APPENDIX E

STRONG HEART STUDY PHASE-III

Questionnaires and Data Forms
THE STRONG HEART STUDY III  
CARDIOVASCULAR DISEASE IN AMERICAN INDIANS  
PERSONAL INTERVIEW FORM 1

ID number: ____________________________  
Community name: ______________________ Community Code: ________  
Social Security Number: ____________________________  

A. DEMOGRAPHIC INFORMATION:

1. Is this still your full name (Last, First, Middle)?  
   Yes |___|1 No |___|2 (If No, what is your current name?)  
   Last: ____________________________ New Last: ____________________________  
   First: ____________________________ New First: ____________________________  
   Middle: ____________________________ New Middle: ____________________________  
   Nickname/Other Name: ____________________________  

2. To which IHS and non-IHS Hospital/Clinic do you usually go? List the one they go to most often first. Give names and codes. Do you want your Strong Heart Study report sent to the named hospitals?  
   Hospital | Chart number | IHS 1=yes, 2=no | Hospital Code | Send Report 1=yes, 2=no  
   a. ____________________________ __________  
   b. ____________________________ __________  
   c. ____________________________ __________  
   d. ____________________________ __________  

3. What is your marital status?  
   (Enter up to 3 options with the most recent one in the left-most box)  
   1= Never married  4 = Separated  
   2= Currently married  5 = Widowed  
   3 = Divorced  6= Adult roommate/partner/significant other  
   Current 2nd 3rd  

4. If married, what is your husband’s/wife’s name?  
   (If not married, skip to Q6)  
   Last First Middle
5. Did your husband/wife also participate in the Strong Heart Study examination?
   Yes [___] 1  No [___] 2

6. Is this your current mailing address?  Yes [___] 1  No [___] 2
   (If No, what is your current mailing address?)
   a. Street/PO Box ____________________________
   b. City/town ________________________________
   c. County _________________________________
   d. State and Zip code ________________________

7. Is this your residential address?  (if different from mailing address)  Yes [___] 1  No [___] 2
   (If No, What is your current address?)
   a. Street/PO Box ____________________________
   b. City/town ________________________________
   c. County _________________________________
   d. State and zip code ________________________

8. What is your home telephone number?
   Or at what telephone number can we reach you
   or leave a message?
   [____] [____] [____] [____] [____] [____] [____] [____] [____] [____] [____] [____] [____] [____] [____]
   0 = Unlisted  9 = No phone

9. What is your work telephone number?
   [____] [____] [____] [____] [____] [____] [____] [____] [____] [____] [____] [____] [____] [____] [____]
   0 = Same as home phone  9 = Not applicable/unknown
THE STRONG HEART STUDY - PHASE III
CARDIOVASCULAR DISEASE IN AMERICAN INDIANS

PERSONAL INTERVIEW FORM II

ID number: _____________________________

A. WEIGHT SATISFACTION

10. Are you satisfied with your present weight?
    Yes [ ] 1 (skip to Section B) No [ ] 2 Unknown/unsure [ ] 9

11. Do you want to lose or gain weight?
    Lose [ ] 1 Gain [ ] 2

12. How do you plan to do this?
    a) Eating Less [ ] 1 More [ ] 2 No change [ ] 3
    b) Physical activity Less [ ] 1 More [ ] 2 No change [ ] 3
    c) Medication Yes [ ] 1 No [ ] 2
    d) Other, please specify: Yes [ ] 1 No [ ] 2

B. PHYSICAL ACTIVITY

13. Have you had any difficulty getting in or out of a bed or chair? Yes [ ] 1 No [ ] 2

14. Since your last SHS exam have you ever spent any time confined to a bed or chair as a result of an injury or an illness for a period greater than one month?
    Yes [ ] 1 No [ ] 2
    a) If “Yes,” how many weeks were you confined to a bed or chair? ________

15. Do any of the following prevent you from exercising as much as you would like? (choose all that apply)
    a. Arthritis, or other health conditions Yes [ ] 1 No [ ] 2
    b. Amputation Yes [ ] 1 No [ ] 2
    c. Difficulty breathing Yes [ ] 1 No [ ] 2
    d. Conditions unsafe for walking/exercising Yes [ ] 1 No [ ] 2
    e. No exercise facility available Yes [ ] 1 No [ ] 2
    f. Not interested in exercise Yes [ ] 1 No [ ] 2
    g. Other, please specify: Yes [ ] 1 No [ ] 2

16. Think about physical activities that require a mild effort such as walking, gardening, yardwork fishing, softball, etc...
    During a typical week for you, how much time do you spend performing activities that require a mild effort?
    Rarely [ ] 1 Occasionally [ ] 2 Often [ ] 3
    (1 - 2 times per week) (3 or more times per week)

17. Think about physical activities that are relatively strenuous (running and other strenuous sports, digging, chopping wood, heavy construction, hauling hay, fixing fences, etc...).
    During a typical week for you, how much time do you spend performing activities that are relatively strenuous?
    Rarely [ ] 1 Occasionally [ ] 2 Often [ ] 3
    (1 - 2 times per week) (3 or more times per week)
C. DENTURE AND EATING PROBLEMS

18. How many natural teeth do you have? All [ ] 1 Most [ ] 2 Some [ ] 3 None [ ] 4

19. Describe how you chew your food. (Please choose only ONE):
I use natural teeth to chew. [ ] 1 I use natural teeth with caps/crowns to chew. [ ] 2
I have natural teeth and a denture or partial. I use them both together to chew. [ ] 3
I use dentures to chew. [ ] 4 I chew with my gums. [ ] 5

20. Rate your ability to chew food (Please choose only ONE) Good [ ] 1 Fair [ ] 2 Poor [ ] 3

D. FAMILY INCOME:

21. Does your household income meet your family’s needs?
Yes [ ] 1 No [ ] 2 Unsure [ ] 3

22. What is your MAIN daily activity(s)? (Please list three main activities)
1 = Caring for Family 4 = Looking for Work
2 = Working for Pay/Profit 5 = Retired/elderly
3 = Going to School 6 = Other, specify: ____________________________

23. Do you receive any income from...? Yes No
1) Wages/Salary [ ] 1 [ ] 2
2) Profits - business [ ] 1 [ ] 2
3) Winnings from gaming/lottery [ ] 1 [ ] 2
4) Unemployment benefits/ workmen’s comp/welfare [ ] 1 [ ] 2
5) Retirement benefits [ ] 1 [ ] 2
6) Social Security benefits [ ] 1 [ ] 2
7) Lease payment [ ] 1 [ ] 2
8) Other, specify: ____________________________ [ ] 1 [ ] 2

24. Of the choices in Question 23, which source provides the most income? [ ]
(Please choose only one: If missing/refused/unknown, code 9)

25. How many hours per week do you work at a job or jobs that pay you a salary or wage? Fill in number of hours [ ] [ ] [ ] [ ] [ ]

26. Which of the following categories best describes your annual household income from all sources? (Please check only one)
less than $5,000 [ ] 1 $25,000 to $35,000 [ ] 6
$5,000 to $10,000 [ ] 2 $35,000 to $50,000 [ ] 7
$10,000 to $15,000 [ ] 3 over $50,000 [ ] 8
$15,000 to $20,000 [ ] 4 don’t know/not sure [ ] 9
$20,000 to $25,000 [ ] 5 refused [ ] 0
E. TOBACCO:

27. Do you smoke cigarettes? Yes |__|1 No |__|2 (go to Q32)

28. On the average, how many cigarettes do you usually smoke per day?
   0= Less than one cigarette per day.
   a) If less than one cigarette per day, number of cigarettes per month?

29. On which occasions are/were you most likely to smoke, or increase your smoking?
   Please read the list and check the appropriate response.
   a) stressful times
   b) casinos
   c) wakes/funerals
   d) when drinking alcohol
   e) social meetings
   f) when you have extra money
   g) bingo
   h) other, specify: ____________________________

   Yes   No
   |___|1  |___|2
   |___|1  |___|2
   |___|1  |___|2
   |___|1  |___|2
   |___|1  |___|2
   |___|1  |___|2

30. On the occasions that your smoking increased, how many cigarettes do/did you smoke per day?

31. Would you like to change your smoking habit? Yes |__|1 No |__|2 (skip to Q32)
   a) If yes, how?
      i) Reduce number of cigarettes per day
      ii) Switch to lower “tar” or “nicotine” cigarettes
      iii) Use nicotine patch/chewing gum
      iv) Quit
      v) Other, please specify:

      Yes   No
      |___|1  |___|2
      |___|1  |___|2
      |___|1  |___|2
      |___|1  |___|2
      |___|1  |___|2

CURRENT CIGARETTE SMOKERS SKIP TO Q34

32. During your lifetime have you smoked 100 cigarettes or more total?
   Yes |__|1 No |__|2 (skip to section Q34)

33. Did you quit smoking since your last SHS exam?
   Yes |__|1 No |__|2 (skip to section Q34)
   a) If you quit since your last SHS exam when did you quit? (just the year)
   b) What were the reason(s) you quit? Answer all that apply:
      i) Doctor’s advice
      ii) Health concerns
      iii) Expenses
      iv) Per family pressure
      v) Other, please specify:

      Yes   No
      |___|1  |___|2
      |___|1  |___|2
      |___|1  |___|2
      |___|1  |___|2
      |___|1  |___|2

34. Whether or not you smoke, on the average, how many hours a day are you exposed to the smoke of others?
   (if none, please fill in zero: enter 1 hour if 30 min. or more, enter 0 if less than 30 min.)
F. ALCOHOL:

“The next few questions are about the use of beer, wine, or liquor”.

READ THE FOLLOWING TO THE PARTICIPANT:
“We are asking these questions about alcohol use, because alcohol consumption may be related to heart disease. We want you to know that this information is strictly confidential. The Strong Heart Study will use this information only to determine to what extent alcohol use is a risk factor for heart disease. This information is analyzed as batches of numbers without any names. Please report your alcohol use as accurately as possible.”

35. Have you consumed alcoholic beverages since your last SHS exam?
   Yes [___] 1 No [___] 2 (this section of the interview is finished, go to Section G)
   a) If yes, when was your last drink? (check one box only)
      [___] 1 Within the last week
      [___] 2 Within the last month
      [___] 3 Within the last year. Number of months ago? [___] [___] [___]
      [___] 4 More than a year ago. (this section of the interview is finished, go to Section G)

36. How many alcoholic drinks do you have in a typical week? (see chart below)
   One Drink = 12 oz of Beer = 4 oz of Wine = 1 oz of Liquor.
   Please choose the type(s) of beverage and write in the Number of Containers under the appropriate volume.

<table>
<thead>
<tr>
<th>Type of Drink</th>
<th>Container Size (Ounces)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 shot</td>
</tr>
<tr>
<td>Beer</td>
<td>X</td>
</tr>
<tr>
<td>Wine</td>
<td>X</td>
</tr>
<tr>
<td>Liquor</td>
<td></td>
</tr>
</tbody>
</table>

* Quart = 32 oz, Liter = 33.8 oz

37. How many days in a typical month do you have at least one drink? (indicate the number of days per month)

38. On the days when you drink any liquor, beer or wine, about how many drinks do you have, on average? (indicate number of drinks per day)

39. When you drink more than your usual amount, how many drinks do you have?
   a) How many times in a month?

40. How many times during the PAST MONTH did you have 5 or more drinks on an occasion? (Enter zero if subject has quit drinking more than one month ago.)

41. How many times during the PAST YEAR did you have 5 or more drinks on an occasion? Indicate times per year. (Enter zero if subject has quit drinking more than one year ago.)
42. Within the last year, have you ever consumed other substances to get the effects of alcohol, such as...  Yes  No
   a. Mouth wash  [ ] 1  [ ] 2
   b. Cough syrup  [ ] 1  [ ] 2
   c. Lysol  [ ] 1  [ ] 2
   d. Hair spray  [ ] 1  [ ] 2
   e. Other, ___________________________  [ ] 1  [ ] 2

G. ADMINISTRATIVE INFORMATION:

43. How reliable was the participant in completing the questionnaire?
   Very reliable  [ ] 1
   Reliable  [ ] 2
   Unreliable  [ ] 3
   Very unreliable  [ ] 4
   Uncertain  [ ] 9

44. Did the participant complete the interview?
   Yes, completed the interview  [ ] 1
   No, refused all questions  [ ] 2

45. Interviewer: ____________________________

44. Date of interview: ____________________________

Strong Heart Study III- 06/20/97 7  Personal Interview Form 2
Now we will ask you a few questions about gambling, since more Indian communities have casinos and gambling may have an impact on the health of these communities.

1. Do you work at a casino/bingo hall?  
   Yes |___|1  No |___|2

2. Overall, what effects do you think gambling has on the following:
   a. Tribal government,  
      Beneficial |___|1  Harmful |___|2  No effects |___|3
   b. Tribal people,  
      Beneficial |___|1  Harmful |___|2  No effects |___|3
   c. You personally  
      Beneficial |___|1  Harmful |___|2  No effects |___|3

3. What type(s) of gambling have you participated in during the last year?
   a) Slot machines?  
      Yes |___|1  No |___|2

      (if Yes, how often? Please check)
      1 or more times a week  
      1 or more times a month  
      Less than once a month |___|3

   b) Lottery?  
      Yes |___|1  No |___|2

      (if Yes, how often? Please check)
      1 or more times a week  
      1 or more times a month  
      Less than once a month |___|3

   c) Bingo?  
      Yes |___|1  No |___|2

      (if Yes, how often? Please check)
      1 or more times a week  
      1 or more times a month  
      Less than once a month |___|3

   d) Card games (i.e. poker)?  
      Yes |___|1  No |___|2

      (if Yes, how often? Please check)
      1 or more times a week  
      1 or more times a month  
      Less than once a month |___|3

   e) Other, specify:  
      Yes |___|1  No |___|2

      (if Yes, how often? Please check)
      1 or more times a week  
      1 or more times a month  
      Less than once a month |___|3

      (skip to Q9 if person does not gamble)

4. In the past year, have you lost more than you won?  
   Yes |___|1  No |___|2

5. In the past year, have you made attempts to control, cut back, or stop gambling?
   a) If Yes, have your attempts been successful?  
      Yes |___|1  No |___|2

6. In the past year, have you had to borrow money to pay basic living expenses (such as food, mortgage/rent), because of gambling losses?  
   Yes |___|1  No |___|2

7. When you are gambling, how much alcohol do you drink that day?  
   # of drinks

8. In the past year, what is the largest amount you have bet on any single day?  
   $ 

9. Did the participant complete the interview?  
   Yes, completed the interview |___|1  No, refused all questions |___|2

10. Interviewer:  
     

11. Date of interview:  
     

Gambling Questionnaire
THE STRONG HEART STUDY III
CARDIOVASCULAR DISEASE IN AMERICAN INDIANS
MEDICAL HISTORY FORM

ID number: ________________________________

B. MEDICAL CONDITIONS:

"Now I’d like to ask you some questions about medical problems. Has a medical person EVER told you that you had any of the following conditions?"

1. High blood pressure? Yes __1__ No __2__ Only during pregnancy __3__ Unknown __9__
   
   If "YES," how old were you when you were first told by a medical person that you had high blood pressure (for women, not during pregnancy)? Indicate the actual age. Don’t know = 999
   ____________

YES NO UNKNOWN

2. Arthritis? __1__ __2__ __9__

3. Any fractures associated with osteoporosis? __1__ __2__ __9__
   If YES, where? ____________________________

4. Rheumatic heart disease? __1__ __2__ __9__

5. Gallstones? __1__ __2__ __9__

6. Cancer, including leukemia and lymphoma? __1__ __2__ __9__
   If YES, specify type of cancer: ____________________________

7. Diabetes? Yes __1__ Impaired glucose tolerance (IGT) __2__ No __3__ Unknown __9__
   (if No, or Unknown, skip to Q8)
   a) If YES, do you still have it now?
      Yes __1__ No __2__ Unknown __9__
   b) How old were you when you were first told by a medical person that you had diabetes? Indicate the actual age. Don’t know = 999 ____________
   c) What type of treatment are you taking for your diabetes? (Check appropriate answer)

   i) insulin __1__ __2__
   ii) oral hypoglycemic agent __1__ __2__
   iii) by dietary control __1__ __2__
   iv) by exercise __1__ __2__
   v) do nothing __1__ __2__
   vi) other: ____________________________ __1__ __2__
8. Has a medical person ever told you that you had kidney failure?  
   a) If YES, are one or both working well now?  
   b) How old were you when you were first told by a medical person that you 
      had kidney failure? **Indicate the actual age. Don’t know = 999**

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>UNKNOWN</th>
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<tbody>
<tr>
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9. Are you currently on renal dialysis?  

<table>
<thead>
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<th>YES</th>
<th>NO</th>
<th>UNKNOWN</th>
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<tbody>
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</table>

10. Have you ever had kidney transplant?  
   a) If YES, is the new kidney working well?  
   b) If NO, are you waiting for a kidney transplant?  

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>UNKNOWN</th>
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</table>

11. Cirrhosis of the liver?  

<table>
<thead>
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<th>YES</th>
<th>NO</th>
<th>UNKNOWN</th>
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12. LUNG PROBLEMS
   a. Emphysema?  
   b. Hay fever?  
   c. Chronic bronchitis?  
   d. Asthma?  

<table>
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<tr>
<th>YES</th>
<th>NO</th>
<th>UNKNOWN</th>
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If YES for asthma, do you still have it now?  

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>UNKNOWN</th>
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13. Have you had a heart catheterization?  

   **(A heart catheterization is a study in which a tube is inserted into 
   the heart through the groin or arm to see how the heart works)**

   a) If Yes, when and where?  
      (record the most recent test)  

<table>
<thead>
<tr>
<th>mo</th>
<th>day</th>
<th>yr</th>
</tr>
</thead>
</table>

   hospital/clinic: ______________________

14. Have you ever had a diagnostic exercise test or Treadmill test to check your heart?  

   a) If Yes, when and where?  
      (record the most recent test)  

<table>
<thead>
<tr>
<th>mo</th>
<th>day</th>
<th>yr</th>
</tr>
</thead>
</table>

   hospital/clinic: ______________________

15. SINCE your last SHS exam, that is (mo) (yr), has a doctor told you that you had any of the 
    following conditions? **(If more than one episode since Exam II, enter information 
    for the MOST RECENT one in the Exam II - Exam III interval)**

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>UNKNOWN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

16. Heart failure?  

   a) If Yes, when and where?  

<table>
<thead>
<tr>
<th>mo</th>
<th>day</th>
<th>yr</th>
</tr>
</thead>
</table>

   hospital/clinic: ______________________

16. Heart attack?  

   a) If Yes, when and where?  

<table>
<thead>
<tr>
<th>mo</th>
<th>day</th>
<th>yr</th>
</tr>
</thead>
</table>

   hospital/clinic: ______________________

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**Strong Heart Study III- 06/20/97**

10 **Medical History Form**
17. Any other heart trouble?  
   Yes [ ] 1  No [ ] 2  Unknown [ ] 9
   If Yes, please specify type: ____________________________
   a) If Yes, when and where?  
      hospital/clinic: ____________________________
   ____________

18. Stroke?  
   Yes [ ] 1  No [ ] 2  Unknown [ ] 9
   If Yes, please specify type: ____________________________
   a) If Yes, when and where?  
      hospital/clinic: ____________________________
   ____________

19. Have you ever had surgery on your chest?  
   a) Was it heart surgery?  
      Yes [ ] 1  No [ ] 2 (skip to Q20)
   If Yes, which surgery have you had?  
   i) Bypass?  
      Yes [ ] 1  No [ ] 2
      If Yes, when and where?  
      hospital/clinic: ____________________________
   ____________
   ii) Valvular repair/replacement?  
      Yes [ ] 1  No [ ] 2
      If Yes, when and where?  
      hospital/clinic: ____________________________
   ____________
   iii) Pacemaker?  
      Yes [ ] 1  No [ ] 2
      If Yes, when and where?  
      hospital/clinic: ____________________________
   ____________
   iv) Other?  
      Yes [ ] 1  No [ ] 2
      Please specify: ____________________________
      If Yes, when and where?  
      hospital/clinic: ____________________________
   ____________

C. ACCESS TO MEDICAL CARE:

20. Source of medical care:
   In the past 5 years, have you received any medical care at:  
   Yes [ ] 1  No [ ] 2
   What is your usual source of medical care: (Check only ONE)
   a) IHS facility  
   b) Tribal facility  
   c) Private facility  
   d) Private practitioner  
   e) Traditional healer  
   f) VA/military facility  
   g) Health maint. org. (HMO)  
   h) Other, list ____________________________  
   i) Nowhere  
   ____________
21. In addition to IHS coverage, what health insurance do you have? (check all that apply)
   - None        | 1
   - Private health insurance | 2
   - Medicaid    | 3
   - Medicare    | 4
   - Veteran/military hospital | 5
   - HMO         | 6
   - Other, list: ____________________________ | 7

22. How do you get to your usual healthcare provider? (check only one)
   - Myself      | 1
   - Community health representative (CHR) | 4
   - Family member | 2
   - Paid driver  | 5
   - Friend      | 3

23. How much does it usually cost, out of pocket, for transportation to your usual healthcare provider? $_______

24. On the average, how long does it take you to get to your usual source of medical care?
   - Less than 15 minutes | 1
   - 15 to 30 minutes    | 2
   - 31 to 45 minutes    | 3
   - 45 to 60 minutes    | 4
   - 1 to 2 hours        | 5
   - More than 2 hours   | 6

25. Does your usual source of medical care see patients by appointment?
   Yes [____] 1
   No [____] 2

26. Once you get to your usual source of medical care, how long do you usually have to wait to see a healthcare provider?
   - Less than 15 minutes | 1
   - 15 to 30 minutes    | 2
   - 31 to 45 minutes    | 3
   - 45 to 60 minutes    | 4
   - 1 to 2 hours        | 5
   - More than 2 hours   | 6

27. If you need to be seen before your appointment, can you walk in and be seen?
   Yes [____] 1 (go to a)
   No [____] 2 (go to b)
   a) As a walk-in, how long does it usually take you to be seen by a physician or a physician’s assistant?
      - Less than 15 minutes | 1
      - 15 to 30 minutes    | 2
      - 31 to 45 minutes    | 3
      - 45 to 60 minutes    | 4
      - 1 to 2 hours        | 5
      - More than 2 hours   | 6
   b) How long does it usually take you to get an extra appointment?
      - 2 days or less      | 1
      - 3 to 4 weeks        | 2
      - 3 days to 1 week    | 3
      - More than 4 weeks   | 4

28. How much do you have to pay “out-of-pocket” to see your usual healthcare provider for an outpatient visit, excluding travel costs? $_______

29. Did the participant complete the interview?
   Yes, completed the interview [____] 1
   No, refused all questions [____] 2

IS THE PARTICIPANT FEMALE? Yes [____] 1 (go to next page)
   No [____] 2

IF THE PARTICIPANT IS MALE, GO TO ROSE QUESTIONNAIRE

30. Interviewer: __________

31. Date of interview: ___/___/____ 1997

Strong Heart Study III- 06/20/97
Medical History Form
THE STRONG HEART STUDY III

REPRODUCTION AND HORMONE USE (WOMEN ONLY)

ID number: ______________________

“The following questions are related to your childbearing organs.”

1. Have your menstrual cycles stopped? Yes [__]1 No [__]2 (go to Q5)

2. If Yes, has it stopped for more than 12 months? Yes [__]1 No [__]2

3. Was your menopause natural or did you have surgery? Natural [__]1 Surgery [__]2
   a) If SURGERY, was ONLY your uterus removed? Yes [__]1 No [__]2 Unknown [__]9

4. How old were you when your periods stopped? Indicate the age in years. 999 = unknown
   Yes [__]1 No [__]2 Unknown [__]9

“ESTROGEN is a female hormone that may be taken after a hysterectomy or menopause.”

5. Except for birth control pills, have you ever taken estrogen (either pills, as a patch or by shot) for any reason? (Estrogen is often called premarin: maybe either purplish brown or yellow football shaped pills) Yes [__]1 No [__]2 (Go to Q8)
   a. If Yes, are you still taking estrogen? Yes [__]1 (go to Q5b) No [__]2
      i. If No, why did you stop taking estrogen?
         - It caused bleeding? Yes [__]1 No [__]2
         - Made breasts tender? Yes [__]1 No [__]2
         - Made me feel bloated? Yes [__]1 No [__]2
         - Made you “funny,” didn’t like the way you felt? Yes [__]1 No [__]2
         - Do not like taking any medications? Yes [__]1 No [__]2
         - Too expensive? Yes [__]1 No [__]2
         - Doctor’s advice? Yes [__]1 No [__]2
         - Concern about long term side effects? Yes [__]1 No [__]2
         - Other: ____________________________ Yes [__]1 No [__]2

b. Do/Did you use estrogen for...
   i. post surgery (hysterectomy/removal of ovaries) Yes [__]1 No [__]2 Unknown [__]9
   ii. relief of menopause symptoms Yes [__]1 No [__]2 Unknown [__]9
   iii. prevent bone loss Yes [__]1 No [__]2 Unknown [__]9
   iv. protect against heart disease Yes [__]1 No [__]2 Unknown [__]9
   v. doctor’s advice Yes [__]1 No [__]2 Unknown [__]9

6. How old were you when you started using estrogen? Indicate the age in years. ____________

7. How many years altogether did you take estrogen? Specify the duration in years.
   If less than 3 months, record 0. If more than 3 months but less than 1 year, record 1. ____________

8. Does the participant complete the interview? Yes, completed the interview [__]1 No, refused all questions [__]2

9. Interviewer: ____________________________

10. Date of interview: ____________________

Strong Heart Study III- 06/20/97

Reproduction and Hormone Use
THE STRONG HEART STUDY III
ROSE QUESTIONNAIRE FOR ANGINA AND INTERMITTENT CLAUDICATION

ID number: [ ]

Section A: Chest Pain on Effort

1. Have you ever had any pain or discomfort in your chest?  
   Yes [ ] 1  No [ ] 2 (go to Section C)

2. Do you get it when you walk uphill, upstairs or hurry?  
   Yes [ ] 1  No [ ] 2 (go to Section B)  
   Never hurries or walks uphill or upstairs [ ] 3  
   Unable to walk [ ] 4 (go to Section B).

3. Do you get it when you walk at an ordinary pace on the level?  
   Yes [ ] 1  No [ ] 2

4. What do you do if you get it while you are walking?  
   Stop or slow down [ ] 1  Carry on [ ] 2 (go to Section B)  
   (Record “stop or slow down” if subject carries on after taking nitroglycerine.)

5. If you stand still, what happens to it?  
   Relieved [ ] 1  Not relieved [ ] 2 (go to Section B.)

6. How soon?  
   10 minutes or less [ ] 1  More than 10 minutes [ ] 2 (go to Section B.)

7. Will you show me where it was?  
   (Record all areas mentioned. Use the diagram below to show the location  
   if participant cannot tell exactly.)

   ![Diagram of chest regions]

   Stemum (upper or middle)  
   Yes [ ] 1  No [ ] 2

   Stemum (lower)  
   Yes [ ] 1  No [ ] 2

   Left anterior chest  
   Yes [ ] 1  No [ ] 2

   Left arm  
   Yes [ ] 1  No [ ] 2

   Other: [ ]_________  
   Yes [ ] 1  No [ ] 2

8. Do you feel it anywhere else?  
   If Yes, record additional information: ________________

______________________________
Section B: Possible Infarction

9. Have you ever had a severe pain across the front of your chest lasting for half an hour or more?
   Yes |__|1  No |__|2

Section C: Intermittent Claudication

10. Do you get pain in either leg on walking?
    Yes |__|1  No |__|2 (go to Q19)  Unable to walk |__|3 (go to Q19)

11. Does this pain ever begin when you are standing still or sitting?
    Yes |__|1 (go to Q19)  No |__|2

12. In what part of your leg did you feel it?
    Pain includes calf/calves |__|1
    Pain does not include calf/calves |__|2 (go to Q19)
    If calves not mentioned, ask, “Anywhere else?” Please specify:

13. Do you get it when you walk uphill, upstairs or hurry?
    Yes |__|1  No |__|2 (go to Q19)
    Never hurries or walks uphill or upstairs |__|3

14. Do you get it if you walk at an ordinary pace on the level?
    Yes |__|1  No |__|2

15. Does the pain ever disappear while you are walking?
    Yes |__|1 (go to Question 19)  No |__|2

16. What do you do if you get it when you are walking?
    Stop or slow down |__|1  Carry on |__|2 (go to Q19)

17. What happens to it if you stand still?
    Relieved |__|1  Not Relieved |__|2 (go to Q19)

18. How soon?
    10 minutes or less |__|1  More than 10 minutes |__|2

---

END OF ROSE QUESTIONNAIRE

19. Does the participant complete the interview?
    Yes, completed the interview |__|1  No, refused all questions |__|2

20. Interviewer:

21. Date of interview:

Strong Heart Study III- 06/20/97
Rose Questionnaire
THE STRONG HEART STUDY III
CARDIOVASCULAR DISEASE IN AMERICAN INDIANS

PHYSICAL EXAMINATION

ID number: ______________________

I. TOBACCO, CAFFEINE, AND ALCOHOL USE

Before examinations start, check TOBACCO AND CAFFEINE USE

“Tobacco, alcohol, caffeine and activity levels can change the results of the exams and laboratory tests we will do today. Because of this, we will ask you a few questions about them.”

1. Have you smoked or used chewing tobacco or snuff within the last 4 hours?  
1 = Yes  2 = No (skip to Q2)

a. How long ago did you last smoke or last use chewing tobacco or snuff?  
Specify the lag by hours.

b. If less than an hour, specify the minutes.

2. How many alcoholic drinks have you had in the last 24 hours? (0 = None, 888 = Refused)

3. Have you done any vigorous physical activity in the last 24 hours?  
Yes [___] 1  No [___] 2

4. Have you had any coffee, tea, caffeinated soft drink or chocolate within the last 4 hours?  
Yes [___] 1  No [___] 2 (skip to instructions below)

a. How long ago did you last have any coffee, tea, caffeinated soft drink or chocolate?  
Specify the lag by hours.

b. If less than an hour, specify the minutes

“We ask you not to use any tobacco, caffeine or alcohol until you have completed your visit with us today. We do this so that your test results are not affected by use of these substances. If you must use any of these, please tell us that you did before you leave.”

II. EXAMINATION OF EXTREMITIES FOR AMPUTATIONS

5. Are any extremities missing?  
Yes, [___] 1 Complete the table on the next page.  
No [___] 2 (skip to Q6)
If YES to amputation, Code the cause of amputation:

- 1 = Diabetes
- 2 = Trauma
- 3 = Congenital
- 4 = Other, please specify
- 9 = Unknown

<table>
<thead>
<tr>
<th>Extremities</th>
<th>Check if Missing</th>
<th>Cause</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Right arm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Right hand</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Right finger(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Left arm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Left hand</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Left fingers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Right leg above knee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Right leg below knee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Right foot</td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Right toe(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>k. Left leg above knee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>l. Left leg below knee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>m. Left foot</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n. Left toe(s)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

III. BLOOD PRESSURE

6. Right arm circumference, measured in centimeters (cm)
   Midway between acromion and olecranon
   [ ]

7. Cuff size (arm circumference in brackets)
   Pediatric (under 24cm) [ ]
   Regular arm (24-32cm) [ ]
   Large arm (33-41cm) [ ]
   Thigh (>41cm) [ ]

8. Pulse obliteration pressure
   [ ]

9. Seated Blood Pressure:
   a) First Blood Pressure Measurement
      Systolic BP [ ]
      Diastolic BP [ ]
   b) Second Blood Pressure Measurement
      [ ]
   c) Third Blood Pressure Measurement
      [ ]

10. Were the above blood pressures taken from LEFT arm because of missing right arm or some other reason?
    Yes [ ]
    No [ ]
    If yes, specify: __________________________

11. Recorder ID (For the SHS staff who took BPs): [ ]
IV. GIRTH MEASUREMENT: in **METRIC SYSTEM** (centimeters/cm/kg), **English System** inches / pounds

12. Height (Standing) | ____ | cm | ____ | in
13. Weight | ____ | kg | ____ | lb
14. Hip circumference | ____ | cm | ____ | in
15. Waist measurement at umbilicus | ____ | cm | ____ | in

V. PEDAL PULSES AND EDEMA

16. Right posterior tibial pulse | ____ | present | ____ | absent | ____ | missing limbs | ____ | unable to assess
17. Right dorsalis pedis pulse | ____ | 1 | ____ | 2 | ____ | 3 | ____ | 9
18. Left posterior tibial pulse | ____ | 1 | ____ | 2 | ____ | 3 | ____ | 9
19. Left dorsalis pedis pulse | ____ | 1 | ____ | 2 | ____ | 3 | ____ | 9
20. Pedal edema | ____ | Absent, ____ | Mild, ____ | Marked (above midpoint between malleolus and patella)

VI IMPEDANCE MEASUREMENT

21. a) Was impedance taken? Yes | ____ | (go to b) No | ____ | 2
   if No, due to: Amputation | ____ | 1 | Wound/dressing | ____ | 2 | Cast | ____ | 3 | Refusal | ____ | 9
   Go to Question 22
   b) Taken on left side? Yes | ____ | 1 No | ____ | 2 (go to c)
   If Yes, due to: Amputation | ____ | 1 | Wound/dressing | ____ | 2 | Cast | ____ | 3 | Refusal | ____ | 9
   c) Resistance | ____ | 1 | d. Reactance | ____ | 1

VII DOPPLER BLOOD PRESSURE

Doppler blood pressure is measured in the posterior tibial artery. If not audible, use dorsalis pedis. Use left arm if left arm was used for standard blood pressure reading.

0 = neither posterior tibial artery nor dorsalis pedis artery was audible.
888 = participant refuses or if blood pressure is not taken for a medical reason or amputation.
999 = unable to oblitrate.

22. a) First systolic B.P. | ____ | 1 | Right arm | ____ | 1 | 2nd | ____ | 1 | 3rd | ____ | 1 | 4th | ____ | 1
   b) Second systolic B.P. | ____ | 1 | Right ankle | ____ | 1 | 2nd | ____ | 1 | 3rd | ____ | 1 | 4th | ____ | 1
   c) Location
   Posterior tibial | ____ | 1 | 2nd Posterior tibial | ____ | 1 | 3rd Dorsalis pedis | ____ | 1 | 4th Dorsalis pedis | ____ | 1

23. Was an ECG performed? Yes | ____ | 1 No | ____ | 2

VIII BREATH CO

24. Was breath CO done? Yes | ____ | 1 (go to a) No | ____ | 2 (go to Q25)
   a) Ambient: | ____ | CO[ppm]: | ____ | ____ | ____ | ____ | ____ | ____ | ____ | 1st | 2nd | 3rd | 4th
   Ambient valid entries -9 to +9

CO: valid entries Generally 0 to 99 (usually only the the 1st and 2nd entries will be completed)

ADMINISTRATIVE INFORMATION

25. Did the participant complete the interview?
   Yes, completed the interview | ____ | 1 No, refused all questions | ____ | 2
26. SHS Code of person completing this form
27. Date of Examination: | ____ | 1

Strong Heart Study III- 06/20/97 18 Physical Examination
1. Is there an ulcer on:
   a) Right foot? Yes | 1 | No | 2
   b) Left foot Yes | 1 | No | 2

2. Is there a history of foot ulcer? Yes | 1 | No | 2

3. Is either foot numb? Yes | 1 | No | 2

4. Label: Sensory level with a “+” if the participant can feel the 10 gram filament and “−” if he/she cannot feel the 10 g filament. Test each site only once. Testing may not be accurate in areas where thick callous or bunion is present.

   a. Right top | 1 | 2
   b. Right large toe | 1 | 2
   c. Right middle toe | 1 | 2
   d. Right small toe | 1 | 2
   e. Right sole front | 1 | 2
   f. Right sole right | 1 | 2
   g. Right sole left | 1 | 2
   h. Right sole back right | 1 | 2
   i. Right sole back left | 1 | 2
   j. Right heel | 1 | 2

5. Unable to measure due to medical reasons? Yes | 1 | No | 2
(If the right foot has been amputated, conduct exam on the left foot)

6. Measured on left foot? Yes | 1 | No | 2

   a. If “Yes,” due to right foot:
      Amputation | 1 | Wound/dressing | 2 | Cast | 3 | Refusal | 8

7. RESULTS: 
   a. Number of positive answers | ___ |
   b. Number of sites tested | ___ |

8. Did the participant complete the exam?
   Yes, completed the interview | 1 | No foot exam | 2

9. Examined by: | ___ |

10. Date of Examination: | ___ mo ___ day ___ yr |
THE STRONG HEART STUDY III
GTT CHECKLIST

ID number: ____________________________
Social Security Number: ________________

1. Fasting One Touch glucose result. 999 = not done

2. Is FASTING blood sample taken?
   Yes, and participant has been fasting [ ]
   Yes, but participant has NOT been fasting [ ]
   No, participant has not been fasting [ ]
   Other, specify __________________________ [ ]
   No, participant refused [ ]

3. When was the last time you ate? (use military time) ______:____

4. Time of collection of fasting samples ________:____

5. Time of collection of urine sample ________:____

6. Was participant given 75 gram glucose beverage?
   Yes [ ]  No [ ]
   a. If Yes, Time the 75 gram glucose beverage was consumed ______:____
   b. If No, why did participant not have OGTT? Check the appropriate answer(s)
      i. diabetes, on insulin treatment [ ]
      ii. diabetes, on oral agent [ ]
      iii. One Touch > 225 mg/dl [ ]
      iv. refusal to have OGTT done [ ]

7. Time of 2-hr blood sample ________:____

8. If the participant vomited after the glucose beverage was given, check here. [ ]
   If “Yes,” when? (Indicate the time): ______________________________________
   Comments: ______________________________________________________________

9. SHS Code of person completing this form ________

10. Date samples collected 06/ _______ 00 day ______ yr____

Strong Heart Study III- 06/20/97

GTT Checklist
THE STRONG HEART STUDY III

Quality of Life

ID number:

Social Security Number:

---

How is this questionnaire administered?
By interviewer [ ]
By self [ ]
Refused [ ]

1. In general, would you say your health is:

(Please check only one)

- Excellent [ ]
- Very good [ ]
- Good [ ]
- Fair [ ]
- Poor [ ]

2. Compared to one year ago, how would you rate your health in general, now?

(Please check only one)

- Much better than one year ago [ ]
- Somewhat better than one year ago [ ]
- About the same [ ]
- Somewhat worse than one year ago [ ]
- Much worse than one year ago [ ]

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

(Please Check One Answer Per Line)

<table>
<thead>
<tr>
<th>Yes, Limited a Lot</th>
<th>Yes, Limited a Little</th>
<th>No Not Limited at All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Lifting or carrying groceries</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Climbing several flights of stairs</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Climbing one flight of stairs</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Bending, kneeling, or stooping</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Walking more than a mile</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Walking several blocks</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Walking one block</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Bathing or dressing yourself</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

---

Strong Heart Study III- 06/20/97

Quality of Life Questionnaire
During the PAST 4 WEEKS, have you had any of the following problems with your work or other regular daily activities AS A RESULT OF YOUR PHYSICAL HEALTH?

(Please Check One Answer Per Line)

13. Cut down on the amount of time you spend on work or other activities.......................... | 1 | 2

14. Accomplish less than you would like......................... | 1 | 2

15. Were limited in the kind of work or other activities.... | 1 | 2

16. Had difficulty performing the work or other activities (for example, it took extra effort)............... | 1 | 2

During the PAST 4 WEEKS, have you had any of the following problems with your work or other regular daily activities AS A RESULT OF ANY EMOTIONAL PROBLEMS (such as feeling depressed or anxious)?

(Please Check One Answer Per Line)

17. Cut down on the amount of time you spend on work or other activities.......................... | 1 | 2

18. Accomplish less than you would like......................... | 1 | 2

19. Didn't do work or other activities as carefully as usual.......................... | 1 | 2

20. During the PAST 4 WEEKS, to what extent has you physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

(Please Check One Answer)

Not at all......................... | 1 
Slightly......................... | 2 
Moderately....................... | 3 
Quite a bit....................... | 4 
Extremely....................... | 5 

21. How much BODILY pain have you had during the PAST 4 WEEKS?

(Please Check One Answer)

None......................... | 1 
Very mild....................... | 2 
Mild......................... | 3 
Moderate....................... | 4 
Severe......................... | 5 
Very severe.................... | 6 

22. During the PAST 4 WEEKS, how much did pain interfere with your normal work, (including both work outside the home and housework)?

(Please Check One Answer)

Not at all......................... | 1 
Slightly......................... | 2 
Moderately....................... | 3 
Quite a bit....................... | 4 
Extremely....................... | 5

Strong Heart Study III- 06/20/97  22  Quality of Life Questionnaire
These questions are about how you feel and how things have been with you during the PAST 4 WEEKS. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the PAST 4 WEEKS...

(Please Check One Answer Per Line)

<table>
<thead>
<tr>
<th>All of the Time</th>
<th>Most of the Time</th>
<th>A Good Bit of the Time</th>
<th>Some of the Time</th>
<th>A Little of the Time</th>
<th>None of the Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>23. Did you feel full of pep? ..........</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Have you been a very nervous person? ..........</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Have you felt so down in the dumps that nothing could cheer you up? ..........</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. Have you felt calm and peaceful? ..</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Did you have a lot of energy? ....</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. Did you feel downhearted and blue? ..........</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29. Did you feel worn out? ..........</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. Have you been a happy person? ....</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31. Did you feel tired? ..........</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

32. During the PAST 4 WEEKS, how much of the time has your PHYSICAL HEALTH or EMOTIONAL PROBLEMS interfered with your social activities (like visiting with friends, relatives, etc.)?

(Please Check One Answer)

- All the time
- Most of the time
- Some of the time
- A Little of the time
- None of the time

How TRUE or FALSE is each of the following statements?

(Please Check One Answer Per Line)

<table>
<thead>
<tr>
<th>Definitely True</th>
<th>Mostly True</th>
<th>Don’t Know</th>
<th>Mostly False</th>
<th>Definitely False</th>
</tr>
</thead>
<tbody>
<tr>
<td>33. I seem to get sick a little easier than other people ..........</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>34. I am as healthy as anybody I know ..........</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35. I expect my health to get worse ..</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>36. My health is excellent ..........</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>37. Interview conducted in: English ..........</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Native language ..........</td>
<td></td>
<td></td>
<td></td>
<td>Specify: ____________________________</td>
</tr>
<tr>
<td>Other ..........</td>
<td></td>
<td></td>
<td></td>
<td>Specify: ____________________________</td>
</tr>
</tbody>
</table>

38. Interviewer _______________________________________

39. Date completed ____________________________

Strong Heart Study III- 06/20/97  Quality of Life
THE STRONG HEART STUDY III
CBC Results

SHS Family Study ID  [ ]   [ ]   [ ]   [ ]   [ ]   [ ]   [ ]   [ ]   [ ]   [ ]
SHS ID number:    [ ]   [ ]   [ ]   [ ]   [ ]   [ ]   [ ]   [ ]   [ ]   [ ]

Each Center’s Results May Appear in Different Order, Please Be Careful When Entering the Results

1. WBC (10⁹/L)

2. RBC (10¹²/L)

3. HGB (g/dL)

4. HCT (%)

5. MCV (fL)

6. MCH (pg)

7. MCHC (g/dL)

8. RDW (%)

9. Platelet count (PLT .. 10⁹/L)

10. MPV (fL)

DIFFERENTIAL

Each Center’s Results May Appear in Different Order, Please Be Careful When Entering the Results

11. NEUT (%)

12. LYMPH (%)

13. MONO (%)

14. EOS (%)

15. BASO (%)

16. Code number of person completing this form

17. Date of data collection

mo   day   yr
I. BLOOD PRESSURE

1. Right arm circumference, measured in CENTIMETERS (cm)  
   Midway between acromion and olecranon
   
2. Cuff size (arm circumference in brackets)  
   Pediatric (under 24cm) | 1  
   Regular arm (24-32cm) | 2  
   Large arm (33-41cm) | 3  
   Thigh (>41cm) | 4

3. Pulse obliteration pressure
   
4. Seated Blood Pressure  
   Systolic BP  
   Diastolic BP  
   a) First Blood Pressure Measurement
   b) Second Blood Pressure Measurement
   c) Third Blood Pressure Measurement

5. Were the above blood pressures taken from LEFT arm?  
   Yes | 1  
   No | 2

If yes, Why?

6. Recorder ID:

II. GIRTH MEASUREMENT

7. Height (Standing) |  cm

8. Weight |  kg

9. Hip circumference |  cm

10. Waist |  cm

III. IMPEDANCE MEASUREMENT

Strong Heart Study III- 06/20/97
11. a) Was impedance taken? Yes [ ] 1 (go to b) No [ ] 2
if NO, due to: Amputation [ ] 1 Wound/dressing [ ] 2 Cast [ ] 3 Refusal [ ] 8

b) Taken on left side? Yes [ ] 1 (go to b) No [ ] 2
if NO, due to: Amputation [ ] 1 Wound/dressing [ ] 2 Cast [ ] 3 Refusal [ ] 8
c) Resistance [ ] [ ] [ ]
d) Reactance [ ] [ ] [ ]

IV. DOPPLER BLOOD PRESSURE

Doppler blood pressure is measured in the posterior tibial artery. If not audible, use dorsalis pedis. Use left arm if it was used for standard blood pressure reading.

0 = neither posterior tibial artery nor dorsalis pedis artery was audible.
888 = participant refuses or if blood pressure is not taken for a medical reason or amputation.
999 = unable to obliterate.

12. a) First systolic B.P. Right Arm [ ] [ ] [ ] Right Ankle [ ] [ ] [ ] Left Ankle [ ] [ ] [ ]

b) Second systolic B.P. [ ] [ ] [ ] [ ] [ ]

c) Location: posterior tibial [ ] [ ] posterior tibial [ ] [ ]
dorsalis pedis [ ] [ ] dorsalis pedis [ ] [ ]

IV. ADMINISTRATIVE INFORMATION

13. Code number of person completing this form [ ] [ ] [ ] [ ] [ ] [ ]

14. Date of data collection [ ] [ ] [ ] mo [ ] day [ ] yr
Please complete as thoroughly as possible and to the best of your knowledge.

1. A. At what time do you usually FALL ASLEEP on weekdays or work days?
   
   [ ] 1 A.M. (Midnight is 12:00 A.M.)
   
   [ ] 2 P.M.

   ___ : ___

B. At what time do you usually FALL ASLEEP on weekends or non-work days?
   
   [ ] 1 A.M. (Midnight is 12:00 A.M.)
   
   [ ] 2 P.M.

   ___ : ___

2. How many minutes does it usually take you to fall asleep at bedtime?
   
   ___ : ___ (Number of minutes)

3. A. At what time do you usually WAKE UP on weekdays or work days?
   
   [ ] 1 A.M. (Midnight is 12:00 A.M.)
   
   [ ] 2 P.M.

   ___ : ___

B. At what time do you usually WAKE UP on weekends or non-work days?
   
   [ ] 1 A.M. (Midnight is 12:00 A.M.)
   
   [ ] 2 P.M.

   ___ : ___

4. How many hours of sleep do you usually get at night (or your primary sleep period on week days or work days)?
   
   ___ : ___ (Number of hours)
5. How many hours of sleep do you usually get at night (or your primary sleep period on weekends or non-work days)?

_______ _______ (Number of hours)

6. During a usual week, how many times do you nap for five minutes or more? (Write in "0" if you take no naps)

_______ _______ (Number of times)

7. Please indicate how often you experience each of the following. (Please check one box for each item)

<table>
<thead>
<tr>
<th>Item</th>
<th>NEVER 0</th>
<th>RARELY 1/month or less</th>
<th>SOMETIMES 2 - 4/month</th>
<th>OFTEN 5 - 15/month</th>
<th>ALMOST ALWAYS 16 - 30/month</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Have trouble falling asleep.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>B. Wake up during the night and have difficulty getting back to sleep.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>C. Wake up too early and are unable to get back to sleep.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>D. Feel unrested during the day, no matter how many hours of sleep you’ve had.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>E. Feel excessively (overly) sleepy during the day.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>F. Do not get enough sleep.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>G. Take sleeping pills or other medication to help you sleep</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Questions 8 through 16 are about snoring and breathing during sleep. To answer these questions, please consider both what others have told you, AND what you know about yourself.

8. Have you ever snored (now or at any time in the past)?

□ 1 YES  □ 0 NO  □ 9 DON'T KNOW  → Skip to Question 14 on page 3

Go to Question 9
9. How often do you snore now? (Please check only one)

- [ ] 0 Do not snore any more  
- [ ] 1 Rarely - less than one night a week.
- [ ] 2 Sometimes - 1 or 2 nights a week.
- [ ] 3 Frequently - 3 to 5 nights a week.
- [ ] 4 Always or almost always - 6 or 7 nights a week.
- [ ] 9 Don’t know.

10. How loud is your snoring? (Please check only one)

- [ ] 1 Only slightly louder than heavy breathing.
- [ ] 2 About as loud as mumbling or talking.
- [ ] 3 Louder than talking.
- [ ] 4 Extremely loud - can be heard through a closed door.
- [ ] 9 Don’t know.

11. How many years have you been snoring?

___ ___ (Number of years) OR Don’t know = 999

12. Is your snoring? (Please check only one)

- [ ] 1 Increasing over time?
- [ ] 2 Decreasing over time?
- [ ] 3 Staying the same?
- [ ] 9 Don’t know.

13. Have you ever had surgery as treatment for your snoring?

- [ ] 1 YES  
- [ ] 0 NO

14. Are there times when you stop breathing during your sleep?

- [ ] 1 YES  
- [ ] 0 NO  
- [ ] 9 DON’T KNOW

Skip to Question 16 on page 4

Go to Question 15
15. How often do you have times when you stop breathing during your sleep?

- □ 1 Rarely - less than one night a week.
- □ 2 Sometimes - 1 or 2 nights a week.
- □ 3 Frequently - 3 to 5 nights a week.
- □ 4 Always or almost always - 6 or 7 nights a week.
- □ 9 Don’t know.

16. A. Have you ever been told by a doctor that you have sleep apnea (a condition in which breathing stops briefly during sleep)?

- □ 1 YES
- □ 0 NO
- □ 9 DON’T KNOW

**Skip to Question 17 below.**

16. B. Do you sleep with either a pressure mask (“CPAP”) or a mouthpiece as treatment for your sleep apnea?

- □ 1 YES
- □ 0 NO

16. C. Have you had surgery as treatment for your sleep apnea?

- □ 1 YES
- □ 0 NO

17. Do you usually use oxygen therapy (oxygen delivered by a mask or nasal cannula) during your sleep?

- □ 1 YES
- □ 0 NO

18. In the past year, how often, on average, have you been awakened with the following?

<table>
<thead>
<tr>
<th>Event</th>
<th>NEVER (0)</th>
<th>RARELY (1/month or less)</th>
<th>SOMETIMES (2-4/month)</th>
<th>OFTEN (5-15/month)</th>
<th>ALMOST ALWAYS (16-20/month)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Coughing or wheezing.</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>B. Chest pain or tightness.</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>C. Shortness of breath.</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>D. Sweats or hot flashes.</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>E. Noise in your surroundings.</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>F. Pain in your joints, muscles, or back.</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>G. Heartburn or indigestion.</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>H. Leg cramps or leg jerks</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>I. Need to go to the bathroom.</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
</tbody>
</table>
19. During the past year, how often have one or more members of your household been in or near the room where you have slept?

- 1 NEVER
- 2 SOMETIMES
- 3 USUALLY

20. What is the chance that you would doze off or fall asleep (not just "feel tired") in each of the following situations? (Please check one box for each situation. If you are never or rarely in the situation, please give your best guess for that situation)

<table>
<thead>
<tr>
<th>Situation</th>
<th>NO CHANCE</th>
<th>SLIGHT CHANCE</th>
<th>MODERATE CHANCE</th>
<th>HIGH CHANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Sitting and reading.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>B. Watching television.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>C. Sitting inactive in a public place (such as a theater or meeting)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>D. Riding as a passenger in a car for an hour without a break.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>E. Lying down to rest in the afternoon when circumstances permit</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>F. Sitting and talking to someone.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>G. Sitting quietly after a lunch (without alcohol).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>H. In a car, while stopped for a few minutes in traffic.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I. At the dinner table.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>J. While driving.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Thank you for your participation in the Strong Heart Study's Sleep Habits Survey.

Field Center Use Only

- 0 Self-administered
- Interviewer administered in:
  - 1 English
  - 2 Spanish
  - 3 Lakota
  - 4 Pima
  - 5 Other, specify: ____________
  - 9 Unknown

Interviewer or Reviewer Code: _______ _______ Date: ______/______/______
THE STRONG HEART STUDY III
CARDIOVASCULAR DISEASE IN AMERICAN INDIANS

ID number: [ ] [ ] [ ] [ ] [ ] [ ] [ ]

A. MEDICATION RECEPTION:

As you know, the Strong Heart Study will be describing prescription medications that its participants are using. We are particularly interested in medications your doctor prescribed for you that were filled by a pharmacist. These include pills, dermal patches, eye drops, creams, salves, and injections. The letter you received about this appointment included a plastic medications bag for all your current medications and asked you to bring them to the clinic.

Have you brought that bag with you?

Yes [ ] 1

No [ ] 2 (Make arrangements to obtain)

Took no meds [ ] 3 (Go to Section C)

Refused [ ] 9 (Cite reasons for refusal in the space below)

Reasons for refusal: ____________________________

B. PRESCRIPTION MEDICATIONS

1. Copy the name of the medication, the strength in milligrams (mg), and the total number of doses prescribed per day, week or month. (Include pills, dermal patches, eye drops, creams, salves, and injections)

2. On the average during the last two weeks, how many of these pills did you take a day/week/month?

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Strength (mg)</th>
<th>Number Prescribed</th>
<th>PRN Medicine?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Print the first 20 letters only. Please print clearly</td>
<td>Write the decimal as one of the digits</td>
<td>Circle: day week month</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>[ ] [ ] [ ] [ ] [ ]</td>
<td>[ ] [ ] [ ] [ ] [ ] [ ] D W M Y N</td>
<td>[ ] D W M</td>
</tr>
<tr>
<td>2</td>
<td>[ ] [ ] [ ] [ ] [ ]</td>
<td>[ ] [ ] [ ] [ ] [ ] [ ] D W M Y N</td>
<td>[ ] D W M</td>
</tr>
<tr>
<td>3</td>
<td>[ ] [ ] [ ] [ ] [ ]</td>
<td>[ ] [ ] [ ] [ ] [ ] [ ] D W M Y N</td>
<td>[ ] D W M</td>
</tr>
<tr>
<td>4</td>
<td>[ ] [ ] [ ] [ ] [ ]</td>
<td>[ ] [ ] [ ] [ ] [ ] [ ] D W M Y N</td>
<td>[ ] D W M</td>
</tr>
<tr>
<td>5</td>
<td>[ ] [ ] [ ] [ ] [ ]</td>
<td>[ ] [ ] [ ] [ ] [ ] [ ] D W M Y N</td>
<td>[ ] D W M</td>
</tr>
<tr>
<td>6</td>
<td>[ ] [ ] [ ] [ ] [ ]</td>
<td>[ ] [ ] [ ] [ ] [ ] [ ] D W M Y N</td>
<td>[ ] D W M</td>
</tr>
<tr>
<td>7</td>
<td>[ ] [ ] [ ] [ ] [ ]</td>
<td>[ ] [ ] [ ] [ ] [ ] [ ] D W M Y N</td>
<td>[ ] D W M</td>
</tr>
<tr>
<td>8</td>
<td>[ ] [ ] [ ] [ ] [ ]</td>
<td>[ ] [ ] [ ] [ ] [ ] [ ] D W M Y N</td>
<td>[ ] D W M</td>
</tr>
<tr>
<td>9</td>
<td>[ ] [ ] [ ] [ ] [ ]</td>
<td>[ ] [ ] [ ] [ ] [ ] [ ] D W M Y N</td>
<td>[ ] D W M</td>
</tr>
<tr>
<td>10</td>
<td>[ ] [ ] [ ] [ ] [ ]</td>
<td>[ ] [ ] [ ] [ ] [ ] [ ] D W M Y N</td>
<td>[ ] D W M</td>
</tr>
<tr>
<td>11</td>
<td>[ ] [ ] [ ] [ ] [ ]</td>
<td>[ ] [ ] [ ] [ ] [ ] [ ] D W M Y N</td>
<td>[ ] D W M</td>
</tr>
<tr>
<td>12</td>
<td>[ ] [ ] [ ] [ ] [ ]</td>
<td>[ ] [ ] [ ] [ ] [ ] [ ] D W M Y N</td>
<td>[ ] D W M</td>
</tr>
<tr>
<td>13</td>
<td>[ ] [ ] [ ] [ ] [ ]</td>
<td>[ ] [ ] [ ] [ ] [ ] [ ] D W M Y N</td>
<td>[ ] D W M</td>
</tr>
<tr>
<td>14</td>
<td>[ ] [ ] [ ] [ ] [ ]</td>
<td>[ ] [ ] [ ] [ ] [ ] [ ] D W M Y N</td>
<td>[ ] D W M</td>
</tr>
<tr>
<td>15</td>
<td>[ ] [ ] [ ] [ ] [ ]</td>
<td>[ ] [ ] [ ] [ ] [ ] [ ] D W M Y N</td>
<td>[ ] D W M</td>
</tr>
</tbody>
</table>

Number unable to transcribe: ____________
C. OVER-THE-COUNTER MEDICATIONS

3. Copy the name of the medication, the strength in milligrams (mg), and the total number of doses prescribed per day, week or month. (Include pills, dermal patches, eye drops, creams, salves, and injections)

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Strength (mg)</th>
<th>Circle: day/week/month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Print the first 20 letters only. Please print clearly</td>
<td>Write the decimal as one of the digits</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>D W M</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>D W M</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>D W M</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>D W M</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>D W M</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td>D W M</td>
</tr>
<tr>
<td>7</td>
<td></td>
<td>D W M</td>
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<tr>
<td>8</td>
<td></td>
<td>D W M</td>
</tr>
<tr>
<td>9</td>
<td></td>
<td>D W M</td>
</tr>
<tr>
<td>10</td>
<td></td>
<td>D W M</td>
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<tr>
<td>11</td>
<td></td>
<td>D W M</td>
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<tr>
<td>12</td>
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<td>D W M</td>
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<td>13</td>
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<td>D W M</td>
</tr>
<tr>
<td>14</td>
<td></td>
<td>D W M</td>
</tr>
<tr>
<td>15</td>
<td></td>
<td>D W M</td>
</tr>
</tbody>
</table>

Comments:

5. Interviewer: 

6. Date of interview: 

Strong Heart Study III- 04/01/97
Medication Form
APPENDIX 4 - THE STRONG HEART STUDY III
DIETARY INTAKE - 24-HOUR RECALL

<table>
<thead>
<tr>
<th>Participant's ID Number (SHS)</th>
<th>Date of Visit</th>
<th>Social Security Number</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Participant's Name</th>
<th>Initials</th>
<th>Intake Day</th>
<th>Interviewer's opinion of information</th>
<th>Was amount eaten</th>
<th>Did you take any supplements (vitamins, minerals, etc)?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1=Sun</td>
<td>1=Typical? 2=Considerably less than usual? 3=Considerably more than usual?</td>
<td></td>
<td>1=No 2=Yes (If &quot;Yes,&quot; describe under Food and Beverage, below)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2=Mon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3=Tue</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4=Wed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5=Thu</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>6=Fri</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>7=Sat</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1=Reliable 2=Unable to recall one or more meals 3=Unreliable for other reasons</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prepared:</th>
<th>1=At home</th>
<th>2=Restaurant</th>
<th>3=Other</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Time eaten</th>
<th>a=m., p.m.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hour</td>
<td>Minute</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Salt added in preparation?</th>
<th>1=No, 2=Yes, 9=Unknown</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Was fat added in preparation?</th>
<th>1=No, 2=Yes, 9=Unknown</th>
</tr>
</thead>
</table>

**Please note type of fat used, in description**

**Food and Beverage**

<table>
<thead>
<tr>
<th>Complete Description</th>
</tr>
</thead>
</table>

**COMMENTS (Give line no. when appropriate):**
<table>
<thead>
<tr>
<th>Line No.</th>
<th>Prepared: 1=At home, 2=Restaurant, 3=Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Time eaten a=a.m., p=p.m.</td>
</tr>
<tr>
<td></td>
<td>Hour</td>
</tr>
<tr>
<td>06</td>
<td></td>
</tr>
<tr>
<td>07</td>
<td></td>
</tr>
<tr>
<td>08</td>
<td></td>
</tr>
<tr>
<td>09</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td></td>
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<td>13</td>
<td></td>
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<tr>
<td>14</td>
<td></td>
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<tr>
<td>15</td>
<td></td>
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<tr>
<td>16</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Salt added in preparation? 1=No, 2=Yes, 9=Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food and Beverage</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
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<table>
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<tr>
<th>Was fat added in preparation? 1=No, 2=Yes, 9=Unknown</th>
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<td>Please note type of fat used, in description</td>
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COMMENTS (Give line no. when appropriate):
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<th>Line No.</th>
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<th>Prepared: 1=At home, 2=Restaurant, 3=Other</th>
<th>Salt added in preparation? 1=No, 2=Yes, 9=Unknown</th>
<th>Food and Beverage</th>
<th>amt.</th>
<th>Was fat added in preparation? 1=No, 2=Yes, 9=Unknown</th>
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<th>Food and Beverage</th>
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