



SEMI-ANNUAL FOLLOW-UP GENERAL INTERVIEW

ID NUMBER:

FORM CODE: G E N

DATE: 12/15/2011
Version 1.0

ADMINISTRATIVE INFORMATION

0a. Completion Date: / / 0b. Staff ID:

Month Day Year

Instructions: This form is completed during the six-month follow up to the participant's annual follow-up interview. The Date is the day the contact is made, or is the date the status determination is 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: "Now I would like to ask some questions about your health that ARIC has not asked you before."

A. GENERAL INTERVIEW

PERSONAL NEUROLOGIC HISTORY

1. Have you ever been told by a doctor or health professional that you have any of the following neurologic disorders, these would be conditions that affect the brain.

	No	Yes	If Yes, age in years at diagnosis
a. Alzheimer's Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	a1. <input type="text"/> <input type="text"/>
b. Parkinson's Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	b1. <input type="text"/> <input type="text"/>
c. Memory loss or cognitive impairment	<input type="checkbox"/>	<input type="checkbox"/>	c1. <input type="text"/> <input type="text"/>
d. Dementia, vascular dementia, or	<input type="checkbox"/>	<input type="checkbox"/>	d1. <input type="text"/> <input type="text"/>
hardening of the arteries of the brain			
e. Any others.....	<input type="checkbox"/>	<input type="checkbox"/>	

If yes, list and record age in years at diagnosis

e1. _____	e1a. <input type="text"/> <input type="text"/>
e2. _____	e2a. <input type="text"/> <input type="text"/>
e3. _____	e3a. <input type="text"/> <input type="text"/>

2. Are you sleepy most of the day?

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

3. In the past month, how many days did you “doze off” during the day other than taking a regular nap?

4. Have you ever been told, or suspected yourself, that you “act out your dreams” while you sleep, for example, punching or flailing your arms in the air, making running movements, shouting, or screaming?

Yes.....
No..... → **Go to Question 5**

4a. How often?

Less than 3 times in total
Less than once a month
1-3 times a month
Once a week
More than once per week

4b. How old were you, when this started?
Age in years

5. Do you have shaking in your hands, arms or legs that you can’t control?

Yes.....
No → **Go to Question 6**

5a. How old were you, when this first started?
Age in years

6. Is your handwriting smaller than it once was?

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

7. Have you ever been told by a physician that you had gout?

Yes.....
No → **Go to Question 8**
Unknown → **Go to Question 8**

7a. How old were you when a physician first told you had gout?
Age in years

7b. When was the last time you had to get health care for your gout?
Time in years

(for the QxQs: within the year = 0 years)

8. How many teeth, if any, have you lost or had removed during the past ten years?

- None.....
- 1 or 2 teeth.....
- 3 or more teeth.....
- Don't know.....

"These next few questions ask about how well you typically function on your own, that is without help from another person or special equipment. For each activity I mention, please tell me how much difficulty you have performing the activity when you are by yourself and without the use of special equipment."

PHYSICAL ABILITY

How much difficulty do you have:	No Difficulty	Some Difficulty	Much Difficulty	Unable To Do	Unknown or Do Not Do
9. Walking for a quarter of a mile (about 2 or 3 blocks)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Walking up 10 steps without resting?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Stooping, crouching or kneeling?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Lifting or carrying something as heavy as 10 pounds?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Doing chores around the house (like vacuuming, sweeping, dusting or straightening up)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Preparing your own meals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Managing your money (such as keeping track of your expenses or paying bills)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Walking from one room to another on the same level?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Standing up from an armless chair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Getting in or out of bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Eating, including holding a fork, cutting food or drinking from a glass?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Dressing yourself, including tying shoes, working zippers and doing buttons?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

"I will now ask you several questions concerning the health care you received in the past six months."

CONTINUITY OF CARE

21. Over the past 6 months, when you received medical care, how often did you see the same doctor or health care provider?

- Always
- Most of the time
- Sometimes
- Rarely or never
- Did not see a doctor or health care provider in the last 6 months → **Go to Question 23**

22. In the past 6 months, how many times have you seen your usual doctor/health care provider?

- 0 (None).....
- 1 (Once).....
- 2 (Twice)
- 3 or more

ACCESS TO CARE

23. In the past 6 months, was there any time when you delayed getting, or did not get medical care when you needed it?

- Yes.....
- No..... → **Go to Question 26**
- Refused..... → **Go to Question 26**

24. In the past 6 months, was there any time when you needed any of the following, but did not get it because you could not afford it?

- | | Yes | No |
|--|--------------------------|--------------------------|
| a. To be seen by doctor or other health care provider..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Mental health care or counseling | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Nursing home care..... | <input type="checkbox"/> | <input type="checkbox"/> |

25. In the past 6 months, aside from costs, what were the reason(s) for which you delayed getting, or did not get medical care when you needed it?

- | | Yes | No |
|--|--------------------------|--------------------------|
| a. You couldn't go through on the telephone..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. You couldn't get an appointment soon enough | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Once you got there, you had to wait too long to see the doctor/health care provider | <input type="checkbox"/> | <input type="checkbox"/> |
| d. The clinic/doctor's office wasn't open when you could get there..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. You didn't have transportation | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Medical care too far away | <input type="checkbox"/> | <input type="checkbox"/> |

COORDINATION OF HEALTH CARE FROM OTHER PROVIDERS

26. In the last 6 months, did you get care from a doctor or other health care provider other than your usual doctor?

- Yes.....
 No, did not see other doctor/health care provider other than usual doctor ... → **Go to Question 30a**
 No, did not see any doctor or health care provider → **Go to Question 32**

27. In the last 6 months, how often did your usual doctor/health care provider seem informed and up-to-date about the care you got from other doctors or health care providers?

- Always
 Usually.....
 Sometimes.....
 Never
 Do not know
 Did not see my usual doctor/health care provider

28. In the last 6 months, did anyone from your health plan, doctor’s office, or clinic help coordinate your care among these doctors or other health care providers?

- Yes.....
 No..... → **Go to Question 30a**

29. How satisfied are you with the help you received to coordinate your care in the last 6 months?

- Very dissatisfied
 Dissatisfied.....
 Neither dissatisfied nor satisfied
 Satisfied
 Very satisfied.....

“I will now ask you about your satisfaction with the medical care that you received in the past six months. There are six questions for which you can give me one of the following four answers: never, sometimes, usually, or always.”

HEALTH CARE SATISFACTION

30. In the last 6 months, how often did doctors or other health care providers?

	Never	Sometimes	Usually	Always
a. Listen carefully to you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Explain medical procedures and tests in a way you could understand?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Show respect for what you had to say?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Spend enough time with you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Involve you in decisions concerning your health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Make decisions concerning your health that you are comfortable with.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

31. Overall, how satisfied are you with the quality of care you received from your health care providers over the last 6 months? Would you say that you are:

- Very satisfied
- Somewhat satisfied.....
- Somewhat dissatisfied.....
- Very dissatisfied.....

CLOSURE SCRIPT:

"Thank you very much for answering these questions. You have previously provided us with information on how to contact you. To help us contact you in the future, please tell me if the information I have is still correct."

"Thank you very much for answering these questions. We will call _____ in about six months."

B. ADMINISTRATIVE INFORMATION

32. sAF General Interview Questions Completion Status:

- a. Complete
- b. Partially complete; contact again within window (interruptions) ..
- c. Partially complete; unable to complete within window (done)