



**Participant ID:**

**Participant Initials:**

**Site:**

**Visit Number:**

**CRF Date:**

**RC ID:**

## MEDICAL HISTORY – SYMPTOMS AND CLINICAL HISTORY

### AP MEDICAL HISTORY MEU QUESTIONS

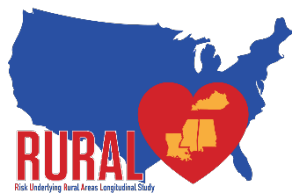
**Cardiovascular History:**

1. Have you ever had any of the below cardiovascular procedures performed on you?

a. Heart Valvular Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> If yes, when (YYYY): _____
b. Exercise Tolerance Test	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> If yes, when (YYYY): _____
c. Coronary artery angioplasty	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> If yes, when (YYYY): _____
d. Coronary bypass surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> If yes, when (YYYY): _____
e. Permanent pacemaker insertion	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> If yes, when (YYYY): _____
f. Femoral or lower extremity surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> If yes, when (YYYY): _____
g. Other Cardiovascular Procedures	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
i. If yes, please specify the procedure(s) and year(s):	<hr/> <hr/>

**Chest Pain:**

2. Do you have any chest discomfort?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
a. Chest discomfort with exertion or excitement?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
b. Chest discomfort when quiet or resting?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
3. If <b>YES</b> , please describe your chest discomfort characteristics: <i>(If NO, skip to question #4)</i>	
a. Date of Onset?	_____ / _____ (MM/YY)
b. Longest Duration?	_____ (in minutes)
c. Location?	<input type="checkbox"/> None <input type="checkbox"/> Central sternum and upper chest <input type="checkbox"/> Left Upper Quadrant



Participant ID:

Participant Initials:

Site:

Visit Number:

CRF Date:

RC ID:

## MEDICAL HISTORY – SYMPTOMS AND CLINICAL HISTORY

	<input type="checkbox"/> Left Lower Ribcage <input type="checkbox"/> Right Chest <input type="checkbox"/> Other <input type="checkbox"/> Combination <input type="checkbox"/> Unknown
d. Radiation?	<input type="checkbox"/> None <input type="checkbox"/> Left shoulder or left arm <input type="checkbox"/> Right shoulder or right arm <input type="checkbox"/> Neck <input type="checkbox"/> Back <input type="checkbox"/> Abdomen <input type="checkbox"/> Other <input type="checkbox"/> Combination <input type="checkbox"/> Unknown
e. Frequency in the past month?	_____ <input type="checkbox"/> Unknown
f. Frequency in the past year?	_____ <input type="checkbox"/> Unknown
g. Type?	<input type="checkbox"/> Pressure, heavy, vise <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Other <input type="checkbox"/> Unknown
h. Relief by Nitroglycerine in <5 min	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Never tried
i. Relief by Rest in < 15 min	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Never tried
j. Relief Spontaneously in <15 min	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Never tried
k. Relief by other cause in <15 min	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Never tried

**Cerebrovascular Disease:**



Participant ID:

Participant Initials:

Site:

Visit Number:

CRF Date:

RC ID:

## MEDICAL HISTORY – SYMPTOMS AND CLINICAL HISTORY

4. Have you ever been told by a physician that you had a stroke (brain attack)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
a. If yes, what was the date of the first stroke?	_____ / _____ (MM/YY) <input type="checkbox"/> Don't Know
5. Have you ever had any sudden loss or changes in speech?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
a. Year symptoms started:	_____ (YYYY) <input type="checkbox"/> Don't Know
6. Have you ever had any sudden muscular weakness?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
a. Year symptoms started:	_____ (YYYY) <input type="checkbox"/> Don't Know
7. Have you ever had a sudden visual defect?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
a. Year symptoms started:	_____ (YYYY) <input type="checkbox"/> Don't Know
<b>IF YES TO ANY OF THE ABOVE (4, 5, 6 OR 7), ANSWER THE FOLLOWING: IF NO TO ALL, CHECK DOES NOT APPLY to #8, #9 AND SKIP TO #10.</b>	
8. Were you seen by a neurologist?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Does not apply
9. Did you have a head CT scan or MRI scan procedure?	<input type="checkbox"/> Neither <input type="checkbox"/> CT Scan <input type="checkbox"/> MRI <input type="checkbox"/> Both <input type="checkbox"/> Unknown <input type="checkbox"/> Does not apply
a. If you had a CT scan, when?	_____ / _____ (MM/YY)
b. If you had an MRI scan, when?	_____ / _____ (MM/YY)

### Venous and Peripheral Arterial Disease:

10. Do you have leg discomfort or calf tightness while walking?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
a. If yes, when walking on level ground, how many feet/miles until symptoms develop?	_____ (ft) OR _____ (miles)
b. Year symptoms started:	_____ (YYYY)
c. Please check which leg(s) have calf tightness symptoms:	



Participant ID:

Participant Initials:

Site:

Visit Number:

CRF Date:

RC ID:

## MEDICAL HISTORY – SYMPTOMS AND CLINICAL HISTORY

i. Tightness in calf while walking:	<input type="checkbox"/> Left leg <input type="checkbox"/> Right leg <input type="checkbox"/> Both <input type="checkbox"/> Don't know
ii. Discomfort in lower extremity (not calf) while walking:	<input type="checkbox"/> Left leg <input type="checkbox"/> Right leg <input type="checkbox"/> Both <input type="checkbox"/> Don't know
iii. Occurs with first steps (worst leg):	<input type="checkbox"/> Left leg <input type="checkbox"/> Right leg <input type="checkbox"/> Don't know
iv. After walking a while (worst leg):	<input type="checkbox"/> Left leg <input type="checkbox"/> Right leg <input type="checkbox"/> Don't know
d. Are these symptoms related to rapidity of walking or steepness of ground you are walking on?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
e. Are you forced to stop walking?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
f. Time for discomfort to be relieved by stopping:	____ (in minutes) <input type="checkbox"/> No relief <input type="checkbox"/> Don't Know <input type="checkbox"/> Does not apply
g. Number of days/months of lower limb discomfort:	_____ (in days) <b>OR</b> _____ (in months) <input type="checkbox"/> Don't know <input type="checkbox"/> Does not apply

### Respiratory Health:

<b>Cough</b>	
11. Do you usually have a cough? <i>(Count a cough with first smoke or on first going out-of-doors. Exclude clearing of throat)</i> <i>If <b>NO</b> skip to #16</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
12. Do you usually cough at all on getting up, or first thing in the morning?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
13. Do you usually cough at all during the rest of the day or at night?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
IF <b>YES</b> TO ANY OF THE ABOVE (11, 12, OR 13), ANSWER THE FOLLOWING: IF <b>NO</b> TO ALL, <b>CHECK DOES NOT APPLY</b> to #14 AND SKIP TO #16.	
14. Do you usually cough like this on most days for 3 consecutive months or more during the year?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Does not apply
15. For how many years have you had this cough?	_____ year(s) <input type="checkbox"/> Does not apply
<b>Phlegm</b>	



Participant ID:

Participant Initials:

Site:

Visit Number:

CRF Date:

RC ID:

## MEDICAL HISTORY – SYMPTOMS AND CLINICAL HISTORY

<p>16. Do you usually bring up phlegm from your chest?</p> <p><i>(Count phlegm with the first smoke or on first going out-of-doors. Exclude phlegm from the nose. Count swallowed phlegm)</i> If <b>NO</b>, skip to #21</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>17. Do you usually bring up phlegm at all on getting up or first thing in the morning?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>18. Do you usually bring up phlegm at all during the rest of the day or at night?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>IF <b>YES</b> TO ANY OF THE ABOVE (16, 17, OR 18), ANSWER THE FOLLOWING: IF <b>NO</b> TO ALL, <b>CHECK DOES NOT APPLY</b> to #19 AND SKIP TO #21</p>	
<p>19. Do you bring up phlegm like this on most days for 3 consecutive months or more during the year?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Does not apply</p>
<p>20. For how many years have you had trouble with phlegm?</p>	<p>_____ year(s) <input type="checkbox"/> Does not apply</p>
<p><b>Wheezing</b></p>	
<p>21. Does your chest ever sound wheezy or whistling:</p>	
<p>a. When you have a cold?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>b. Occasionally apart from colds?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>c. Most days or nights?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>IF <b>YES</b> TO ANY OF THE ABOVE (21 a, b, c), ANSWER THE FOLLOWING: IF <b>NO</b> TO ALL, <b>CHECK DOES NOT APPLY</b> to #22 AND SKIP TO #24</p>	
<p>22. For how many years has this been present?</p>	<p>_____ year(s) <input type="checkbox"/> Does not apply</p>
<p>23. Have you ever had an ATTACK of wheezing that has made you feel short of breath?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>IF <b>YES</b> TO #23, ANSWER THE FOLLOWING: IF <b>NO</b>, <b>CHECK DOES NOT APPLY</b> to #23 a,b,c AND SKIP TO #24</p>	
<p>a. How old were you when you had your first such attack?</p>	<p>_____ years old <input type="checkbox"/> Does not apply</p>
<p>b. Have you had 2 or more such episodes?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Does not apply</p>
<p>c. Have you ever required medicine or treatment for the(se) attack(s)?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Does not apply</p>
<p><b>Breathlessness</b></p>	



Participant ID:

Participant Initials:

Site:

Visit Number:

CRF Date:

RC ID:

## MEDICAL HISTORY – SYMPTOMS AND CLINICAL HISTORY

24. If disabled from walking by any condition other than heart or lung disease, please describe and proceed to #26	Nature of condition(s):
25. Are you troubled by shortness of breath when hurrying on level/flat ground or walking up a slight hill?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Does not apply
IF <b>YES</b> TO #25, ANSWER THE FOLLOWING: IF <b>NO</b> , <b>CHECK DOES NOT APPLY</b> to #25 a, b, c, d AND SKIP TO #26	
a. Do you have to walk slower than people of your age on level/flat ground because of breathlessness?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Does not apply
b. Do you ever have to stop for breath when walking at your own pace on level/flat ground?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Does not apply
c. Do you ever have to stop for breath after walking about 100 yards (or after a few minutes) on level/flat ground?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Does not apply
d. If yes to #25, are you too breathless to leave the house or are breathless on dressing or undressing?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Does not apply
<b>Past Illnesses</b>	
26. Did you have any lung trouble before the age of 16?	<input type="checkbox"/> Yes <input type="checkbox"/> No
27. Have you ever had attacks of bronchitis? (IF <b>NO</b> , SKIP TO #28)	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. Was it confirmed by a doctor?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Does not apply
b. At what age was your first attack?	_____ years old <input type="checkbox"/> Does not apply
28. Have you ever had pneumonia (include bronchopneumonia)? (IF <b>NO</b> , SKIP TO #29)	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. Was it confirmed by a doctor?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Does not apply
b. At what age did you first have it?	_____ years old <input type="checkbox"/> Does not apply
29. Have you ever had chronic bronchitis or emphysema or COPD (chronic obstructive pulmonary disease)? (IF <b>NO</b> , SKIP TO #30)	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If yes, was it confirmed by a doctor?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Does not apply
b. If yes, at what age did it start?	_____ years old <input type="checkbox"/> Does not apply
30. Has a doctor or other healthcare professional ever told you that you have sleep apnea? (IF <b>NO</b> , SKIP TO #31)	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. At what age were you first told this?	_____ years old
b. What treatment was recommended?	<input type="checkbox"/> CPAP <input type="checkbox"/> Dental Device <input type="checkbox"/> Surgery <input type="checkbox"/> Other (Please specify: _____)
<b>Allergies</b>	
31. In the past 12 months, have you been bothered by sneezing or a runny or blocked nose when you DID NOT have a cold or the flu?	<input type="checkbox"/> Yes <input type="checkbox"/> No



**Participant ID:**

**Participant Initials:**

**Site:**

**Visit Number:**

**CRF Date:**

**RC ID:**

## MEDICAL HISTORY – SYMPTOMS AND CLINICAL HISTORY

32. In the past 12 months, have you been bothered by watery, itchy, or burning eyes when you DID NOT have a cold or the flu?	<input type="checkbox"/> Yes <input type="checkbox"/> No
33. When you are near animals (such as cats, dogs, or horses) or near feathers (including pillows, quilts, or comforters) or in a dusty or moldy part of the house, do you ever:	
a. start to cough?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. start to wheeze?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. get a feeling of tightness in your chest?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. get a runny or stuffy nose or start to sneeze?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. get itching or watering eyes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
34. When you are near trees, grass, or flowers, or when there is a lot of pollen in the air, do you ever:	
a. start to cough?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. start to wheeze?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. get a feeling of tightness in your chest?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. get a runny or stuffy nose or start to sneeze?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. get itching or watering eyes?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**For Research Coordinator use only:** CRF was:       Self-administered       Interviewer-administered