

Multi-Ethnic Study of Atherosclerosis



Physician Questionnaire:
Cardiac/PVD

Participant ID: 8000028 02

Sequence Num: (For MESA Field Center use only)

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Participant Name: _____

Date-of-Birth: ____/____/____

Please complete only this page if participant has not had any condition listed in Question 2 below, OR if you are not familiar with participant's medical history.

Please fill in the appropriate bubbles and write responses in the blanks provided.

1. Are you familiar with the participant's medical history?

Yes No →

Please complete Question 2 below.

Are you aware of another physician who could provide information regarding this participant?

Yes No

Please sign and date the form at the bottom of page 4 and return form.

Please fill in the physician's name and address, sign and date the form at the bottom of page 4 and return form.

2. In your opinion, has the participant had any of the conditions below? (Please check any that apply.)

- MI *Please complete section A on page 2.*
- Angina *Please complete section B on page 2.*
- CHF *Please complete section C on page 2.*
- PAD/AA* *Please complete section D on page 2.*

None ***Please sign and date at the bottom of page 4 and return form.***

If participant has had any of the conditions listed, we would appreciate copies of pertinent office notes, including physical exams, reports of stress tests, caths and EKGs.

* Peripheral Arterial Disease/Aortic Aneurysm.

A. Myocardial Infarction

Has the participant ever been diagnosed with a myocardial infarction?

- Yes No Unknown

If "Yes," when was the most recent event of this type?

		/			/				
Month			Day			Year			

Was the participant hospitalized?

- Yes No Unknown

If "Yes," where was the participant hospitalized?

Name of Hospital: _____

City, State: _____

The certainty of the diagnosis is:

- Definite Probable

Go to next relevant section or, if none, skip to Question 3.

B. Angina

Has the participant ever been diagnosed with angina pectoris or coronary insufficiency?

- Yes No Unknown

If "Yes," did s/he have chest pain or equivalent, or was the diagnosis only the result of diagnostic tests?

- Pain or pain equivalent
 No pain; diagnostic testing only

If pain (or pain equivalent), when was the most recent episode of this type?

		/			/				
Month			Day			Year			

Was the participant hospitalized for angina/coronary insufficiency?

- Yes No Unknown

If "Yes," where was the participant hospitalized?

Name of Hospital: _____

City, State: _____

The certainty of the diagnosis is:

- Definite Probable

Go to next relevant section or, if none, skip to Question 3.

C. CHF

Has the participant ever been diagnosed with congestive heart failure or congestive cardiomyopathy?

- Yes No Unknown

If "Yes," when was the most recent episode of this type?

		/			/				
Month			Day			Year			

Was the participant hospitalized?

- Yes No Unknown

If "Yes," where was the participant hospitalized?

Name of Hospital: _____

City, State: _____

The certainty of the diagnosis is:

- Definite Probable

Go to next relevant section or, if none, skip to Question 3.

D. PAD

Has the participant ever been diagnosed with claudication, peripheral artery disease, or abdominal aortic aneurysm?

- Yes No Unknown

If "Yes," when was the most recent episode of this type?

		/			/				
Month			Day			Year			

Was the participant hospitalized?

- Yes No Unknown

If "Yes," where was the participant hospitalized?

Name of Hospital: _____

City, State: _____

The certainty of the diagnosis is:

- Definite Probable

Go to next relevant section or, if none, skip to Question 3.

3. Please complete the following sections for the most recent event.

If participant has been diagnosed with MI, Angina or CHF, please complete all sections on pages 3 and 4.

If participant has been diagnosed with PAD only, complete only relevant items in sections a and b.

Section a.

Which (if any) of the following diagnostic tests did the participant have? (Please attach copy of report.)

	Yes	No	Unknown
Electrocardiogram	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trial of Nitroglycerin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Excercise Tolerance Test	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
---With Thallium?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cardiac Enzymes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Echocardiogram	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Angiography	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chest X-Ray	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If Other, please specify:

Pertinent Results: _____

Section b.

Which (if any) of the following procedures were done?
When were they performed?

Cardiac Catheterization Yes No Unknown

Date: / /

Month Day Year

Angioplasty or Stent Placement Yes No Unknown

Date: / /

Month Day Year

CABG (Coronary Artery Bypass Graft) Yes No Unknown

Date: / /

Month Day Year

Intravenous or Intracoronary Thrombolytic Therapy (TPA, Streptokinase) Yes No Unknown

Date: / /

Month Day Year

Leg angioplasty or other leg revascularization Yes No Unknown

Date: / /

Month Day Year

Section c.

Which (if any) of the following medications were prescribed as a therapy?

	Yes	No	Unknown
Nitroglycerin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Beta-Blockers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Calcium Channel Blockers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Aspirin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diuretics	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ace Inhibitors	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Digitalis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Oxygen	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other Vasodilators	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If other, please specify:

Section d.

Were any of the following present?

	Yes	No	Unknown
Chest pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Jugular Venous Distention	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Carotid Bruit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Basilar Rales or Crackles Only	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rales or Crackles Above Bases	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wheezing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
S-3 Gallop	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cardiac Murmur	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hepatojugular Reflex	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hepatomegaly	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Peripheral/Ankle Edema	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Thank you very much for your contribution to MESA. Please sign and date this questionnaire and return it to us in the self-addressed, stamped envelope with copies of pertinent office notes or tests. If you do not have the envelope, the address is:

Notes: _____

Form completed by: _____ Date: _____

For MESA Field Center Use Only:												
		/			/							
						Reviewer ID:				Data Entry ID:		