MESA FU26

Specific Medical Conditions

Participant ID #: ☐☐☐☐☐☐☐ Acrostic: ☐☐☐☐☐☐☐

Technician ID: ☐☐☐☐ Date: ☐☐ / ☐☐ / ☐☐☐☐
Month Day Year

Complete form for each condition reported as 'Yes' on "General Health" or "General Health—Death" form. If the participant has died, change 'you' or 'your' to decedent's name for all questions below.

You said that a doctor or other health care professional told you that you had _____ **(read and mark specific condition name reported previously below)**

- ○ A myocardial infarction or heart attack
- ○ Angina pectoris or chest pain due to heart disease
- ○ Heart failure or congestive heart failure
- ○ Peripheral arterial disease, intermittent claudication or pain in your legs from a blockage of the arteries
- ○ Atrial fibrillation
- ○ Deep vein thrombosis or clots in your legs
- ○ A transient ischemic attack (TIA) or mini-stroke
- ○ Stroke →
- ○ Blockage in the carotid artery
- ○ Cancer, specify type: _____
- ○ COVID-19 infection

Regarding symptoms that you had from your stroke, do you feel that you have made a complete recovery?

○ Yes ○ No ○ Unsure

In the last two weeks, did you require help from another person for everyday activities?

○ Yes ○ No ○ Unsure

A. What was the name and address of the doctor you saw?

[OPTIONAL. Only record name and address if they are use to Events staff.]

Name: _____

Address: _____

_____

B. What was the date of the diagnosis or hospitalization?

(Probe for exact date. If exact date cannot be recalled, ask participant to estimate month and year. Record day as 15).

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Month Day Year

C. Were you in the hospital at least one night for this condition since our last contact with you on [date of last follow up]?

○ Yes ↓

Continue to part D on next page.

○ No →

○ Unsure →

Ask about next condition reported on "General Health" or "General Health—Death" form, and record details on an additional form. If there are no additional conditions, go to next question on "General Health" form.

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D. Would you please tell me the dates of each hospitalization and where you were hospitalized?

(Probe for exact date. If exact date cannot be recalled, ask participant to estimate month and year. Record day as 15.)

	Date	Hospital Code	Length of Stay (days)
(1)	☐☐ / ☐☐ / ☐☐☐☐	☐☐☐☐	☐☐☐
	Month Day Year		
(2)	☐☐ / ☐☐ / ☐☐☐☐	☐☐☐☐	☐☐☐
	Month Day Year		
(3)	☐☐ / ☐☐ / ☐☐☐☐	☐☐☐☐	☐☐☐
	Month Day Year		
(4)	☐☐ / ☐☐ / ☐☐☐☐	☐☐☐☐	☐☐☐
	Month Day Year		
(5)	☐☐ / ☐☐ / ☐☐☐☐	☐☐☐☐	☐☐☐
	Month Day Year		

Ask about the next condition reported as 'Yes' on "General Health" or "General Health-Death" form and record details on an additional form. If condition is "COVID-19 infection", complete part E. If no additional conditions are reported as 'Yes', go to next question on "General Health" form.

Complete part E below if the selected condition is "COVID-19 infection" and answer is 'Yes' to part C (hospitalization).

E. While in the hospital, did you have any of the following? Please check all that apply.

- ○ Oxygen (by mask or nose)
- ○ A breathing tube or ventilator
- ○ "Intensive care unit" or ICU monitoring
- ○ Dialysis
- ○ Unsure
- ○ Decline to answer