

Participant ID #:	Acrostic:
Technician ID:	Date: Month Day Year

Thank you for participating in this MESA survey. The first set of questions ask you to verify your contact information.

1. Please review the phone numbers and email address that we have for you. For each, please verify that the information is correct or select "Delete this number" if it should be removed.

Partici	pant	phone	num	bers:

Home:		0	Correct as is	0	Delete this number
Work:		0	Correct as is	0	Delete this number
Cell:		0	Correct as is	0	Delete this number
Email:		0	Correct as is	0	Delete this email
	ave a new phone number to add?				
0					
O	a. What is your new phone number?			_	
	b. What type of phone number is this?				
	O Home				
	O Cell				
	O Work				
Do you h	ave a new email address to add?				
0	Yes — a. What is your new email address?				
0	No				
	contact you via email or text (check all that apply)? Email Text				



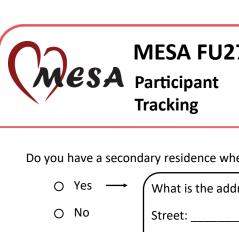
Participant ID #:					Acrostic:				
Technician ID:			D	ate:	/		/		

Month

Day

Year

Do you still live at?
Street:
City:
State:
Zip:
○ Yes
○ No → a. Do you live in the United States?
O Yes → What is your current address?
Street:
City:
State: Zip:
○ No → In what city and country do you live?
City: Country:
In what month and year did you move?
Month:
Year:
you have a different mailing address?
O Yes —
O No
a. What is your mailing address
Street:
City:
State:
Zip:



Dage A	MESA FU27	Participant ID	#: 🔲		Acı	ostic:			
MESA	Participant Tracking	Technician II	D:		Date: Mo	onth D	ay .	/ Year	
Do you have a seco	ondary residence where y	ou spend 4 or mo	re weeks per y	vear?					
○ Yes →	What is the address	of your secondary	residence?						
O No	Street:								
	City:								
	State:								
	Zip:				-				
	When did you begin	using this seconda	ry address?						
	Month:								
	Year:								
	estions will ask you to ver e cannot reach you.	ify the contact info	ormation for t	he friends o	r relatives t	that you ha	ive lis	ted as your	
If contacts are protheir information.	vided: Next we'll review	the contacts that y	ou have name	ed in case w	e can't rea	ch you in th	ne fut	ure. Let's revie	N
If contacts are not future?	provided: Do you have a	contact person th	at we can add	l to your ME	SA record	in case we	can't	reach you in the	е
Contact 1									
Would you like to k	keep the person listed be	low? O Yes O	No						
1) Contact firs	st name								
1) Contact mi									
1) Contact las	t name								
1) Contact sec	cond sur-name								
Was this contact us	sed as a proxy for this int	erview? O Yes	O No						
was tills contact us	sed as a proxy for this life	erview: O res	0 110						
Relationship to p	articipant:								
Spouse	○ Son	O Au	ınt	0	Father-in-	·law	0	Granddaughte	er
Sister	O Daughte	r O Br	other-in-law	0	Friend		0	Grandson	
Brother	O Nephew	O Sis	ster-in-law	0	Neighbor		0	Other relative	
Mother	Niece	O Co	ousin	0	Son-in-lav	v	0	Other	

Mother-in-law

Uncle

O Daughter-in-law

Father



Participant ID #:					Acrostic:					
Technician ID:			D	ate:	Month /	 ay]/	Ye	ar	

Contact p	hone numbers:				
Home: _			Address:		
Work: _			City:		
Cell: _			State:		
Email: _			ZIP:		
Can this p	person provide informa	ation about your health s	status? O Yes O No		
Would yo	u like to keep the pers	on listed below? O Ye	es O No		
<u>Contact</u>	: 2				
2) Con	ntact first name				
2) Cor	ntact middle initial				
2) Con	ntact last name				
2) Cor	ntact second sur-name				
Was tl	his contact used as a p	roxy for this interview?	P O Yes O No		
Relatio	onship to participant:				
0	Spouse	O Son	O Aunt	O Father-in-law	O Granddaughter
0	Sister	O Daughter	O Brother-in-law	O Friend	O Grandson
0	Brother	O Nephew	O Sister-in-law	O Neighbor	O Other relative
0	Mother	O Niece	O Cousin	O Son-in-law	O Other
0	Father	O Uncle	O Mother-in-law	O Daughter-in-law	
Contact	t phone numbers:				
Home:			Address:		
Work:			City:		
Cell:			State:		
Email:			ZIP:		
Can this	s person provide infor	mation about your healt	lth status? O Yes O No		



Participant ID #:					Acrostic:				
Technician ID:			D	ate:]/		

Iracking		oran izi	Month Day	Year
Would you like to keep the person	listed below? O Ye	s O No		
Contact 3				
3) Contact first name				
3) Contact middle initial				
3) Contact last name				
3) Contact second sur-name				
Was this contact used as a pro	xy for this interview?	○ Yes ○ No		
Relationship to participant:				
O Spouse O	Son	O Aunt	O Father-in-law	O Granddaughter
O Sister O	Daughter	O Brother-in-law	O Friend	O Grandson
O Brother O	Nephew	O Sister-in-law	O Neighbor	O Other relative
O Mother O	Niece	O Cousin	O Son-in-law	O Other
O Father O	Uncle	O Mother-in-law	O Daughter-in-law	
Contact phone numbers:				
Home:		Address:		
Work:		City:		
Cell:		State:		
Email:		ZIP:		

Can this person provide information about your health status? O Yes O No



Participant ID #:	Acrostic:	
Technician ID:	Date: Month Day	Year

			WOULT DO	ay rear
Would you like to keep the	person listed below? () Yes () No		
Contact 4				
4) Contact first name				
4) Contact middle initia	I			-
4) Contact last name				-
4) Contact second sur-r	name			-
Was this contact used a	s a proxy for this intervi			-
Relationship to particip	ant:			
O Spouse	O Son	O Aunt	O Father-in-law	O Granddaughter
O Sister	O Daughter	O Brother-in-law	O Friend	O Grandson
O Brother	O Nephew	O Sister-in-law	O Neighbor	O Other relative
O Mother	O Niece	O Cousin	O Son-in-law	O Other
O Father	O Uncle	O Mother-in-law	O Daughter-in-law	
Contact phone numbers	:			
Home:	_	Address:		_
Work:		City:		
Cell:		State:		
Email:		ZIP:		
Can this person provide	information about your h	nealth status? O Yes <i>C</i>) No	



Participant ID #:	Acrostic:
Technician ID:	Date: Month Day Year

Would you like to keep the	e person listed below?(O Yes O No		
Contact 5				
5) Contact first name				
5) Contact middle initia				-
5) Contact last name				_
5) Contact second sur-				-
Was this contact used a	as a proxy for this intervi			-
Relationship to particip	pant:			
O Spouse	O Son	O Aunt	O Father-in-law	O Granddaughter
O Sister	O Daughter	O Brother-in-law	O Friend	O Grandson
O Brother	O Nephew	O Sister-in-law	O Neighbor	O Other relative
O Mother	O Niece	O Cousin	O Son-in-law	O Other
O Father	O Uncle	O Mother-in-law	O Daughter-in-law	
Contact phone numbers:	:			
Home:		Address:		_
Work:		City:		
Cell:		State:		
Email:		ZIP:		



Participant ID #:	Acrostic:
Technician ID:	Date: Month Day Year

Would you like to keep th	he person listed below?() Yes () No		
Contact 6				
6) Contact first name				
6) Contact middle init				-
6) Contact last name				-
6) Contact second sur				-
Was this contact used	d as a proxy for this intervi	ew? () Yes () No		-
O Spouse	O Son	O Aunt	O Father-in-law	O Granddaughter
O Sister	O Daughter	O Brother-in-law	O Friend	O Grandson
O Brother	O Nephew	O Sister-in-law	O Neighbor	O Other relative
O Mother	O Niece	O Cousin	O Son-in-law	O Other
O Father	O Uncle	O Mother-in-law	O Daughter-in-law	
Contact phone number	rs:			
Home:		Address:		_
Work:		City:		
Cell:		State:		
Email:		ZIP:		
Can this person provide	e information about your h	nealth status? O Yes O) No	



Participant ID #:	Acrostic:
Technician ID:	Date: Month Day Year

lew Con	tact Person								
o you h	ave another contact	perso	on that you wou	ıld like to	add to your records?	0	Yes O No		
Conta	ct first name								
Conta	ct middle initial	_						•	
Conta	ct last name							•	
Conta	ct second sur-name								
Was t	his contact used as a	prox	y for this interv	iew?					
0	Yes								
0	No								
Relati	onship to participant	:							
0	Spouse	0	Son	С	Aunt	0	Father-in-law	0	Granddaughter
0	Sister	0	Daughter	С	Brother-in-law	0	Friend	0	Grandson
0	Brother	0	Nephew	С	Sister-in-law	0	Neighbor	0	Other relative
0	Mother	0	Niece	С	Cousin	0	Son-in-law	0	Other
0	Father	0	Uncle	С	Mother-in-law	0	Daughter-in-law		
Conta	ct phone numbers:								
Home	e:				Address:				
Work	:				City:			_	
Cell:					State:			_	
Email	:				ZIP:			_	
Can tl	nis person provide in	form	ation about you	ır health	status? O Yes (O No			



Participant ID #:					Acrostic:					
Technician ID:			D	ate:	Month /	ay]/	Ye	ar	

Day

Next, let's review the contact information for your health care providers.
Health Care Provider 1
Would you like to keep the health care provider listed below? O Yes O No
Please review and update the contact information for this health care provider.
1) Health care provider first name:
1) Health care provider last name:
1) Health care provider title (MD, PA, etc.)
1) Health care provider pace of business (name of clinic or hospital):
Address:
City:
State:
Zip:
1) Health care provider phone:
1) Would you like to send MESA Exam results to this health care provider?
O Yes
O No
Health Care Provider 2
Would you like to keep the health care provider listed below? O Yes O No
Please review and update the contact information for this health care provider.
2) Health care provider first name:
2) Health care provider last name:
2) Health care provider title (MD, PA, etc.)
2) Health care provider pace of business (name of clinic or hospital):
Address:
City:
State:
Zip:
2) Health care provider phone:
2) Would you like to send MESA Exam results to this health care provider?
O Yes
O No



Participant ID #:					Acrostic:					
Technician ID:			D	ate:	Month /	ay]/	Ye	ar	

Health Care Provider 3
Would you like to keep the health care provider listed below? O Yes O No
Please review and update the contact information for this health care provider.
3) Health care provider first name:
3) Health care provider last name:
3) Health care provider title (MD, PA, etc.)
3) Health care provider pace of business (name of clinic or hospital):
Address:
City:
State:
Zip:
3) Health care provider phone:
3) Would you like to send MESA Exam results to this health care provider?
O Yes
O No
Health Care Provider 4
Would you like to keep the health care provider listed below? O Yes O No
Would you like to keep the health care provider listed below? O Yes O No Please review and update the contact information for this health care provider.
Please review and update the contact information for this health care provider.
Please review and update the contact information for this health care provider. 4) Health care provider first name:
Please review and update the contact information for this health care provider. 4) Health care provider first name: 4) Health care provider last name:
Please review and update the contact information for this health care provider. 4) Health care provider first name: 4) Health care provider last name: 4) Health care provider title (MD, PA, etc.)
Please review and update the contact information for this health care provider. 4) Health care provider first name: 4) Health care provider last name: 4) Health care provider title (MD, PA, etc.) 4) Health care provider pace of business (name of clinic or hospital):
Please review and update the contact information for this health care provider. 4) Health care provider first name: 4) Health care provider last name: 4) Health care provider title (MD, PA, etc.) 4) Health care provider pace of business (name of clinic or hospital): Address:
Please review and update the contact information for this health care provider. 4) Health care provider first name:
Please review and update the contact information for this health care provider. 4) Health care provider first name:
Please review and update the contact information for this health care provider. 4) Health care provider first name: 4) Health care provider last name: 4) Health care provider title (MD, PA, etc.) 4) Health care provider pace of business (name of clinic or hospital): Address: City: State: Zip:
Please review and update the contact information for this health care provider. 4) Health care provider first name:
Please review and update the contact information for this health care provider. 4) Health care provider first name:



Participant ID #:					Acrostic:					
Technician ID:			D	ate:	Month /	ay]/	Ye	ar	

Health Care Provider 5
Would you like to keep the health care provider listed below? O Yes O No
Please review and update the contact information for this health care provider.
5) Health care provider first name:
5) Health care provider last name:
5) Health care provider title (MD, PA, etc.)
5) Health care provider pace of business (name of clinic or hospital):
Address:
City:
State:
Zip:
5) Health care provider phone:
5) Would you like to send MESA Exam results to this health care provider?
O Yes
O No
Health Care Provider 6
Would you like to keep the health care provider listed below? O Yes O No
Please review and update the contact information for this health care provider.
6) Health care provider first name:
6) Health care provider last name:
6) Health care provider title (MD, PA, etc.)
6) Health care provider pace of business (name of clinic or hospital):
Address:
City:
State:
Zip:
6) Health care provider phone:
6) Would you like to send MESA Exam results to this health care provider?
O Yes



Participant ID #:					Acrostic:					
Technician ID:			D	ate:	Month	 ay	/	Ye	ar	

New Health Care Provider				
Do you have any new health care providers that you would like to add?				
O Yes				
O No				
Health care provider first name:				
Health care provider last name:				
Health care provider title (MD, PA, etc.)				
Health care provider pace of business (name of clinic or hospital):				
Address:				
City:				
State:				
Zip:				
Health care provider phone:				
Send participant's results to this person:				
O Yes				
O No				