



Exam 6
Home Visit:
Medical History
Interviewer Administered

Participant ID #:

Acrostic:

Technician ID:

Date: / /
Month Day Year

The following are some questions about your medical history. Please answer to the best of your knowledge.

1. In general, would you say your health is:

- ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

2. How would you say your health currently compares with other persons of your age?

- ☐ Better ☐ Same ☐ Worse

The following two questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
3. MODERATE ACTIVITIES, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Climbing SEVERAL flights of stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

During the PAST 4 WEEKS, have you had any of the following problems with your work or other regular activities AS A RESULT OF YOUR PHYSICAL HEALTH?

	Yes	No
5. ACCOMPLISHED LESS than you would like	<input type="radio"/>	<input type="radio"/>
6. Were limited in the KIND of work or other activities	<input type="radio"/>	<input type="radio"/>

During the PAST 4 WEEKS, were you limited in the kind of work you do or other regular activities AS A RESULT OF ANY EMOTIONAL PROBLEMS (such as feeling depressed or anxious)?

	Yes	No
7. ACCOMPLISHED LESS than you would like	<input type="radio"/>	<input type="radio"/>
8. Didn't do work or other activities as CAREFULLY as usual	<input type="radio"/>	<input type="radio"/>

	Not at all	A little bit	Moderately	Quite a bit	Extremely
9. During the PAST 4 WEEKS, how much did PAIN interfere with your normal work (including both work outside the home and housework)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



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The next three questions are about how you feel and how things have been DURING THE PAST 4 WEEKS. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the PAST 4 WEEKS -

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
10. Have you felt calm and peaceful?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Did you have a lot of energy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Have you felt downhearted and blue?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. During the PAST 4 WEEKS, how much of the time has your PHYSICAL HEALTH OR EMOTIONAL PROBLEMS interfered with your social activities (like visiting with friends, relatives, etc.)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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14. Are you unable to walk due to a condition other than shortness of breath?

☐ Yes

☐ No



What is the nature of the condition?

(skip to question 19)

	Yes	No	Don't know
15. Do you get short of breath when hurrying on level ground or walking up a slight hill?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. Do you walk slower than people of the same age on level ground because of breathlessness or have to stop for breath when walking at your own pace on level ground?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. Do you stop for breath after walking about 100 yards or after a few minutes on level ground?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. Are you too breathless to leave the house or breathless when dressing?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. Are you taking aspirin on a regular basis?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If Yes → a. How many days a week?



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20. Do you usually have a cough on most days for 3 or more months during the year?

- ☐ Yes → For how many years have you had this cough? years
- ☐ No

21. Do you usually bring up phlegm from your chest on most days for 3 or more months during the year?

- ☐ Yes → For how many years have you brought up phlegm from your chest like this? years
- ☐ No

22. In the last 12 months, have you had wheezing or whistling in your chest?

- ☐ Yes
- ☐ No → Skip to Q23

a. In the last 12 months, how often have you had this wheezing or whistling? (*Read the options*)

- ☐ most days or nights ☐ a few days or nights a **month**
- ☐ a few days or nights a **week** ☐ a few days or nights a **year**

b. In the last 12 months, have you had an attack of wheezing or whistling in the chest that has made you feel short of breath?

- ☐ Yes
- ☐ No

Has a doctor ever told you that you have any of the following conditions?

Note: Skip any of 23-30 if previously reported

	Yes	No	Don't know
23. Diabetes?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If Yes → a. Are you currently taking medicine for your diabetes?

- ☐ Yes →
- ☐ No
- ☐ Unsure
- What kind of medicine are you taking for your diabetes?

☐ Pills ☐ Insulin and pills

☐ Insulin ☐ Other injections



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Has a doctor ever told you that you have any of the following conditions?

Note: Skip any of 23-30 if previously reported

	Yes	No	Don't know
24. High blood pressure?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25. High cholesterol?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26. Emphysema or Chronic Obstructive Pulmonary Disease (COPD)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
27. Asthma?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If Yes →

a. For some people, asthma symptoms completely go away as they grow older. Later in life, however, asthma may recur. At approximately what ages did you experience each of the following events?

Age developed first asthma symptoms	<input type="text"/> <input type="text"/> years	<input type="radio"/> As a child (age not known)	<input type="radio"/> Don't know
Age doctor first diagnosed asthma	<input type="text"/> <input type="text"/> years	<input type="radio"/> Never diagnosed by a doctor	<input type="radio"/> Don't know
Age at start of 10 year (or more) period without asthma symptoms	<input type="text"/> <input type="text"/> years	<input type="radio"/> Not applicable (symptoms never went away for 10 or more years)	<input type="radio"/> Don't know
Age at first recurrence of asthma symptoms	<input type="text"/> <input type="text"/> years	<input type="radio"/> Not applicable	<input type="radio"/> Don't know

	Yes	No	Don't know
28. Atrial Fibrillation?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
29. Kidney disease?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If Yes → a. Did you have kidney failure, requiring dialysis or transplantation?

☐ Yes ☐ No



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Has a doctor ever told you that you have any of the following conditions?

Note: Skip any of 23-30 if previously reported

Yes No Don't know

30. Has your doctor or health care provider ever told you that you had a kidney stone? ☐ ☐ ☐

If Yes —————> a. How old were you during your first stone episode? Age

b. How many kidney stones have you had in the past?

☐ None ☐ 1 ☐ 2-5 ☐ More than 5

If No —————> go to Question 32

Yes No Don't know

31. Did you pass a kidney stone since your last MESA visit? ☐ ☐ ☐

If Yes —————> a. How many kidney stones did you pass?

☐ 1 ☐ 2 - 5 ☐ More than 5

Yes No Don't know

32. Have any first degree relatives (i.e. mother, father, siblings, children) ever had a kidney stone? ☐ ☐ ☐

33. Has a dentist ever told you that you had periodontitis, or that you had bone loss around your teeth? ☐ ☐ ☐

34. Has a dentist ever told you that you had gum disease? ☐ ☐ ☐

35. *For participants with history of pacemaker or implanted cardioverter defibrillator based on prior event investigation (skip if answered at FU18):*

a. Based on your prior MESA interviews, I see that you have had a [pacemaker or other device type from investigation] implanted on Month/Day/Year [CC inserts date of insertion based on event investigation]. Is that right? Do you still have an implanted device?

☐ Yes ☐ No ☐ Don't know

For participants without history of device:

b. Do you have an implanted cardiac pacemaker or an implanted cardioverter-defibrillator (ICD)?

☐ Yes ☐ No ☐ Don't know



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(Q35 continued)

If yes to a or b:

c. Is it a cardiac pacemaker or a cardioverter-defibrillator?

- ☐ cardiac pacemaker ☐ cardioverter-defibrillator

d. What doctor do you see for regular evaluation of that device?

Name:

City, state:

Reproductive History (WOMEN ONLY -- MEN are finished with this questionnaire.)

36. Between the ages of 16 and 40, about how long was your average menstrual cycle (time from first day of one period to the first day of the next period)?

- ☐ Less than 25 days
☐ 25-43 days
☐ 35-60 days
☐ More than 60 days
☐ Totally variable

Yes

No

Don't know

37. Have you ever had hot flashes or night sweats related to menopause?

☐

☐

☐

If Yes →

a. At what age did the hot flashes or night sweats start?

☐ Don't know

b. At what age did the hot flashes or night sweats end?

☐ Still ongoing

☐ Don't know

c. Were the symptoms:

- ☐ Mild (symptom did not interfere with usual activities)
☐ Moderate (symptom interfered somewhat with usual activities)
☐ Severe (symptom was so bothersome that usual activities could not be performed)

38. At what age did you go through menopause (change of life)?

(skip if previously reported)

39. Did you go through menopause naturally, or as a result of surgery (hysterectomy or removal of both ovaries)?

- ☐ Naturally
☐ As a result of surgery
☐ Don't know



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If participant has previously reported removal of both ovaries -- skip to question 40c

40. Have you had surgery to remove your ovaries?

	Yes	No	Don't know
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	↓	↓	↓
	Go to Q41	Go to Q41	Go to Q41

a. At what age? ☐ Don't know

b. How many ovaries were removed?

☐ 1 ☐ 2

c. What was the reason for removing your ovaries? (Select all that apply)

<input type="checkbox"/> Ovarian cyst	<input type="checkbox"/> Removed at the time of a hysterectomy
<input type="checkbox"/> Ovarian cancer	<input type="checkbox"/> Removed at the time of a tubal ligation to prevent pregnancy
<input type="checkbox"/> Non-cancerous tumor	<input type="checkbox"/> Endometriosis
<input type="checkbox"/> Family history of ovarian cancer or breast cancer	<input type="checkbox"/> Don't know
	<input type="checkbox"/> Other, please specify: <input type="text"/>

d. Were you still having menstrual periods at the time of the surgery?

	Yes	No	Don't know
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If No → How long before surgery did your periods stop? ☐ months ☐ Don't know
☐ years

If participant has previously reported hysterectomy -- skip to question 41b

41. Have you had a hysterectomy (surgery to remove your uterus/womb)?

	Yes	No	Don't know
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	↓	↓	↓
	Go to Q42	Go to Q42	Go to Q42

a. At what age? ☐ Don't know

b. What was the reason for removing your uterus? (Select all that apply)

<input type="checkbox"/> Fibroids	<input type="checkbox"/> Prolapse
<input type="checkbox"/> Endometrial (uterine) cancer	<input type="checkbox"/> Endometriosis
<input type="checkbox"/> Heavy bleeding	<input type="checkbox"/> Family history of ovarian cancer or endometrial cancer
<input type="checkbox"/> Pregnancy/delivery complication	<input type="checkbox"/> Don't know
<input type="checkbox"/> Cervical cancer	<input type="checkbox"/> Other, please specify: <input type="text"/>

c. Were you still having menstrual periods at the time of the surgery?

	Yes	No	Don't know
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If No → How long before surgery did your periods stop? ☐ months ☐ Don't know
☐ years



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42. Have you ever used birth control pills?

☐ Yes

→

At what age did you stop taking birth control pills?

☐ Don't know

☐ No

43. Since your last MESA visit, have you taken hormone replacement therapy?

☐ No

→

Questionnaire Completed

☐ Yes

→

a. Are you currently using hormone replacement therapy?

☐ Yes

→

At what age did you begin?

☐ Don't know

☐ No

→

At what ages did you take hormones?

Age started

☐ Don't know

Age stopped

☐ Don't know

b. Which type of therapy were you on?

☐ Estrogen alone (like Premarin or Estratab)

☐ Estrogen with progestin (like Prempro)

☐ Other types of hormone replacement therapy

Specify:

☐ Don't know