HCHS/SOL Participant Safety Screening Form

A. Safety and Access Questions

1. FEMALES only: Are you pregnant?
   - No 0
   - Yes 1 → **STOP, Exclude from Baseline Examination**

2. Do you need any kind of assistance reading, hearing questions, or getting on an examination table?
   - No 0 → **GO to Question 3**
   - Yes 1 → **GO to Question 2a**

   2a. Specify: _________________________________

3. Do you have either a heart pacemaker or defibrillator (AICD)?
   - No 0
   - Yes 1 → **Exclude from BIA & Bronchodilator use**

4. Has a doctor or health professional ever told you that you have diabetes (high sugar in blood or urine)?
   - No 0
   - Yes 1 → **Exclude from OGTT**

**NOTE TO STAFF:** Use appropriate clinic scheduling script when completing this form.
B. Periodontal Exam Exclusion Questions

5. Do you have artificial valves in your heart?
   - No 0
   - Yes 1 → Periodontal Exam Exclusion

6. Have you been treated by a physician for infective endocarditis?
   - No 0
   - Yes 1 → Periodontal Exam Exclusion

7. Do you have a serious heart condition from birth?
   - No 0
   - Yes 1 → Periodontal Exam Exclusion

8. Have you had a heart transplant?
   - No 0
   - Yes 1 → Periodontal Exam Exclusion

9. Do you have artificial joints or prostheses?
   - No 0
   - Yes 1 → Periodontal Exam Exclusion

C. Pulmonary Function Test Exclusion Question

10. Have you had a heart attack, stroke, or eye surgery in the last 6 months (or 3 months prior to examination closeout)?
   - No 0
   - Yes 1 → Pulmonary Test Exclusion

D. Other Exclusion(s)

11. Specify condition or circumstance: __________________________________________________________

11a. Procedure(s)/test(s) excluded: __________________________________________________________

11b. Name or Staff ID authorizing this exclusion: _______ __________________________

Record ALL Yes responses to Questions 2-10 on the Exam Itinerary Checklist form