ANNUAL FOLLOW-UP FORM

ID NUMBER: ________________________ FORM CODE: A F U DATE: 01/22/14

ADMINISTRATIVE INFORMATION

0a. Completion Date: __/__/____ 0b. Staff ID: ________

Instructions: This form should be completed during the interview portion of the participant’s follow-up. The Date is the day the contact was made or is the date the status determination was made. Special missing values are allowed for cases where the response “Don’t know”, “Refused”, “Unknown”, or “N/A” is not listed as an option.

INTRODUCTION SCRIPT: "Hello, this is [your name] from the ARIC Study. May I please speak with [name of contact]?

"Hello [name of respondent]. My name is [your name] and I am from the ARIC Study. May I have a few minutes of your time to ask about your recent health?"

A. STATUS

1. Result of contact for the interview (select one)
   a. Participant contacted, agreed to be interviewed... □ → GO TO QUESTION 17
   b. Participant contacted, refused to be interviewed... □ → GO TO QUESTION 71
   c. Proxy/Informant contacted ........................................... □
   d. Other person contacted ........................................... □
   e. Contact pending; continue to attempt to contact... □ → SAVE AND CLOSE FORM
   f. Window closed; unable to contact ....................... □ → SAVE AND CLOSE FORM

2. Is the participant deceased?
   Yes ................................ □ → GO TO QUESTION 29
   No ................................ □

B. DEATH INFORMATION

3. Death reported by: (select one)
   Relative/Spouse/Acquaintance ........................................... □
   Surveillance ..................................................................... □
   Other (e.g., Obituary, Social Security Administration) ....... □

Public reporting burden for this collection of information is estimated to average 6-15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0281). Do not return the completed form to this address.
4. Date of death: □ □/□ □/□ □ □

5. Location of death:
   a. City: __________________________
   b. County: ________________________
   c. State: □ □

6. Are you able to answer some questions about any hospitalizations that occurred since our last contact with [name] on [mm/dd/yyyy]?
   Yes..................................................... □ → GO TO QUESTION 7
   No .................................................. □

6a. Is there someone else who could answer these questions?
   Yes - person located................................................................. □
   Yes - reschedule remainder of interview................................. □ → GO TO QUESTION 71
   No .......................................................................................... □ → GO TO QUESTION 71

HOSPITALIZATIONS FOR HEART ATTACK / CONDITION / STROKE (for deceased participants)

7. Was [name] hospitalized for a heart attack, or heart condition, or stroke since our last contact on [mm/dd/yyyy]?
   Yes..................................................... □
   No .................................................. □ → GO TO QUESTION 10

8a. Hospital Name, City, State: □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □

8a1. Specify hospital name, city, and state if not in drop down list: ______________________________

8b. Approximate date of hospitalization: □ □/□ □ □ □

Second hospitalization, if applicable

9a. Hospital Name, City, State: □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □

9a1. Specify hospital name, city, and state if not in drop down list: ______________________________

9b. Approximate date of hospitalization □ □/□ □ □ □
OTHER HOSPITALIZATIONS (for deceased participants)

10. Did [name] stay overnight as a patient in a hospital for any other reason since our last contact?
   Yes ...........................................
   No ........................................... → GO TO QUESTION 14

11a. Hospitalization Reason: _______________________________

11b. Hospital Name, City, State: ▼

11b1. Specify hospital name, city, and state if not in drop down list: _______________________________

11c. Approximate date of hospitalization □ □/□ □
   Month Year

   Second hospitalization, if applicable

12a. Hospitalization Reason: _______________________________

12b. Hospital Name, City, State: ▼

12b1. Specify hospital name, city, and state if not in drop down list: _______________________________

12c. Approximate date of hospitalization □ □/□ □
   Month Year

   Third hospitalization, if applicable

13a. Hospitalization Reason: _______________________________

13b. Hospital Name, City, State: ▼

13b1. Specify hospital name, city, and state if not in drop down list: _______________________________

13c. Approximate date of hospitalization □ □/□ □
   Month Year

OUTPATIENT TREATMENT (for deceased participants)

14. Was [name] admitted to an emergency room or a medical facility for outpatient treatment since our last contact?
   Yes ...........................................
   No ........................................... → GO TO QUESTION 71

15. Was this related to a heart problem or difficulty breathing?
   Yes ...........................................
   No ........................................... → GO TO QUESTION 71
16a. Hospital/Medical Facility Name, City, State: ▼

16a1. Specify hospital/medical facility name, city, and state if not in drop down list: _________________

16b. Approximate date of admission: □□/□□/□□ ▸ GO TO QUESTION 71

C. GENERAL HEALTH

17. Now I will ask you some questions about your health. Over the past year, compared to other people your age, would you say that your health has been excellent, good, fair or poor?

Excellent □
Good □
Fair □
Poor □

[QUESTIONS 18-20 MOVED TO MCU FORM]

21a. Are there times when you wake up at night because of difficulty breathing?
   Yes □
   No □

21b. Do you have trouble breathing or shortness of breath when hurrying on a level surface?
   Yes □
   No □
   Unable to Walk □ ▸ GO TO QUESTION 22

21c. Do you have trouble breathing or shortness of breath when walking at ordinary pace on a level surface?
   Yes □
   No □

21d. Do you stop for breath when walking at your own pace?
   Yes □
   No □

21e. Do you stop for breath after walking 100 yards on a level surface?
   Yes □
   No □

21f. Do you have to walk slower than people of your own age on a level surface because of shortness of breath?
   Yes □
   No □

22. Do you have difficulty breathing when you are not walking or active?
   Yes □
   No □
23. Do you usually have some cough or wheezing?
   Yes.................
   No .................

[QUESTIONS 24-25 MOVED TO MCU FORM]

26. Do you have pain in your legs caused by a blockage of the arteries?
   Yes.................
   No .................

27. Do you often have swelling in your feet or ankles at the end of the day?
   Yes.................
   No .................→ GO TO QUESTION 28

27a. Is the swelling in your feet or ankles gone in the morning?
   Yes.................
   No .................

28. Since we last contacted you, has a doctor said you had cancer?
   Yes.................
   No .................→ GO TO QUESTION 36

28a. Can you tell me in what part of the body the most recently diagnosed cancer was located?
   __________________________

28b. What is the approximate date the cancer was diagnosed?
   __________________________

DOCTOR INFORMATION FOR CANCER

“Please provide the contact information of the doctor you most recently visited for your cancer.”

28c. Contact information of the doctor you last saw for your cancer:
   28c1. Doctor Name: __________________________
   28c2. Clinic or Institution Name: __________________________
   28c3. Address: __________________________
   28c4. City: ________________
   28c5. State: ____________
   28c6. Approximate date: __________________________
“The ARIC study would like to ask your health care providers to tell us more about your cancer diagnosis and treatment. If you agree to do this, I will send you a form that tells your providers that you authorize the ARIC study to get this information from them. Once you sign that form and mail it back to me, I will contact your health care providers.”

28d. May I send you this release form and an addressed envelope for you to mail it back?

Yes ............................................. □ → GO TO QUESTION 36
No ............................................. □ → GO TO QUESTION 36

D. CARDIOVASCULAR EVENTS

29. May I ask you some questions about [name’s] health?

Yes .............. □ → GO TO QUESTION 36
No .............. □

29a. Is there someone else we can ask?

Yes, person located............................................. □ → GO TO QUESTION 36
Yes, reschedule remainder of interview............... □ → GO TO QUESTION 71
No ........................................................................ □ → GO TO QUESTION 71

RECENT HEART FAILURE DIAGNOSIS

[QUESTIONS 30-35 MOVED TO MCU FORM]

36. Since we last contacted you [name] on [mm/dd/yyyy], has a doctor said you [name] had a heart attack?

Yes ............................................. □
No ............................................. □ → GO TO QUESTION 40

37. Were you (Was [name]) hospitalized at that time?

Yes ............................................. □
No ............................................. □ → GO TO QUESTION 40

HOSPITAL INFORMATION FOR HEART ATTACK

38a. Hospital Name, City, State: ▼

38a1. Specify hospital name, city, and state if not in drop down list: _____________________________

38b. Approximate date of hospitalization □ □/□ □ □ □

Second hospitalization, if applicable

39a. Hospital Name, City, State: ▼

39a1. Specify hospital name, city, and state if not in drop down list: _____________________________
39b. Approximate date of hospitalization

40. Since we last contacted you [name], has a doctor said you [name] had angina, angina pectoris or chest pain due to heart disease?

   Yes ................................
   No ................................

[QUESTION 41 MOVED TO MCU FORM]

42. Since we last contacted you [name], has a doctor said that you [name] had a blood clot in a leg or deep vein thrombosis?

   Yes ................................
   No ................................ → GO TO QUESTION 45

43. At that time, were you (was [name]) hospitalized or did you [name] stay in a hospital observation unit for a blood clot in a leg or deep vein thrombosis?

   Yes ................................
   No ................................ → GO TO QUESTION 45

HOSPITALIZATION FOR BLOOD CLOT IN LEG

44a. Hospital Name, City, State: ▼

44a1. Specify hospital name, city, and state if not in drop down list: _____________________________

44b. Approximate date of hospitalization

45. Since we last contacted you [name], has a doctor said that you [name] had a blood clot in your lungs or a pulmonary embolus?

   Yes ................................
   No ................................ → GO TO QUESTION 48

46. Were you (was [name]) hospitalized for a blood clot in your lungs or a pulmonary embolus at that time?

   Yes ................................
   No ................................ → GO TO QUESTION 48

HOSPITALIZATION FOR BLOOD CLOT IN LUNGS

47a. Hospital Name, City, State: ▼

47a1. Specify hospital name, city, and state if not in drop down list: _____________________________

47b. Approximate date of hospitalization
48. Since we last contacted you [name], has a doctor said that you [name] had a stroke, slight stroke, transient ischemic attack, or TIA?
   Yes .................................. □
   No .................................. □ → GO TO QUESTION 51

49. Were you (was [name]) hospitalized for this stroke, slight stroke, transient ischemic attack, or TIA?
   Yes .................................. □
   No .................................. □ → GO TO QUESTION 51

HOSPITALIZATION FOR STROKE OR TIA

50a. Hospital Name, City, State: ▼

50a1. Specify hospital name, city, and state if not in drop down list: _____________________________

50b. Approximate date of hospitalization □ □/□ □ □ □

E. ADMISSIONS

51. Since our last contact, were you (was [name]) hospitalized or did you [name] stay in a hospital observation unit for any reason that you have not yet mentioned?
   Yes .................................. □
   No .................................. □ → GO TO QUESTION 57

HOSPITALIZATION FOR OTHER REASON

52a. Hospitalization Reason: ________________________________

52b. Hospital Name, City, State: ▼

52b1. Specify hospital name, city, and state if not in drop down list: _____________________________

52c. Approximate date of hospitalization □ □/□ □ □ □

HOSPITALIZATION FOR OTHER REASON

53a. Hospitalization Reason: ________________________________

53b. Hospital Name, City, State: ▼

53b1. Specify hospital name, city, and state if not in drop down list: _____________________________

53c. Approximate date of hospitalization □ □/□ □ □ □
HOSPITALIZATION FOR OTHER REASON

54a. Hospitalization Reason: _______________________________

54b. Hospital Name, City, State: ▼

54b1. Specify hospital name, city, and state if not in drop down list: _______________________________

54c. Approximate date of hospitalization □□/□□□□

HOSPITALIZATION FOR OTHER REASON

55a. Hospitalization Reason: _______________________________

55b. Hospital Name, City, State: ▼

55b1. Specify hospital name, city, and state if not in drop down list: _______________________________

55c. Approximate date of hospitalization □□/□□□□

HOSPITALIZATION FOR OTHER REASON

56a. Hospitalization Reason: _______________________________

56b. Hospital Name, City, State: ▼

56b1. Specify hospital name, city, and state if not in drop down list: _______________________________

56c. Approximate date of hospitalization □□/□□□□

EMERGENCY ROOM/MEDICAL FACILITY INFORMATION

57. Were you (Was [name]) seen at an emergency room or a medical facility for outpatient treatment since our last contact on [mm/dd/yyyy]?

Yes……………………… □ 
No ……………………… □ → GO TO QUESTION 60

58. Was this related to a heart problem or difficulty breathing?

Yes……………………… □ 
No ……………………… □ → GO TO QUESTION 60

59a. ER/Facility Name, City, State: ▼

59a1. Specify ER/Facility name, city, and state if not in drop down list: _______________________________
59b. Approximate date □ □/□ □ □

60. Since our last contact, have you (has [name]) stayed overnight as a patient in a nursing home?
   Yes ......................... □
   No ......................... □

61. Are you ([name]) currently a resident of a nursing home or long-term care facility?
   Yes ......................... □
   No ......................... □

F. INVASIVE PROCEDURES

Next I am going to ask about various types of surgery and medical procedures. We are interested in those that occurred in the hospital, or as an outpatient.

62. Since we last contacted you [name] on [mm/dd/yyyy], have you (has [name]) had any surgery on your [name’s] heart, or the arteries of your [name’s] neck or legs, not counting surgery for varicose veins?
   Yes ......................... □
   No ......................... □ ➔ GO TO QUESTION 64

63. Did you [name] have:
   a. Coronary bypass?
      Yes ......................... □
      No ......................... □

   b. Other heart procedure?
      Yes ......................... □ ➔ Specify: ______________________________
      No ......................... □

   c. Carotid endarterectomy?
      Yes ......................... □ ➔ GO TO QUESTION 63e
      No ......................... □ 

   d. Site:
      Right ......................... □
      Left ......................... □
      Both ......................... □

   e. Other arterial revascularization?
      Yes ......................... □ ➔ Specify: ______________________________
      No ......................... □

   f. Any other type of surgery on your heart or the arteries of your [name’s] neck or legs?
      Yes ......................... □
      No ......................... □
64. Since we last contacted you [name] on [mm/dd/yyyy], have you (has [name]) had a balloon angioplasty or stent on the arteries of your [name’s] heart, neck, or legs?

Yes.................................................
No ............................................. → **Go to Question 65**

Did you [name] have:

a. Angioplasty or stent of the coronary arteries of your [name’s] heart:

Yes.................................................
No .............................................

b. Angioplasty or stent in the arteries of your [name’s] neck:

Yes.................................................
No .............................................

c. Angioplasty or stent of the lower extremity arteries:

Yes.................................................
No .............................................

**Angioplasty or stent facility information**

d. Facility Name, City, State: ▼

e. Specify Facility name, city, and state if not in drop down list: ________________________________

f. Approximate date  □□□□ □□□□

**G. INTERVIEW**

Now I would like to ask about medication use during the past four weeks.

65. Did you [name] take any medications prescribed by a health professional during the past four weeks?

Yes.................................................
No ............................................. → **Go to Question 66**

Did you [name] take any prescribed medications for:

a. High blood pressure or hypertension?

  a. ......................... Yes □
  b. ......................... No □

b. High blood cholesterol?

  a. ......................... Yes □
  b. ......................... No □
c. Diabetes or high blood sugar?
   a. ..................Yes  
   b. ..................No  

d. Heart failure?
   a. ..................Yes  
   b. ..................No  

e. Asthma?
   a. ..................Yes  
   b. ..................No  

f. Chronic bronchitis or emphysema?
   a. ..................Yes  
   b. ..................No  

g. Chest pain or angina?
   a. ..................Yes  
   b. ..................No  

h. Abnormal heart rhythm?
   a. ..................Yes  
   b. ..................No  

i. Blood thinning?
   a. ..................Yes  
   b. ..................No  

j. Stroke?
   a. ..................Yes  
   b. ..................No  

k. Mini-stroke or TIA?
   a. ..................Yes  
   b. ..................No  

l. Leg pain while walking or claudication?
   a. ..................Yes  
   b. ..................No  

m. Depression?
   a. ..................Yes  
   b. ..................No
Next I would like to ask you about your regular use of aspirin. This includes aspirin alone or in a combination with another drug, such as aspirin in a cold medicine. By regular use, I mean taking aspirin at least once a week for several months.

66. Do you (Does [name]) regularly take any aspirin or aspirin-containing products including Alka-Seltzer, cold and allergy medication or headache powder? This does not include acetaminophen (for example, Tylenol), ibuprofen (for example, Advil, Motrin or Nuprin), and naproxen (for example, Aleve).

   Yes ................................
   No ................................

66a. Do you (Does [name]) regularly take medicine for pain or inflammation that does NOT contain aspirin? This would include Tylenol, Advil, Motrin, Nuprin, Midol, or Ibuprofen among others.

   Yes ................................
   No ................................

[Questions 67-68 deleted]

Next, I have a few miscellaneous questions.

69. Do you (Does [name]) now smoke cigarettes?

   Yes ................................
   No ................................

70. Please tell me which of the following describes your [name’s] current marital status:

    Married ..............................
    Widowed .............................
    Divorced ............................
    Separated ...........................
    Never Married .....................

H. ADMINISTRATIVE INFORMATION

71. AFU Completion Status:
   a. Complete ................................
   b. Partially complete; contact again within window (interruptions) ...
   c. Partially complete; unable to complete within window (done) ....

CLOSURE SCRIPT:

If participant deceased: “We may need to contact a family member later. When would be a good time to call in that case?”