)	1 oz. servings of brandy or cordials.....	8.5 ☐☐☐

9. In the past year, have you been seen by a physician or examined at an emergency room facility? 9.

1) No..... ☐1

2) Yes..... ☐2

If "Yes", please describe: _____

_____

For each food item (or group) listed below please put a check mark in the category which best describes the frequency with which you usually eat that food item.

FOOD ITEM	More than once/day (1)	Once/ day (2)	3-6 times/ week (3)	Once or twice/ week (4)	Once/ month or less (5)	Never (6)
10.1 Shrimp	☐	☐	☐	☐	☐	☐
10.2 Other fish	☐	☐	☐	☐	☐	☐
10.3 Liver	☐	☐	☐	☐	☐	☐
10.4 Eggs	☐	☐	☐	☐	☐	☐
10.5 Poultry	☐	☐	☐	☐	☐	☐
10.6 Nuts	☐	☐	☐	☐	☐	☐
10.7 Meat	☐	☐	☐	☐	☐	☐
10.8 Bacon, salt pork or sausage	☐	☐	☐	☐	☐	☐
10.9 Cold cuts, weiners	☐	☐	☐	☐	☐	☐
10.10 Jelly, jam or syrup	☐	☐	☐	☐	☐	☐
10.11 Soft drinks	☐	☐	☐	☐	☐	☐
10.12 Candy (other than chocolate)	☐	☐	☐	☐	☐	☐
10.13 Chocolate	☐	☐	☐	☐	☐	☐
10.14 Fruit or juice	☐	☐	☐	☐	☐	☐
10.15 Alcoholic beverages: beer, wine, whiskey	☐	☐	☐	☐	☐	☐
10.16 Skim (non-fat) milk	☐	☐	☐	☐	☐	☐
10.17 2% milk	☐	☐	☐	☐	☐	☐
10.18 Whole milk	☐	☐	☐	☐	☐	☐
10.19 Butter	☐	☐	☐	☐	☐	☐
10.20 Cream (light, heavy, sour)	☐	☐	☐	☐	☐	☐
10.22 Ice cream	☐	☐	☐	☐	☐	☐
10.22 Non-dairy coffee cream	☐	☐	☐	☐	☐	☐
10.23 Non-dairy whipped cream	☐	☐	☐	☐	☐	☐

FOOD ITEM	More than once/day (1)	Once/ day (2)	3-6 times/ week (3)	Once or twice/ week (4)	Once/ month or less (5)	Never (6)
10.24 Non-dairy sour cream	☐	☐	☐	☐	☐	☐
10.25 Stick margarine	☐	☐	☐	☐	☐	☐
10.26 Tub (soft) margarine	☐	☐	☐	☐	☐	☐
10.27 Cheese (American, processed, Swiss, and other)	☐	☐	☐	☐	☐	☐
10.28 Pies, cakes, cookies	☐	☐	☐	☐	☐	☐
10.29 Sweet rolls, buns, coffee cake, waffle, dough[illegible]	☐	☐	☐	☐	☐	☐
10.30 Snack type crackers, potato chips	☐	☐	☐	☐	☐	☐
10.31 French fries	☐	☐	☐	☐	☐	☐
10.32 Ready to serve mixed dishes or meals, i.e., TV dinners	☐	☐	☐	☐	☐	☐

11. Are you currently on a cholesterol-lowering diet? — 11.

1) No ☐1

2) Yes ☐2

12. Are you currently on any other type of diet? — 12.

1) No ☐1

2) Yes ☐2

If "Yes", please specify: _____

_____

13. Are you presently taking any of the following drugs to lower cholesterol? — 13.

1) No ☐1

2) Yes ☐2

If "Yes", check the appropriate box(es) of the lipid lowering drug(s) presently being taken and enter the number of times per day each drug is being taken.

Medication	Taken	Times/Day
13.1 colestipol Colestid	☐1	☐☐
13.2 cholestyramine Questran	☐2	☐☐
13.3 clofibrate Atromid-S	☐3	☐☐
13.4 nicotonic acid (niacin) Nicobid, Nico-Span, etc.	☐4	☐☐
13.5 si tosterols Cytellin	☐5	☐☐
13.6 probucol Lorelco	☐6	☐☐
13.7 dextrothyroxine Choloxin	☐7	☐☐
13.8 gemfibrozil Lopid	☐8	☐☐
13.9 mevinolin	☐9	☐☐
13.10 Other	☐0	☐☐

Name of drug: _____

14. Are you presently taking any other prescription drugs? — 14.

1) No ☐1

2) Yes ☐2

If "Yes", please specify: _____

_____

Please have name of drug(s) and dosage(s) for clinic staff.

15. Are you presently taking any non-prescription drugs? — 15.

1) No..... ☐1

2) Yes..... ☐2

If "Yes", please specify: _____

_____

Please have name of drugs(s) and dosage(s) for clinic staff.

16. In the past year year, have you been involved in any other clinical studies? — 16.

1) No..... ☐1

2) Yes..... ☐2

If "Yes", please specify: _____

_____

17. How many aspirin tablets do you consume in an average week?..... 17. ☐☐☐

In the past year, have you experienced any of the following symptoms?

		No	Yes
18.1	Pain or discomfort in your chest.....	☐1	☐2
18.2	Pressure or heaviness in your chest.....	☐1	☐2
18.3	A change in bowel habits.....	☐1	☐2
18.4	Bleeding from rectum or urinary bladder.....	☐1	☐2
18.5	A persistent cough.....	☐1	☐2
18.6	A sore on your skin or in your mouth which has not healed	☐1	☐2
18.7	Pain in either leg on walking.....	☐1	☐2
18.8	Abdominal pain.....	☐1	☐2
18.9	Unexplained weight loss.....	☐1	☐2
18.10	Difficulty swallowing.....	☐1	☐2
18.11	Heartburn.....	☐1	☐2

In the past year, have you been hospitalized or diagnosed as having any of the following illnesses?

		No	Yes
19.1	Heart attack.....	☐1	☐2
19.2	Other heart disease.....	☐1	☐2
19.3	Stroke.....	☐1	☐2
19.4	Malignant tumor or growth (cancer).....	☐1	☐2
19.5	Benign tumor or growth.....	☐1	☐2
19.6	Leukemia.....	☐1	☐2
19.7	High blood pressure.....	☐1	☐2
19.8	Active peptic ulcer	☐1	☐2
19.9	Other diseases of the stomach or intestines....	☐1	☐2
19.10	Gallbladder disease.....	☐1	☐2
19.11	Back trouble (Lumbar and Disk disease).....	☐1	☐2
19.12	Other Specify: _____	☐1	☐2

_____

_____

In the past year, have you had the following surgery performed?

		No	Yes
20.1	Coronary bypass.....	1	2
20.2	Coronary angioplasty.....	1	2
20.3	Other Specify operations: _____	1	2

In the past year, have you had any of the following procedures performed?

		No	Yes
21.1	Endoscopic examination of the colon and rectum.....	1	2
21.2	Endoscopic examination of the esophagus, stomach and/or duodenum.....	1	2
21.3	X-ray of the gastrointestinal tract.....	1	2
21.4	Coronary angiography.....	1	2
21.5	Biopsy.....	1	2
21.6	Other Specify procedures: _____	1	2