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OMB#: 0925-0584
Exp. 8/31 /2017

HCHS/SOL Follow-up Interview Form Contact Year 4

ID NUMBER:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	FORM CODE: FE4 VERSION: 1, 4/20/2015	Contact Occasion	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	SEQ #	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
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ADMINISTRATIVE INFORMATION

0a. Completion Date: / /

0b. Staff ID:

Instructions: See the detailed QxQ instructions for completion of the Annual Follow-up form.

INTRODUCTION

Hello, my name is (*interviewer name*), and I am calling to follow up with (*participant name*) about the Hispanic Community Health Study / Study of Latinos (SOL), a health study in which s/he is currently enrolled. Is s/he available?

No → When would it be convenient to call back? Thank you. I will call again.

Yes → Hello, (*participant name*), this is (*interviewer name*) with the Hispanic Community Health Study / Study of Latinos (SOL). I'm calling to see how you have been since your last telephone interview and to update our SOL records. Do you have a few minutes to speak on the phone?

No → When would it be convenient to call back? Thank you. I will call again.

Yes → We'd like to gather information about your general health and about specific medical conditions that you may have had in the past year. I will ask you some questions about your health since the last telephone interview with you on (*date of last follow-up call*). I want you to focus on what happened from (*date of last follow-up call*) until today.

[GHE section for data entry screens begins here]

A. GENERAL HEALTH STATUS

1. Participant status (choose one):

- Participant contacted and alive, agrees to interview 1 Go to item 2
- Participant contacted and refused interview 2 Go to *Contact tracking (CIE form)*, item 49
- Designated respondent contacted, reported alive 3 Go to *Hospitalizations (HOE form)*, item 3
- Other respondent contacted, reported alive 4 Go to *Contact tracking (CIE form)*, item 49
- Not contacted, reported deceased 5 Continue to 1a, below
- Unknown 9 Go to *Contact tracking (CIE form)*, item 49

1a. What was the date of death? / /

1b. What city, state, and country did the death occur? _____

1c. Do you know if (insert decedent's name) was hospitalized or visited an emergency room for any reason since (date of last time interviewed) and his/her death?

- No 0 End interview
- Yes 1 Record date and name of each hospitalization and/or ER visit. End interview after last event is reported

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GENERAL HEALTH

2. Since our last telephone interview with you on (date), would you say, in general, your health is Excellent, Very good, Good, Fair, Poor,?
- Excellent 1 Very good 2 Good 3 Fair 4 Poor 5

[HOE section for data entry screens begins here]

B. HOSPITALIZED AND EMERGENCY ROOM EVENTS

"The following questions are about any hospitalizations or visits to an emergency room you may have had since our last telephone interview with you on (date)." [Note: This section will repeat depending upon number of reported events]

3. Since our last telephone interview with you on (date), have you at any time been admitted to a hospital or seen in an emergency room?
- No 0 Go to item 5 (OPE form)
Yes 1
Unsure 9 Go to item 5 (OPE form)

"The next few questions are about one event, if there were more than one we would like to talk about each one separately, let's start with the first event since our last telephone interview with you on (date)."

4. Was this visit to the emergency room only, a hospital admission only, or a visit to the emergency room that resulted in being admitted to the hospital?

Emergency Department (only) 1
Hospital Admission (only) 2
Both 3
Unsure 9

- 4a. What was the main reason for going to the (insert emergency room or hospital) that day?

[Check one and do not read choices]

Myocardial infarction, heart attack 0
Angina, chest pain 1
Heart failure 2
Stroke or TIA 3
Peripheral vascular disease 4
Venous thrombosis or pulmonary embolism 5
Chronic Obstructive Pulmonary Disease, emphysema, or chronic bronchitis 6
Asthma 7
Other: Specify: _____ 8
Pregnancy related, birth, complication of pregnancy 9

- 4b. What was the date of this event? / /

4c. What is the name of the medical facility? _____

4d. What is the address of this medical facility? _____
(Leave blank if unknown)

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4e. For clarification of our records, under what name is this record?

4e1. First Name: _____

4e2. Second Name: _____

4e3. Last Name: _____

4e4. Maternal Last Name: _____

4f. Were you admitted to a hospital or seen at an ER at any another time since your last telephone interview?

No 0 Go to item 5 (OPE form)

Yes 1 (Line entry saved, screen refreshes to a new series at item 4)

[OPE section for data entry screens begins here]

C. OUT-PATIENT SELF-REPORTED CONDITIONS

“Now I would like to ask you about conditions that may have resulted in you seeing a doctor or health profession at a clinic or doctor’s office, but not actually being admitted to the hospital or visiting an emergency room.”

5. Since our last telephone interview with you on (date), has a doctor or health professional told you that you had emphysema, chronic bronchitis, or chronic obstructive pulmonary disease (COPD)? This does not include doctor’s visits for tuberculosis or TB.

No 0 Go to item 6

Yes 1

Unsure 9 Go to item 6

Did your doctor or healthcare professional order any of the following tests to help make the diagnosis?

5a. Breathing test or pulmonary function test?

No 0 Yes 1 Unsure 9

5b. Chest X-ray:

No 0 Yes 1 Unsure 9

5c. CT Scan of your chest:

No 0 Yes 1 Unsure 9

5d. Were you told by a doctor or health professional that you were having an attack, worsening or an exacerbation of your emphysema, chronic obstructive pulmonary disease (COPD), or chronic bronchitis?

No 0 Go to item 6

Yes 1

Unsure 9 Go to item 6

5e. Did the doctor or health care professional prescribe a change in your medication, such as increasing your inhalers, oxygen or pills for your lungs or prescribing a steroid pill for your lungs?

No 0 Yes 1 Unsure 9

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6. Since our last telephone interview with you on *(date)*, has a doctor or health professional told you that you had asthma?

- No 0 Go to item 7
Yes 1
Unsure 9 Go to item 7

Did your doctor or healthcare professional order any of the following tests to help make the diagnosis?

6a. Breathing test or pulmonary function test

- No 0 Yes 1 Unsure 9

6b. Chest X-ray

- No 0 Yes 1 Unsure 9

6c. CT Scan of your chest

- No 0 Yes 1 Unsure 9

6d. Were you told by a doctor or health professional that you were having an attack, worsening or an exacerbation of your asthma?

- No 0 Go to item 7
Yes 1
Unsure 9 Go to item 7

6e. Did the doctor or health care professional prescribe a change in your medication, such as increasing your inhalers, oxygen or pills for your lungs or prescribing a steroid pill for your lungs?

- No 0 Yes 1 Unsure 9

7. Since our last telephone interview with you on *(date)*, has a doctor or health professional told you that you had diabetes or high sugar in the blood?

- No 0 Go to item 8
Yes 1
Unsure 9 Go to item 8

7a. Did the doctor recommend any new or different treatments?

- No 0 Go to item 8
Yes 1
Unsure 9 Go to item 8

7b. What treatment was recommended? (Do not prompt for specific response. Mark all that apply)

- Pills
Insulin Alone
Insulin and pills
Referred for eye exam
Advice to change diet
Advice to stop smoking
Advice to increase exercise
Other Specify: _____

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8. Since our last telephone interview with you on *(date)*, has a doctor or health professional told you that you had high blood pressure or hypertension?

- No 0 Go to item 9
Yes 1
Unsure 9 Go to item 9

8a. Did the doctor recommend any new or different treatments?

- No 0 Go to item 9
Yes 1
Unsure 9 Go to item 9

8b. What treatment was recommended? *(Do not prompt for specific response. Mark all that apply)*

- Start new medicine
Increase dose of existing medicine
Advice to lose weight
Advice to change diet
Advice to stop smoking
Advice to increase exercise
Other Specify: _____

9. Since our last telephone interview with you on *(date)*, has a doctor or health professional told you that you had high blood cholesterol?

- No 0 Go to item 10 *(EVE form)*
Yes 1
Unsure 9 Go to item 10: *(EVE form)*

9a. Did the doctor recommend any new or different treatments?

- No 0 Go to item 10 *(EVE form)*
Yes 1
Unsure 9 Go to item 10 *(EVE form)*

9b. What treatment was recommended? *(Do not prompt for specific response. Mark all that apply.)*

- Start new medicine
Increase dose of existing medicine
Advice to lose weight
Advice to change diet
Advice to stop smoking
Advice to increase exercise
Other Specify: _____

[EVE section for data entry screens begins here]

D. SELF REPORT OF EVENTS

"Now I would like to ask you about symptoms you may have had since our last telephone interview with you on (date)."

10. Since our last telephone interview with you on *(date)*, has a doctor or health professional told you that you had atrial fibrillation?

- No 0 Yes 1 Unsure 9

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11. Since our last telephone interview with you on *(date)*, has a doctor or health professional told you that you had heart failure?
No 0 Yes 1 Unsure 9
12. Since our last telephone interview with you on *(date)*, has a doctor or health professional told you that you had a blood clot in your leg vein or lung requiring blood thinning medicine?
No 0 Yes 1 Unsure 9
13. Since our last telephone interview with you on *(date)*, do you often have swelling in your feet or ankles at the end of the day?
No 0 Yes 1 Unsure 9
14. Since our last telephone interview with you on *(date)*, are there times when you wake up at night because of difficulty breathing?
No 0 Yes 1 Unsure 9
15. Since our last telephone interview with you on *(date)*, are there times when you have been troubled by shortness of breath when hurrying on level ground or walking up a slight hill?
No 0 Yes 1 Unsure 9
16. Since our last telephone interview with you on *(date)*, are there times when you stop for breath when walking at your own pace on level ground?
No 0 Yes 1 Unsure 9
17. Since our last telephone interview with you on *(date)*, are there times when you have difficulty breathing when you are not walking or active?
No 0 Yes 1 Unsure 9
18. Since our last telephone interview with you on *(date)*, have you had a cough on most days or nights of the week during at least 3 months in a row?
No 0 Yes 1 Unsure 9
19. Since our last telephone interview with you on *(date)*, have you brought up phlegm from your chest on most days or nights of the week during at least 3 months in a row?
No 0 Yes 1 Unsure 9
20. Since our last telephone interview with you on *(date)*, have you had wheezing or whistling in your chest?
No 0 Go to item 21
Yes 1
Unsure 9 Go to item 21
- 20a. Have you had an attack of wheezing or whistling in the chest that has made you feel short of breath?

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No 0 Yes 1 Unsure 9

21. Since our last telephone interview with you on (date), has a doctor or health professional told you that you have sleep apnea?

No 0 Go to item 22

Yes 1

Unsure 9 Go to item 22

21a. Has your sleep apnea been treated with any of the following? (check all that apply)

- Surgery
- Use of a dental appliance during sleep (a device put in your mouth at night that moves the jaws open)
- Use of oxygen during sleep
- A pressure machine such as CPAP or BILEVEL?

22. How often do you snore now?

Never 1

Rarely (1-2 nights a week) 2

Sometimes (3-5 nights a week) 3

Always or almost always (6-7 nights a week) 4

Don't know 9

[MEE section for data entry screens begins here]

E. MEDICATIONS

"Now I would like to ask about the prescription medications you currently use. By currently I mean in the past two weeks. Can you bring all these prescription medications to the telephone?"

23. (Interviewer: Do not ask) Does the participant have medications to report?

No 0 Go to items 44

Yes 1

Participant refused 2 Go to items 44

Please read the names of all the medications prescribed by a doctor. This includes pills, liquid medications, skin patches, inhalers, injections and suppositories. Please do not include over the counter medications unless prescribed by a doctor. (If they ask what do we mean by 'medications you are currently taking', that means medications you have taken in the last 2 weeks.)

#	(a) Medication UPC / NDC	Medication name (b)	
24.	<input type="text"/>		
	(c) Strength		(d) Units
25.	<input type="text"/>		
	(c) Strength		(d) Units

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#	(a) Medication UPC / NDC	Medication name (b)
26.	<input type="text"/>	
	(c) Strength (d) Units	
	<input type="text"/>	
27.	<input type="text"/>	
	(c) Strength (d) Units	
	<input type="text"/>	
28.	<input type="text"/>	
	(c) Strength (d) Units	
	<input type="text"/>	
29.	<input type="text"/>	
	(c) Strength (d) Units	
	<input type="text"/>	
30.	<input type="text"/>	
	(c) Strength (d) Units	
	<input type="text"/>	
31.	<input type="text"/>	
	(c) Strength (d) Units	
	<input type="text"/>	
32.	<input type="text"/>	
	(c) Strength (d) Units	
	<input type="text"/>	
33.	<input type="text"/>	
	(c) Strength (d) Units	
	<input type="text"/>	
34.	<input type="text"/>	
	(c) Strength (d) Units	
	<input type="text"/>	
35.	<input type="text"/>	
	(c) Strength (d) Units	
	<input type="text"/>	
36.	<input type="text"/>	
	(c) Strength (d) Units	
	<input type="text"/>	

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#	(a) Medication UPC / NDC	Medication name (b)	
37.	<input type="text"/>		
	(c) Strength <input type="text"/>		(d) Units <input type="text"/>
	<input type="text"/>		<input type="text"/>
38.	<input type="text"/>		
	(c) Strength <input type="text"/>		(d) Units <input type="text"/>
	<input type="text"/>		<input type="text"/>
39.	<input type="text"/>		
	(c) Strength <input type="text"/>		(d) Units <input type="text"/>
	<input type="text"/>		<input type="text"/>
40.	<input type="text"/>		
	(c) Strength <input type="text"/>		(d) Units <input type="text"/>
	<input type="text"/>		<input type="text"/>
41.	<input type="text"/>		
	(c) Strength <input type="text"/>		(d) Units <input type="text"/>
	<input type="text"/>		<input type="text"/>
42.	<input type="text"/>		
	(c) Strength <input type="text"/>		(d) Units <input type="text"/>
	<input type="text"/>		<input type="text"/>
43.	<input type="text"/>		
	(c) Strength <input type="text"/>		(d) Units <input type="text"/>
	<input type="text"/>		<input type="text"/>

“Next, I would like to ask you about your regular use of aspirin. By regular use, I mean taking aspirin every other day or more frequently.”

44. Are you NOW taking aspirin, or a medicine containing aspirin, on a regular basis? This does NOT include Tylenol or Advil or Motrin, ibuprofen.

- No 0 Go to item 49 (CIE form)
 Yes 1
 Unsure 9 Go to item 49 (CIE form)

44a. What dose do you take?

- 81 mg per day of aspirin 0
 325 mg per day of aspirin 1
 Other 2 specify: _____

Thank you so much for answering these questions. We greatly appreciate your participation in the SOL study. Now, I'd just like to make sure our records are up to date.

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[CIE section for data entry screens begins here.]

G. PARTICIPANT TRACKING

Interviewer: Current tracking information from SOL database is shown below. Record tracking information changes reported during the interview in the space provided.

"It is very important for this study to be able to reach you in the future. Although you provided your contact information at the time of your visit, in order to keep our records up to date please provide us with your current home address. All information you give us is strictly confidential and will not be shared with anyone else".

49. Current home address*

49.A.1. PO Box, Box &/or Route and Number

49.B.1. Street Number Prefix

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49.B.2. **Street Number**

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49.B.3. Street Number Suffix

--	--	--	--	--

49.C.1. Street Name Prefix

--	--	--	--	--

49.C.2. **Street Name**

49.C.3. **Street Name Type**

--	--	--	--

49.C.4. Street Name Suffix

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49.D.1. Unit Type

--	--	--	--

49.D.2. Unit Type Identifier

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49.D.3. Unit Subtype

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49.D.4. Unit Subtype Identifier

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49.E.1. Other

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49.F.1. City

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49.G.1. County

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49.H.1. State

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49.I.1. Country/Territory (Select code from list)

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49.J.1. Zip Code

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*IF THE PARTICIPANT LIVES AT SEVERAL LOCATIONS, ENTER WHERE HE OR SHE LIVES MOST. IF THE EXACT ADDRESS IS UNKNOWN, ENTER THE NAME OF THE INTERSECTION OR STREET CLOSEST TO THE HOME LOCATION IN 49.C.2. AND THE NAME OF THE BUILDING OR LOCATION IN 49.E.1.

IF THE ONLY KNOWN HOME ADDRESS IS A POST OFFICE BOX, BOX, OR ROUTE AND NUMBER, ENTER IT IN 49.A.1., BUT ALSO ENTER THE NAME OF THE INTERSECTION OR STREET CLOSEST TO THE ACTUAL HOME LOCATION IN 49.C.2. AND THE NAME OF THE BUILDING OR LOCATION IN 49.E.1.

50. Primary Phone Number: () -

51. What is the best time of day to reach you at this number?

- Morning 1
- Afternoon 2
- Evening 3

52. Secondary Phone Number: () -

53. What is the best time of day to reach you at this number?

- Morning 1
- Afternoon 2
- Evening 3

Local Contact 1 (primary contact)

54 a. Title: _____ b. First Name: _____

c. Middle/Second Name: _____

d. Paternal Last Name: _____

e. Maternal Last Name: _____

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55. Relationship: _____

56. Current home address of primary contact*

56.A.1. PO Box, Box &/or Route and Number

56.B.1. Street Number Prefix

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56.B.2. **Street Number**

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56.B.3. Street Number Suffix

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56.C.1. Street Name Prefix

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56.C.2. **Street Name**

56.C.3. **Street Name Type**

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56.C.4. Street Name Suffix

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56.D.1. Unit Type

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56.D.2. Unit Type Identifier

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56.D.3. Unit Subtype

--	--	--	--	--

56.D.4. Unit Subtype Identifier

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56.E.1. Other

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56.F.1. City

56.G.1. County

--	--	--	--	--	--	--	--	--	--

56.H.1. State

--	--

56.I.1. Country/Territory *(Select code from list)*

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56.J.1. Zip Code

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*IF THE PERSON LIVES AT SEVERAL LOCATIONS, ENTER WHERE HE OR SHE LIVES MOST. IF THE EXACT ADDRESS IS UNKNOWN, ENTER THE NAME OF THE INTERSECTION OR STREET CLOSEST TO THE HOME LOCATION IN 56.C.2. AND THE NAME OF THE BUILDING OR LOCATION IN 56.E.1.

IF THE ONLY KNOWN HOME ADDRESS IS A POST OFFICE BOX, BOX, OR ROUTE AND NUMBER, ENTER IT IN 56.A.1., BUT ALSO ENTER THE NAME OF THE INTERSECTION OR STREET CLOSEST TO THE ACTUAL HOME LOCATION IN 56.C.2. AND THE NAME OF THE BUILDING OR LOCATION IN 56.E.1.

57. Telephone: () - -

Local Contact 2 (secondary contact)

58. a. Title: _____ b. First Name: _____

c. Middle/Second Name: _____

d. Paternal Last Name: _____

e. Maternal Last Name: _____

59. Relationship: _____

60. Current home address of secondary contact*

60.A.1. PO Box, Box &/or Route and Number

60.B.1. Street Number Prefix

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60.B.2. **Street Number**

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60.B.3. Street Number Suffix

--	--	--	--	--

60.C.1. Street Name Prefix

--	--	--	--	--

60.C.2. **Street Name**

60.C.3. **Street Name Type**

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60.C.4. Street Name Suffix

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60.D.1. Unit Type

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60.D.2. Unit Type Identifier

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60.D.3. Unit Subtype

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60.D.4. Unit Subtype Identifier

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60.E.1. Other

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60.F.1. City

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60.G.1. County

--	--	--	--	--	--	--	--	--	--

60.H.1. State

--	--

60.I.1. Country/Territory (Select code from list)

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60.J.1. Zip Code

						-			
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61. Telephone: () -

*IF THE PERSON LIVES AT SEVERAL LOCATIONS, ENTER WHERE HE OR SHE LIVES MOST. IF THE EXACT ADDRESS IS UNKNOWN, ENTER THE NAME OF THE INTERSECTION OR STREET CLOSEST TO THE HOME LOCATION IN 60.C.2. AND THE NAME OF THE BUILDING OR LOCATION IN 60.E.1.

IF THE ONLY KNOWN HOME ADDRESS IS A POST OFFICE BOX, BOX, OR ROUTE AND NUMBER, ENTER IT IN 60.A.1., BUT ALSO ENTER THE NAME OF THE INTERSECTION OR STREET CLOSEST TO THE ACTUAL HOME LOCATION IN 60.C.2. AND THE NAME OF THE BUILDING OR LOCATION IN 60.E.1.

Local Contact 3

62. a. Title: _____ b. First Name: _____

c. Middle/Second Name: _____

d. Paternal Last Name: _____

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e. Maternal Last Name: _____

63. Relationship: _____

64. Current home address of third contact*

64.A.1. PO Box, Box &/or Route and Number

64.B.1. Street Number Prefix

--	--	--	--	--

64.B.2. **Street Number**

--	--	--	--	--	--	--	--	--	--

64.B.3. Street Number Suffix

--	--	--	--	--

64.C.1. Street Name Prefix

--	--	--	--	--

64.C.2. **Street Name**

64.C.3. **Street Name Type**

--	--	--	--

64.C.4. Street Name Suffix

--	--	--	--	--

64.D.1. Unit Type

--	--	--	--

64.D.2. Unit Type Identifier

--	--	--	--	--

64.D.3. Unit Subtype

--	--	--	--	--

64.D.4. Unit Subtype Identifier

--	--	--	--

64.E.1. Other

--	--	--	--	--	--	--	--	--	--

64.F.1. City

64.G.1. County

--	--	--	--	--	--	--	--	--	--

ID NUMBER:									
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64.H.1. State

--	--

64.I.1. Country/Territory (Select code from list)

--	--

64.J.1. Zip Code

						-				
--	--	--	--	--	--	---	--	--	--	--

65. Telephone: () -

66. For this portion of the call, I have one more question. What is the name of your physician or other health care provider (HCP)?”

a. Name: _____

b. Address: _____

c. City: _____, State: _____, Zip Code: _____

H. END OF THIS PORTION OF THE CALL

“Thank you for answering the questions about your health. We wish to continue to stay in touch with you and will be contacting you again next year”

ID NUMBER:							
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Contact
Occasion

0	4
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SEQ #

0	1
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Location Codes for Questions 45, 49, 56, 60, 64

01	Afghanistan	47	New Zealand
02	Anguilla	48	Nicaragua
03	Antigua and Barbuda	49	Norway
04	Argentina	50	Pakistan
05	Aruba	51	Panama
06	Australia	52	Paraguay
07	Austria	53	Peru
08	Bangladesh	54	Philippines
09	Belgium	55	Poland
10	Belize	56	Portugal
11	Bolivia	57	Puerto Rico
12	Brazil	58	Russia
13	Canada	59	South Africa
14	Chile	60	Spain
15	China	61	Sweden
16	Colombia	62	Switzerland
17	Costa Rica	63	United States
18	Cuba	64	Uruguay
19	Czech Republic	65	Venezuela
20	Denmark	66	Virgin Islands
21	Dominican Republic	67	Other
22	Ecuador	99	Unknown/refused
23	El Salvador		
24	Finland		
25	France		
26	Germany		
27	Great Britain		
28	Greece		
29	Guam		
30	Guatemala		
31	Haiti		
32	Holland		
33	Honduras		
34	Hungary		
35	India		
36	Indonesia		
37	Iran		
38	Iraq		
39	Ireland		
40	Israel		
41	Italy		
42	Japan		
43	Korea		
44	Lebanon		
45	Malaya		
46	Mexico		