PHYSICIAN QUESTIONNAIRE FOR DECEDENTS

Please complete the following questions to the best of your ability by completely filling in the appropriate circle or writing the answer neatly in the blank provided. Then please return it in the enclosed self-addressed, stamped envelope. Thank you for your contribution to the Cardiovascular Health Study.

PHYSICIAN: _____

A. Details of death

1. Are you familiar with the events surrounding the decedent's death

   ○ 1 YES ○ 0 NO

2. Did you witness the death?

   ○ 1 YES ○ 0 NO

If you answered YES to Question 1 or Question 2 or both, please skip to Question 4.

3. If you answered NO to both Questions 1 and 2, are you aware of another physician who could provide information regarding the death?

   ○ 1 YES ○ 0 NO

   If you answered NO, please skip to the top of page 3.

   If you answered Yes, please provide the physician's name and address, then skip to the top of page 3.

   Name of physician: _____

   Address: _____

   _____

4 Please describe briefly the events surrounding the death:

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Public reporting burden for the collection of information is estimated to average 5 minutes, including the time for reviewing instructions, gathering needed information and completing and reviewing the questionnaire. If you have comments regarding this burden please send them to Reports Clearance Officer, PHS, 721 -H Hubert H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201, Attention:PRA, and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

5. What do you believe to be the cause or causes of death? Please answer all parts of this question.

	1 Yes	0 No	9 UK
CARDIAC ARREST	○	○	○
ACUTE MYOCARDIAL INFARCTION	○	○	○
ACUTE ISCHEMIC HEART DISEASE	○	○	○
CORONARY INSUFFICIENCY OR CHRONIC ISCHEMIC HEART DISEASE	○	○	○
ARRHYTHMIA	○	○	○
SPECIFY:			
CONGESTIVE HEART FAILURE OR CONGESTIVE CARDIOMYOPATHY	○	○	○
ACUTE PULMONARY EDEMA	○	○	○
RESPIRATORY FAILURE	○	○	○
PULMONARY EMBOLISM	○	○	○
PNEUMONIA	○	○	○
CEREBROVASCULAR DISEASE/STROKE	○	○	○
OTHER CAUSE	○	○	○
SPECIFY:			
OTHER CAUSE	○	○	○
SPECIFY:			
OTHER CAUSE	○	○	○
SPECIFY:			

6 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.

- ○ 1.) LESS THAN 1 MINUTE
- ○ 2.) 1 TO 5 MINUTES
- ○ 3.) 5 MINUTES TO 1 HOUR
- ○ 4.) 1 HOUR TO 6 HOURS
- ○ 5.) 6 TO 12 HOURS
- ○ 6.) 12 TO 24 HOURS
- ○ 7.) MORE THAN 24 HOURS
- ○ 9.) UNKNOWN

B. Acute Symptoms

7. Was there an acute episode of pain in the chest, left arm or jaw during the 72 hours prior to death?

○ 1 Yes ○ 0 No ○ 9 Unknown

8. Did the decedent take or was s/he given nitrates or nitroglycerin at the time of the acute episode?

○ 1 Yes ○ 0 No ○ 9 Unknown

9. Did the decedent take or receive any other medicines at the time of the acute episode?

○ 1 Yes ○ 0 No ○ 9 Unknown

If you answered YES, please specify the medication(s):

10. Was coronary reperfusion (intravenous or intracoronary streptokinase, urokinase or TPA, angioplasty, etc.) attempted between the acute episode and death?

○ 1 Yes ○ 0 No ○ 9 Unknown

If you answered YES, please specify the agent(s) or procedure:

11. Was cardiopulmonary resuscitation performed within 24 hours prior to death?

○ 1 Yes ○ 0 No ○ 9 Unknown

12. Was cardioversion performed within 24 hours prior to death?

○ 1 Yes ○ 0 No ○ 9 Unknown

13. Did the patient complain of severe headache during the acute episode?

○ 1 Yes ○ 0 No ○ 9 Unknown

14. Did the decedent go into a coma prior to death?

○ 1 Yes ○ 0 No ○ 9 Unknown

C. Medical history

15. Are you familiar with the decedent's past medical history?

○ 1 Yes ○ 0 No ○ 9 Unknown

If you answered No, please skip to the bottom of this page.

16. Did the decedent have a past medical history of any of the following conditions/procedures/medications prior to the acute event which led to death?

	1-Yes	0-No	9-Unk
A. MYOCARDIAL INFARCTION	○	○	○

If Yes, date of first MI: ☐☐ / ☐☐ / ☐☐☐☐

Date of most recent MI: ☐☐ / ☐☐ / ☐☐☐☐

	1-Yes	0-No	9-Unk
B. ANGINA PECTORIS, CORONARY INSUFFICIENCY OR OTHER CHRONIC ISCHEMIC HEART DISEASE	○	○	○

If Yes, date of first diagnosis: ☐☐ / ☐☐ / ☐☐☐☐

	1-Yes	0-No	9-Unk
C. VALVULAR DISEASE	○	○	○
D. CONGESTIVE HEART FAILURE OR CONGESTIVE CARDIOMYOPATHY	○	○	○

If Yes, date of first diagnosis: ☐☐ / ☐☐ / ☐☐☐☐

	1-Yes	0-No	9-Unk
E. ATRIAL FIBRILLATION/FLUTTER	○	○	○
F. VENTRICULAR TACHYCARDIA	○	○	○
G. STROKE (CVA)	○	○	○

If Yes, date of first CVA: ☐☐ / ☐☐ / ☐☐☐☐

Date of most recent CVA: ☐☐ / ☐☐ / ☐☐☐☐

	1-Yes	0-No	9-Unk
H. TRANSIENT ISCHEMIC ATTACK	○	○	○

If Yes, date of first diagnosis: ☐☐ / ☐☐ / ☐☐☐☐

	1-Yes	0-No	9-Unk
I. SYNCOPE	○	○	○
J. INTERMITTENT CLAUDICATION OR OTHER PERIPHERAL VASCULAR DISEASE	○	○	○

If Yes, date of first diagnosis: ☐☐ / ☐☐ / ☐☐☐☐

	1-Yes	0-No	9-Unk
K. LOWER EXTREMITY BYPASS, ANGIOPLASTY OR AMPUTATION SECONDARY TO PERIPHERAL VASCULAR DISEASE	○	○	○
L. CORONARY BYPASS SURGERY	○	○	○
M. CORONARY ANGIOPLASTY	○	○	○
N. CARDIO-PULMONARY RESUSCITATION	○	○	○
O. CARDIAC ARREST	○	○	○
P. THROMBOLYTIC THERAPY	○	○	○

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

Chief complaint: _____

Date of Visit: ☐☐ / ☐☐ / ☐☐☐☐

Primary diagnosis: _____

Changes in medical management:

_____

_____

Thank you very much for your contribution to the Cardiovascular Health Study. Please sign and date this questionnaire below and return it to us in the self-addressed, stamped envelope. If you do not have the envelope, the mailing address is:

_____

_____

Form completed by: (Signature) _____

Date: ☐☐ / ☐☐ / ☐☐☐☐