

**Multi-Ethnic Study of Atherosclerosis**



**Physician Questionnaire:  
Cardiovascular Death**

**Participant ID:** 8000028 02

**Hospital Code:**

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**Sequence Num:**

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Public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD, 20892-7974, ATTN: PRA 0925- . Do not return the completed form to this address.

Please complete the following questions to the best of your ability by filling in the appropriate bubbles or writing the answer in the blank provided. Please return completed forms in the self addressed stamped envelope provided. Thank you for your contribution to MESA.

**Details of Death**

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

- Yes       No

2. Did you witness the death?

- Yes       No

*If you answered "Yes" to both or either of Questions 1 and 2, please skip to Question 4.*

3. If you answered "No" to both Questions, are you aware of another physician who could provide information regarding the death?

- Yes       No

*If "No," please sign and date the form at the bottom of page 2.*

*If "Yes," please provide the physician's name and address, then sign and date the form at the bottom of page 2.*

Name of physician: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Circumstances Surrounding Death**

4. What do you believe to be the underlying cause of death?

- Acute Myocardial Infarction
- Other Ischemic Heart Disease
- Cerebrovascular Disease
- Other Cardiovascular Disease
- Non-Cardio/Cerebrovascular  
(Please specify)

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5. 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.

- Less than 5 minutes
- 5 minutes to 1 hour
- 1 hour to 24 hours
- More than 24 hours
- Unknown

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

- Yes       No       Unknown

7. Was there an acute episode of shortness of breath during the 72 hours prior to death?

- Yes       No       Unknown

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

- Yes       No       Unknown

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**Medical History**

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

- Yes       No

*If you answered "No," please skip to the bottom of the page*

10. Did the decedent have a medical history of any of the following conditions or medications prior to the acute event which led to death?

Myocardial Infarction (MI)

- Yes       No       Unknown

If "Yes," date of most recent MI:

/   /      
 Month                  Day                  Year

Angina Pectoris, Coronary Insufficiency or Other Chronic Ischemic Heart Disease

- Yes       No       Unknown

If "Yes," date of first diagnosis:

/   /      
 Month                  Day                  Year

Congestive Heart Failure (CHF) or Congestive Cardiomyopathy

- Yes       No       Unknown

Stroke (CVA)

- Yes       No       Unknown

If "Yes," date of most recent CVA:

/   /      
 Month                  Day                  Year

*Continued next column*

Transient Ischemic Attack (TIA)

- Yes       No       Unknown

If "Yes," date of first diagnosis:

/   /      
 Month                  Day                  Year

Intermittent Claudication or Other Peripheral Vascular Disease (PVD)

- Yes       No       Unknown

Lower Extremity Bypass, Angioplasty or Amputation Secondary to PVD

- Yes       No       Unknown

Coronary Bypass Surgery

- Yes       No       Unknown

Coronary Angioplasty

- Yes       No       Unknown

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

Date of Visit:

/   /      
 Month                  Day                  Year

Chief Complaint: \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_

Changes in Medical Management: \_\_\_\_\_

Form completed by: \_\_\_\_\_ Date: \_\_\_\_\_

For MESA Field Center Use Only:

/   /

Reviewer ID:

Data Entry ID: