

**Multi-Ethnic Study of Atherosclerosis  
Exam 4**



*Clinic Check off Sheet*

**Participant Id#:**

**Acrostic:**

Clinic Exam Date: \_\_ / \_\_ / \_\_\_\_

Order	Start Time	End Time	Form / Procedure	Comments / Notes	Tech ID
1			Reception (Consent & Participant Contact Form) <i>Meds: Y N S Diabetic: Y N Fasting Time: _____</i>		
2			Anthropometry		
3			Seated Blood Pressure <i>Cuff size: _____ Arm Circum: _____</i>		
4			Phlebotomy		
5			Snack		
			Medical History		
			Medications		
			Personal History <input type="checkbox"/> <i>Completed in clinic</i> <input type="checkbox"/> <i>Sent home with participant</i>		
			Health and Life Questionnaire		
			Sleep Questionnaire		
			Exit		
			MRI Appointment Day: _____ Date: _____ Time: _____		
			CT Appointment Day: _____ Date: _____ Time: _____		
			Ultrasound Appointment Day: _____ Date: _____ Time: _____		

**DO NOT SCAN**