



# HCHS/SOL Personal Medical History MHE

ID NUMBER:

FORM CODE: MHE  
VERSION: 2, 1/27/2020

Contact Occasion

0  3

Occurrence

0  1

## ADMINISTRATIVE INFORMATION

0a. Completion Date:   /   /

0b. Staff ID:

0c. Participant Gender:  (1=Male; 2=Female) [Prefilled from DEM1] 0d. Age:   [At V3 from DEM3]

0e. Last visit date:   /   /     [System prefilled]

**Instructions:** Enter the answer given by the participant for each response. Set CDART Field Status to 'Refused', 'No Response', 'Missing', etc. for those questions that do not list these values as possible answer choices.

**Introduction:** Next, I would like to update our records for any health issues you may have experienced. Some are questions we asked before, but we want to make sure we don't miss anything.

I will ask you some questions that may make you feel uncomfortable. You may not feel like answering them completely or at all. Please, take your time to think through your answers. We want to understand these aspects of your health, and at the same time we want you to feel respected and comfortable. You are important to us, and your participation in the study is extremely valuable.

### A. Since the last SOL visit, has a doctor said that you had any of the following medical problems?

	No	Yes	Unsure
1. Heart attack?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
2. A balloon angioplasty, a stent, or bypass surgery to the arteries in your heart to improve the blood flow to your heart?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
3. Angina?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
4. Heart Failure?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
5. Stroke?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
6. A mini-stroke or TIA (transient ischemic attack)?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
7. A balloon angioplasty or surgery to the arteries of your neck to prevent or correct a stroke?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
8. An aortic aneurysm, an AAA, or ballooning of your aorta? If NO skip to Q10	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
9. Have you had a repair of your aorta—the big artery in your abdomen?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
<b>10. Peripheral arterial disease (problems with circulation, blocked arteries to the legs)?</b>	<b>0 <input type="checkbox"/></b>	<b>1 <input type="checkbox"/></b>	<b>9 <input type="checkbox"/></b>
<b>10a. IF YES to PAD, did you have leg surgery, a balloon angioplasty, or stent for this condition?</b>	<b>0 <input type="checkbox"/></b>	<b>1 <input type="checkbox"/></b>	<b>9 <input type="checkbox"/></b>
<b>10b. IF YES to PAD, did you have amputation for this condition?</b>	<b>0 <input type="checkbox"/></b>	<b>1 <input type="checkbox"/></b>	<b>9 <input type="checkbox"/></b>

11. Liver disease? No 0  **Go to Question 12** Yes 1  Unsure 9  **Go to Question 12**

IF YES to liver disease, then what type of liver disease?

- 11a. Hepatitis No 0  → **Go to Question 11d** Yes 1
- 11b. What type? Type A 1  → **Go to Question 11d**
- Type B 2  → **Go to Question 11d**
- Type C 3  → **Go to Question 11c**
- Don't know 9  → **Go to Question 11d**

ID NUMBER:								
------------	--	--	--	--	--	--	--	--

FORM CODE: MHE  
VERSION: 2, 1/27/2020

Contact Occasion

0	3
---	---

Occurrence

0	1
---	---

11c. Has a doctor ever prescribed medicine to treat Hepatitis C? No 0  Yes 1  Unsure 9

11d. Cirrhosis No 0  Yes 1

No Yes Unsure

12. Has a doctor ever told you that you had gallstones? 0  1  9

12a. IF YES, have you ever had medical treatment to dissolve or remove gallstones? 0  1  9

12b. IF YES, have you ever had gallbladder surgery? 0  1  9

12c. IF YES, at what AGE?

13. Have you ever had weight loss surgery, also called bariatric surgery? 0  1  9

13a. IF YES, at what AGE?

14. Since our last SOL visit 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 Question 15** Yes 1  Unsure 9  **Go to Question 15**

14a. Did the doctor or health care professional prescribe a medication, such as inhalers, oxygen or pills for your lungs or prescribing a steroid pill for your lungs?

No 0  Yes 1  Unsure 9

15. Since our last SOL visit with you on (date), has a doctor or health professional told you that you had asthma?

No 0  **Go to Question 16** Yes 1  Unsure 9  **Go to Question 16**

15a. Did the doctor or health care professional prescribe a medication, such as inhalers, oxygen or pills for your lungs or prescribing a steroid pill for your lungs?

No 0  Yes 1  Unsure 9

16. Since our last SOL visit with you, has a doctor or health professional told you that you had diabetes or high sugar in the blood?

No 0  **Go to Question 17** Yes 1  Unsure 9  **Go to Question 17**

16a. Did the doctor recommend any treatments?

No 0  **Go to Question 17** Yes 1  Unsure 9  **Go to Question 17**

16b. What treatment was recommended? (Do not prompt for specific response. Mark all that apply)

	No	Yes
b1. Pills	0 <input type="checkbox"/>	1 <input type="checkbox"/>
b2. Insulin alone	0 <input type="checkbox"/>	1 <input type="checkbox"/>
b3. Insulin and pills	0 <input type="checkbox"/>	1 <input type="checkbox"/>
b4. Referred for eye exam	0 <input type="checkbox"/>	1 <input type="checkbox"/>
b5. Advice to change diet	0 <input type="checkbox"/>	1 <input type="checkbox"/>
b6. Advice to stop smoking	0 <input type="checkbox"/>	1 <input type="checkbox"/>
b7. Advice to increase exercise	0 <input type="checkbox"/>	1 <input type="checkbox"/>
b8. Other	0 <input type="checkbox"/>	1 <input type="checkbox"/> Specify: _____

17. Since our last SOL visit with you on (date), has a doctor or health professional told you that you had high blood pressure or hypertension?

No 0  **Go to Question 18** Yes 1  Unsure 9  **Go to Question 18**

ID NUMBER:								
------------	--	--	--	--	--	--	--	--

FORM CODE: MHE  
VERSION: 2, 1/27/2020

Contact Occasion

0	3
---	---

Occurrence

0	1
---	---

17a. Did the doctor recommend any treatments?  
 No 0  **Go to Question 18**      Yes 1       Unsure 9  **Go to Question 18**

17b. What treatment was recommended? (Do not prompt for specific response. Mark all that apply)

- |  | No                         | Yes                                       |
|--|----------------------------|---|
| b1. Start new medicine                 | 0 <input type="checkbox"/> | 1 <input type="checkbox"/>                |
| b2. Increase dose of existing medicine | 0 <input type="checkbox"/> | 1 <input type="checkbox"/>                |
| b3. Advice to lose weight              | 0 <input type="checkbox"/> | 1 <input type="checkbox"/>                |
| b4. Advice to change diet              | 0 <input type="checkbox"/> | 1 <input type="checkbox"/>                |
| b5. Advice to stop smoking             | 0 <input type="checkbox"/> | 1 <input type="checkbox"/>                |
| b6. Advice to increase exercise        | 0 <input type="checkbox"/> | 1 <input type="checkbox"/>                |
| b7. Other                              | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> Specify: _____ |

18. Since our last SOL visit with you on (date) has a doctor or health professional told you that you had high blood cholesterol?

No 0  **Go to Question 19**      Yes 1       Unsure 9  **Go to Question 19**

18a. Did the doctor recommend treatments?  
 No 0  **Go to Question 19**      Yes 1       Unsure 9  **Go to Question 19**

- 18b. What treatment was recommended? (Do not prompt for specific response. Mark all that apply.)
- |  | No                         | Yes                                      |
|--|----------------------------|--|
| b1. Start new medicine                 | 0 <input type="checkbox"/> | 1 <input type="checkbox"/>               |
| b2. Increase dose of existing medicine | 0 <input type="checkbox"/> | 1 <input type="checkbox"/>               |
| b3. Advice to lose weight              | 0 <input type="checkbox"/> | 1 <input type="checkbox"/>               |
| b4. Advice to change diet              | 0 <input type="checkbox"/> | 1 <input type="checkbox"/>               |
| b5. Advice to stop smoking             | 0 <input type="checkbox"/> | 1 <input type="checkbox"/>               |
| b6. Advice to increase exercise        | 0 <input type="checkbox"/> | 1 <input type="checkbox"/>               |
| b7. Other                              | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> Specify _____ |

**B. In the Past 12 months, have you had any of the following problems?**

- |   | No                         | Yes                        | Unsure                     |
|---|----------------------------|----------------------------|----------------------------|
| 19. Do you often have swelling in your feet or ankles at the end of the day?  | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 9 <input type="checkbox"/> |
| 20. Do you have difficulty lying flat in bed or on a single pillow because this position makes you short of breath? | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 9 <input type="checkbox"/> |
| 21. Are there times when you wake up at night because of difficulty breathing?                                      | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 9 <input type="checkbox"/> |
| 22. Are there times when you have difficulty breathing when you are not walking or active?                          | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 9 <input type="checkbox"/> |

23. Has a doctor ever told you that you had any of the following conditions that affect the brain:
- |   | No                         | Yes                        |
|---|----------------------------|----------------------------|
| 23a. Dementia?  | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| 23b. Alzheimer's disease?   | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| 23c. Vascular dementia or hardening of the arteries of the brain? | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| 23d. Mild Cognitive Impairment (or MCI)?                          | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| 23e. Parkinson's Disease?   | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| 23f. Brain Tumor?   | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |

ID NUMBER:									
------------	--	--	--	--	--	--	--	--	--

FORM CODE: MHE  
VERSION: 2, 1/27/2020

Contact Occasion

0	3
---	---

Occurrence

0	1
---	---

**In the past 12 months have you:**

**No**      **Yes**

- 24. Received dialysis (either hemodialysis or peritoneal dialysis)?      0       1
- 25. Received a kidney transplant?      0       1

**In the past 12 months have you had or do you currently have:**

- 26. Pain in your face?      0       1
- 27. Pain in your jaw joint?      0       1

**[Complete if Q26 and/or Q27=Yes]**

**In the past 6 months**

**Never**      **Some days**      **Most days**      **Every day**

- 28. How often did you have pain?      0       1       2       3
- 29. How often did pain limit your life or work activities?      0       1       2       3

**C. Other Health Questions**

*Now I'm going to ask you a few questions about getting tested for HIV. Remember, an HIV test checks whether someone has the virus that causes AIDS.*

30. Have you ever had an HIV test?

- No      0  **[End Form]**
- Yes      1  **Go to Question 31**
- Don't Know      9  **[End Form]**
- Refuse to Answer      7  **[End Form]**

31. Have you ever tested positive for HIV, that is, do you have HIV?

- No      0  **Go to Question 32**
- Yes      1  **Go to Question 33**
- Don't Know      9  **Go to Question 32**
- Refuse to Answer      7  **[End Form]**

32. When did you have your most recent HIV test? Please tell me the month and year  
(Use *CDART Field Status* for *Don't know* or *Refusal* answers).

Date of most recent HIV test (mm/yyyy): /  **[End Form]**

33. When did you first test positive? Please tell me the month and year  
(Use *CDART Field Status* for *Don't know* or *Refusal* answers).

Date of first positive test (mm/yyyy): /