HCHS/SOL Physician Questionnaire

ADMINISTRATIVE INFORMATION

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

Instructions: Please complete the following questions to the best of your ability by filling in the appropriate bubbles or writing the answer in the blank provided. Please return completed forms in the self addressed stamped envelope provided to the local HCHS/SOL field center.

DETAILS OF DEATH

1. Are you familiar with the events surrounding the decedent's death?
   - No 0 □
   - Yes 1 □

2. Did you witness the death?
   - No 0 □
   - Yes 1 □

If informant answered “Yes” to one or both of Items 1 and 2, please skip to Item 4.

3. If you answered "No" to both Questions, are you aware of another physician who could provide information regarding the death?
   - No 0 □  Please sign and date the bottom of this form
   - Yes 1 □

3a. Provide contact information. Please then sign and date the bottom of this form.

   Name of physician: __________________________

   Address:
   __________________________
   __________________________
CIRCUMSTANCES SURROUNDING DEATH

4. What do you believe to be the underlying cause of death?
   - Acute Myocardial Infarction
   - Other Ischemic Heart Disease
   - Cerebrovascular Disease
   - Other Cardiovascular Disease
   - Emphysema, chronic bronchitis or chronic obstructive pulmonary disease (COPD)
   - Pneumonia
   - Asthma
   - Other Lung Disease
   - Non Cardiovascular Pulmonary Disease

   Specify: __________________________

5. Please specify the time between the onset of the acute episode of symptoms and death. (We are defining death as the point where spontaneous breathing ceased and the patient never recovered.) Please check the appropriate time period.
   - Less than 5 minutes
   - 5 minutes to 1 hour
   - 1 hour to 24 hours
   - More than 24 hours
   - 1 day to 3 days
   - More than 3 days
   - Unknown

6. Was there an acute episode of pain in the chest, left arm or jaw during the last 72 hours prior to death?
   - No
   - Yes
   - Unknown

7. Was there an acute episode of shortness of breath during the 72 hours prior to death?
   - No
   - Yes
   - Unknown

8. Was there an acute episode of wheezing during the 72 hours prior to death?
   - No
   - Yes
   - Unknown
9. Did the decedent take or was s/he given nitrates or nitroglycerin at the time of the acute episode?

   No  0 □  
   Yes 1 □  
   Unknown 9 □

**MEDICAL HISTORY**

10. Are you familiar with the decedent’s medical history?

   No  0 □  End questionnaire  
   Yes 1 □

11. Did the decedent have a medical history of any of the following conditions prior to the acute event which led to death?

   11a. Myocardial Infarction (MI)?

      No  0 □  Skip to 11b  
      Yes 1 □  
      Unknown 9 □  Skip to 11b

      i. Date of most recent MI:  / /  
        month  day  year

   11b. Angina Pectoris, Coronary Insufficiency or Other Chronic Ischemic Heart Disease?

      No  0 □  Skip to 11c  
      Yes 1 □  
      Unknown 9 □  Skip to 11c

      i. Date of first diagnosis:  / /  
        month  day  year

   11c. Congestive Heart Failure (CHF) or Congestive Cardiomyopathy?

      No  0 □  Skip to 11d  
      Yes 1 □  
      Unknown 9 □  Skip to 11d

      i. Date of first exacerbation:  / /  
        month  day  year
11d. Stroke (CVA)?

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<th>Choice</th>
<th>Value</th>
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<td>Yes</td>
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Skip to 11e

i. Date of most recent CVA: [ ]/ [ ]/ [ ]

11e. Transient Ischemic Attack (TIA)?

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<td>Yes</td>
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Skip to 11f

i. Date of first diagnosis: [ ]/ [ ]/ [ ]

11f. Intermittent Claudication or Other Peripheral Arterial Disease (PAD)?

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<tr>
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Skip to 11g

11g. Lower Extremity Bypass, Angioplasty or Amputation Secondary to PAD?

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Skip to 11h

11h. Coronary Bypass Surgery?

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11i. Coronary Angioplasty?

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11j. Emphysema, chronic bronchitis, or Chronic Obstruction Pulmonary Disease (COPD)?

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Skip to 11k
i. Date of first exacerbation (or onset): \[\square/\square/\square\]  

11k. Asthma?  
   No 0  
   Yes 1  
   Unknown 9  

i. Approximate age asthma first started: \[\square\]  

12. If you saw the participant within one month of death, please fill out the following for the most recent visit:  

12a. Date of visit: \[\square/\square/\square\]  

12b. Chief Complaint: ____________________________________________  

12c. Primary Diagnosis: ____________________________________________  

12d. Changes in Medical Management: ____________________________________________  

Form completed by: ___________________________ Date: ___________________________