



Participant ID:

Participant Initials:

Site:

Visit Number:

CRF Date:

RC ID:

MEDICAL HISTORY – SYMPTOMS AND CLINICAL HISTORY

Cardiovascular History:

1. Have you ever been told by a doctor you had a heart attack or myocardial infarction?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
a. If yes, when?	_____ / _____ (MM/YY) _____ / _____ (MM/YY) _____ / _____ (MM/YY) _____ / _____ (MM/YY)
2. Have you ever been told you have/had atrial fibrillation?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
a. If yes, what was the date of the first episode?	_____ / _____ / _____ (MM/DD/YY)
3. Have you ever been diagnosed with heart failure?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
a. If yes, when?	_____ / _____ (MM/YY)
b. If yes, were you hospitalized for heart failure?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
i. If yes, when?	_____ / _____ (MM/YY)
4. Have you ever been told by a doctor you had a stroke (brain attack)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know

COVID-19 History:

5. Has a healthcare provider ever told you that you had COVID-19?	<input type="checkbox"/> No <input type="checkbox"/> Yes, definitely <input type="checkbox"/> Yes, probably or suspected
a. What was the approximate date of this illness?	____ / ____ / ____ (MM/DD/YY)
b. Have you recovered to your usual state of health from your COVID-19 illness?	<input type="checkbox"/> No <input type="checkbox"/> Yes

Hypertension History:

6. Has a doctor or other health professional ever told you that you have hypertension or high blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
a. If YES , how old were you when you were first told you had this condition?	_____ years old <input type="checkbox"/> Don't Know
b. Do you currently take prescribed medication for your hypertension or high blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know



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High Cholesterol History:

7. Has a doctor or other health professional ever told you that your blood cholesterol level was high?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
a. If YES , how old were you when you were first told you had this condition?	_____ years old <input type="checkbox"/> Don't Know
b. Do you currently take prescribed medication for your high blood cholesterol?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know

Diabetic History:

8. Has a doctor or other health professional ever told you that you have diabetes or high blood sugar?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
a. If YES , how old were you when you were first told you had this condition?	_____ years old <input type="checkbox"/> Don't Know
b. Was this during pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
i. If YES , during pregnancy were you treated with insulin?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
c. Have you ever been treated for your diabetes without insulin? For example, with diet and pills only	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
d. Do you currently take prescribed medication for your diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know

Respiratory Health:

Past Illnesses	
9. Have you ever had chronic bronchitis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. Do you still have it?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Does not apply
b. Was it confirmed by a doctor?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Does not apply
c. At what age did it start?	_____ years old <input type="checkbox"/> Does not apply
10. Have you ever had asthma?	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. Do you still have it?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Does not apply
b. Was it confirmed by a doctor?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Does not apply
c. At what age did it start?	_____ years old <input type="checkbox"/> Does not apply



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d. If you no longer have it, at what age did it stop?

_____ years old Does not apply

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