

Multi-Ethnic Study of Atherosclerosis
Follow-up Phone Call 16



General Health

Participant Id#:

Acrostic:

Date:

Month

Day

Year

INTRODUCTION

Hello, my name is [interviewer name], and I'm calling to speak with [participant name]. Is [participant name] available?

If no → When would it be convenient to call back? _____ Thank you. I will call again.

If yes → Hello, [participant name], this is [interviewer name] with the [MESA/MESA Air] Study. I'm calling to see how you have been since our last telephone interview with you and update our [MESA/MESA Air] records. Do you have a few minutes to speak on the phone?

If No → When would it be convenient to call back? _____
Thank you. I will call again.

If Yes → We'd like to ask you some questions about your general health and specific medical conditions since our last telephone interview with you on _____. I realize that we have asked you some of these questions several times, but learning about changes in your health is very important in helping us understand more about the causes of heart disease and stroke and how these diseases may be related to other things in your life.

First, I'd next like to make sure our records are up to date. Could you please tell me if the following information I have is still correct?

(Go to "Participant Tracking" form and verify the tracking information that appears in the left-hand column)

1 Would you say, in general, your health is (read all response categories except Unsure)

- Excellent Good Poor
 Very Good Fair Unsure

2 Since our last telephone interview with you, have you at any time seen a doctor or other health care professional?
Optional: A 'health care professional' is a doctor, nurse, nurse practitioner, or other certified specialist working in a clinic, hospital, or ambulance. This person may also be a practitioner of non-Western medicine (e.g. an acupuncturist or Asian herbalist) but should not include chiropractors, exercise instructors, or diet coaches.

(Circle answer)

- Yes No

Since our last telephone interview with you, have you had an overnight stay in a hospital or nursing home?

(Circle answer)

- Yes No

Did the participant answer 'Yes' to either part of Question 2 (seen a health professional or overnight stay)?

Yes
↓
Go to Question 3a

No
 Unsure
↓
Skip to Question 7

3a Has your doctor or health care professional told you that you had diabetes?

- Unsure (Go to question 3b)**
- No (Go to question 3b)**
- Yes** → **If Yes to Diabetes :**

Is this a new diagnosis since our last telephone interview with you?

- Unsure**
- No**
- Yes**

3b Has your doctor or health care professional told you that you had one of the following since our last telephone interview with you? **(Read each diagnosis.)**

	Yes	No	Unsure
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If Yes: Was this a new diagnosis since our last contact with you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High Cholesterol Level	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If Yes: Was this a new diagnosis since our last contact with you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4 Since our last telephone interview with you, has a doctor or health care professional told you that you had any of the following? **(read each diagnosis):**

	Yes	No	Unsure
A myocardial infarction or heart attack-----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Angina pectoris or chest pain due to heart disease-----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart failure or congestive heart failure-----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Peripheral arterial disease, intermittent claudication or pain in your legs from a blockage of the arteries-----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Atrial fibrillation-----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Deep vein thrombosis or blood clots in your legs-----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A transient ischemic attack (TIA) or mini-stroke-----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A stroke-----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Blockage in the carotid artery-----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cancer-----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



Complete "Specific Medical Conditions" form for each item with a Yes response.

5 Since our last telephone interview with you, have you had any other condition that resulted in an:

	Yes	No	Unsure
Overnight Hospital stay	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Overnight Stay at a nursing home or rehabilitation center	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



Complete "Other Admissions" form for each item with a Yes response.

6 Since our last telephone interview with you, have you had any of the following tests or procedures in or out of the hospital? (read each procedure):

	Yes	No	Unsure
An angioplasty procedure or stent to open up arteries to your heart	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coronary bypass surgery	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
An angioplasty procedure or stent to open up arteries in either of your legs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



Complete "Specific Medical Procedures" form for each item with a Yes response.

7 Which of the following best describes your current smoking status?

- Never smoked → **Skip to Question 10**
- Former smoker, quit more than 1 year ago → **Skip to Question 10**
- Former smoker, quit less than 1 year ago
- Current smoker
- Don't know

8 Have you smoked cigarettes during the last 30 days?

- Yes
- No → **Skip to question 10**

9 On average, about how many cigarettes a day do you smoke?

--	--	--

10 During the past year about how many hours per week were you in close contact with people when they were smoking? (e.g. in your home, in a car, at work or other close quarters)

--	--	--

11 Did anyone smoke in your residence in the past 12 months? (This includes you.)

- Yes →
- No
- Don't Know

11a On average, how often did someone smoke in your residence in the past 12 months?

- Less than once a month
- A few days each month
- More than half of the days of the month, but less than daily
- Every day or almost every day

12 Have you ever used an electronic cigarette or e-cigarette?

- Yes →
- No
- Don't Know

12a When did you start using e-cigarettes?

--	--

Month

--	--	--	--

Year

12b Do you still use e-cigarettes? Yes No Don't Know

If yes, skip to 12d

12c When did you stop using e-cigarettes?

--	--

Month

--	--	--	--

Year

12d How often do/did you use e-cigarettes?

- Every day
- Most days (4 or more days per week)
- Some days (1-3 days per week)
- Less than once a week
- Less than once a month

12e How many times a day do/did you use an e-cigarette?

12f In one week, how many e-cigarettes cartridges do/did you use?

12g What brand of e-cigarettes do/did you use?

- blu
- NJOY
- Henley
- V2
- Joye
- Other, please specify:

--

- | | Yes | No | Don't Know |
|--|-----------------------|-----------------------|-----------------------|
| 13 When walking on level ground, do you get more breathless than people your own age? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 14 When walking up hills or stairs, do you get more breathless than people your own age? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 15 Do you ever have to stop walking because of breathlessness? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 16 Are you taking aspirin on a regular basis? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
- If Yes → How many days a week?

17 Since [Date of last Medications Form] have you taken any non-aspirin blood thinners or anticoagulants?

- Yes →
- No
- Don't Know
- Refused

17a Which blood thinner or anticoagulant have you taken since [Date of last Medications Form]? (check all that apply)

- | | |
|---|---|
| <input type="radio"/> Coumadin [warfarin] | <input type="radio"/> Brilinta [ticagrelor] |
| <input type="radio"/> Plavix [clopidogrel] | <input type="radio"/> Effient [prasugrel] |
| <input type="radio"/> Pradaxa [dabigatran] | <input type="radio"/> Persantine [dipyridamole] |
| <input type="radio"/> Xarelto [rivaroxaban] | <input type="radio"/> Savaysa [edoxaban] |
| <input type="radio"/> Equilis [apixiban] | <input type="radio"/> Other, please specify: <input type="text"/> |
| | <input type="radio"/> Don't Know |

17b What month and year did you start taking [insert drug name]?

Start date:

Month

Year

Don't Know

17c What month and year did you stop taking [insert drug name]?

Stop date:

Month

Year

Don't Know

If still taking drug, enter 99/9999

17d Did you start and stop [insert drug name] more than once since your last Medications Questionnaire?

Yes No Don't Know

*If yes, go to Q17e
If no, ask Q17b-f for next drug or if no other drugs reported in 17a, go to Q18*

17e What is the next month and year that you started taking [insert drug name]?

Start date:

Month

Year

Don't Know

17f What is the next month and year that you stopped taking [insert drug name]?

Stop date:

Month

Year

Don't Know

If still taking drug, enter 99/9999

The next two questions ask about food security, which will help MESA researchers understand how access to healthy food is related to cardiovascular health. Please tell me whether the following statements are often true, sometimes true, or never true.

	Often True	Sometimes True	Never True
18 Within the past 12 months, you worried whether food would run out before you got money to buy more.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19 Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

The next questions ask about your living situation.

20 Do you currently live in:

- Your own home or apartment →
- Assisted living center
- Nursing home
- Other, please specify:

20a Do you get help with your daily activities from a caregiver, friend or relative that allows you to live in your own home or apartment?

Yes No

21 Has a doctor or other health professional ever told you that you had gout?

- Yes →
- No
- Don't know
- Refused

21a How old were you when you were first told you had gout?

Age in years

Don't know Refused

END: Thank you so much for talking with me today. We greatly appreciate your participation in [MESA/MESAAir]. Should you have any questions, please feel free to call us at the clinic at [clinic phone number].

For MESA Field Center Use Only:		Data Collection Method: <input type="radio"/> Computer <input type="radio"/> Paper	
Interviewer ID:	<input type="text"/>	Reviewer ID:	<input type="text"/>
		Data Entry ID:	<input type="text"/>