

**THE STRONG HEART— FAMILY STUDY
GENETICS OF CARDIOVASCULAR DISEASE IN AMERICAN INDIANS**

**Screening for Pregnancy and Lactation
WOMEN ONLY**

SHS Family Study ID: |_F_|_A_|_M_|_I_|_D_|_|_| SHS ID number: |_I_|_D_|_N_|_O_|_|_|

Did the participant have a Pregnancy and Lactating form?

PH4_STAT

Administered to women < 50 years of age at time consent is obtained. It can be self-administered.

1. Are you pregnant? Yes |__|1 No |__|2 Not sure |__|9

PREG4_1

2. When was your last menstrual period? |__|_|_|/|__|_|_|/|__|_|_|_|_| **PREG4_2**
If unknown, leave the boxes blank
mo day yr

3. When did your last pregnancy end? |__|_|_|/|__|_|_|/|__|_|_|_|_|

PREG4_3

Never pregnant = 01-01-1001 mo day yr

Currently pregnant = 01-01-1900

4. Are you now breast-feeding? Yes |__|1 No |__|2

PREG4_4

5. If "yes", how long you have been breast-feeding (in months)? |__|_|_| **PREG4_5**

Women who think they may be pregnant should not be examined or have blood drawn, because pregnancy changes the blood lipids. Women who think they may be pregnant should be referred for prenatal care. Women can participate in the Family Study six weeks postpartum even if they are lactating.

6. Code number of person completing this form |__|_|_|_| **INT_CODE**

7. Date of data collection |__|_|_|/|__|_|_|/|__|_|_|_|_| **INT_DATE**
mo day yr

THE STRONG HEART— FAMILY STUDY

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PERSONAL INTERVIEW FORM II

SHS Family I.D. F A M I D

SHS. I.D.: I D N O

A. WEIGHT SATISFACTION

1. Are you satisfied with your present weight? **INT24_1**
 Yes |1 (*skip to B*) No |2 Unknown/unsure |9
2. Do you want to lose or gain weight? Lose |1 Gain |2 **INT24_2**
3. How do you plan to do this? Less More No change
- a) Eating |1 |2 |3 **INT24_3**
- b) Physical activity |1 |2 |3 **INT24_4**
- c) Medication Yes |1 No |2 **INT24_5**
- d) Other, specify: **INT24_7** Yes |1 No |2 **INT24_6**

B. FAMILY INCOME:

4. Does your household income meet your family's needs? **INT24_11**
 Yes |1 No |2 Unsure |9
5. Are you going to school? Yes |1 No |2 **INT24_12**
6. 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*) ||| **INT24_26**
7. Which of the following categories best describes your annual **household** income from all sources? *Please show a list.* **INT24_27**
- Less than 5,000 |1 20,000 to 25,000 |5 Don't know/not sure |9
- 5,000 to 10,000 |2 25,000 to 35,000 |6 Refused |0
- 10,000 to 15,000 |3 35,000 to 50,000 |7
- 15,000 to 20,000 |4 Over 50,000 |8

C. TOBACCO:

8. During your lifetime have you smoked 100 cigarettes or more total? **INT24_28**
 Yes |1 No |2 (**skip to Q16**)
9. How old were you when you first started smoking regularly? ||| **INT24_29**
(Indicate age at which you started smoking)
 0 = Never smoked regularly 999 = Unknown
10. Did you quit smoking? Yes |1 No |2 (**skip to Q11**) **INT24_51**
- a) If you quit, when did you last smoke?
(Just the year, please) |||| **INT24_52**
- b) What reason(s) did you have for quitting?
 Please check *all that apply*:
- | | Yes | No | |
|---------------------|-----------------------------|-----------------------------|-----------------|
| i) Doctor's advice | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | INT24_53 |
| ii) Health concerns | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | INT24_54 |
| iii) Expenses | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | INT24_55 |
| iv) Family pressure | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | INT24_56 |
| v) Peer pressure | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | INT24_57 |
| vi) Other | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | INT24_58 |
- specify: _____ **INT24_58A**
11. On the average, how many cigarettes do/did you usually smoke per day? ||| **INT24_31**
 0= Less than one cigarette per day
- a) If less than one cigarette per day, number of cigarettes per month? ||| **INT24_32**

12. On which occasions are/were you most likely to smoke, or increase your smoking?

Please read the list and check the appropriate response.

Yes No

- | | | |
|---|-----------------------------|--------------------------------------|
| a) stressful times | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 INT24_33 |
| b) casinos | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 INT24_34 |
| c) wakes/funerals | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 INT24_35 |
| d) when drinking alcohol | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 INT24_36 |
| e) social meetings | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 INT24_37 |
| f) when you have extra money | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 INT24_38 |
| g) bingo | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 INT24_39 |
| h) school | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 INT24_40 |
| i) other, specify: <u> INT24_42 </u> | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 INT24_41 |

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

||| INT24_43

14. Do you smoke cigarettes now?

Yes |1 No |2 INT24_30
(if No, skip to Q16)

15. If you currently smoke, would you like to change your smoking habit?

Yes |1 No |2 INT24_44
(if No, skip to Q16)

a) If yes, would you prefer to...

Yes No

- | | | |
|--|-----------------------------|--------------------------------------|
| i) Reduce number of cigarettes per day | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 INT24_45 |
| ii) Switch to lower "tar" or "nicotine" cigarettes | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 INT24_46 |
| iii) Use nicotine patch/chewing gum/medications | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 INT24_47 |
| iv) Quit | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 INT24_48 |

v) Other, specify: INT24 50 |__|1 |__|2 INT24_49

16. Do you use chewing tobacco/snuff now? Yes |__|1 No |__|2 INT24_59
 17. If yes, how many times a day do you use it? INT24 59A times/day (Enter 0 if less than once a day or use sporadically)

D. PASSIVE SMOKING:

18. When you were growing up, did your father or male guardian ever smoke cigarettes regularly? INT24_60

Yes |__|1 No father/male guardian |__|3

No |__|2 Unknown |__|9

19. When you were growing up, did your mother or female guardian ever smoke cigarettes regularly? INT24_61

Yes |__|1 No mother/female guardian |__|3

No |__|2 Unknown |__|9

20. When you were growing up, did someone you spent a lot of time with smoke cigarettes regularly? INT24_62

Yes |__|1 No such person |__|3

No |__|2 Unknown |__|9

21. Whether or not you smoke, on the average, how many hours a day are you exposed to the smoke of others? |__|_|__|_|__| INT24_63
 (If none, fill in 0; enter 1 for 30 minutes or more, enter 0 if less than 30 minutes)

E. ALCOHOL:

**PLEASE READ THE FOLLOWING TO THE PARTICIPANT:
 ALCOHOL QUESTIONS**

The next few questions are about the use of wine, beer, or liquor, including all kinds of alcoholic beverages. We are asking these questions about alcohol because we think alcohol consumption may be related to heart disease. We assure you that this information is strictly confidential and that we are not judging your drinking habits and do not intend to report them to anyone. GIVE DRINKS CHART TO PARTICIPANT. Sometimes it's hard to count drinks, so here is a chart to show you what we mean. REVIEW CHART WITH PARTICIPANT: READ IF NECESSARY.

- One whole 12 ounces can of beer = 1 drink*
- A whole six-pack of beer = 6 drinks*
- One case of beer=24 drinks*
- One quart of beer=2.5 drinks*
- One pint of beer=1.3 drinks*
- One 40 ounces of beer=3.3 drinks*
- A glass (4 ounces) of wine = 1 drink*
- One pint (16 ounces) of wine=4 drinks*
- One quart (32 ounces) of wine=8 drinks*
- A shot or gulp of straight hard liquor, like whisky = 1 drink*

One pint (16 ounces) of hard liquor=12 drinks
 One quart (32 ounces) of hard liquor=24 drinks
 A full glass of a mixed drink, like everclear in punch = 1 drink

22. Have you ever consumed alcoholic beverages? INT24_64

Yes |1 No |2 *(this section of the interview is finished, go to Question 29)*

a) If yes, when was your last drink? (Choose only one) INT24_65

|1 Within the last week

|2 Within the last month

|3 Within the last year. Number of months |_|_|_| INT24_66

|4 More than a year ago

(If over a year, this section of the interview is finished, please go to Question 29)

23. How many alcoholic drinks do you have in a typical week? |_|_|_| INT24_67

24. How many days in a typical month do you have at least one drink?
(Indicate the number of days per month) |_|_|_| INT24_68

25. 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)* |_|_|_| INT24_69
(# Drinks)

26. When you drink more than your usual amount, how many **total** drinks do you have? |_|_|_| INT24_70
(# Drinks)

a) How many times in a month? |_|_|_| INT24_71
(# Times/Month)

27. How many times during the **PAST MONTH** did you have 5 or more drinks on an occasion? Indicate times per month. *(Enter zero if subject has quit drinking more than one month ago.)* |_|_|_| INT24_73

28. How many times during the **PAST YEAR** did you have 5 or more drinks on an occasion? |_|_|_| INT24_74

F. PERCEIVED STRESS:

In the past month, how often have you (Q29-35):

Not at all Rarely Sometimes Often Most of Not sure
the time

29. been upset because of something
 that happened unexpectedly? |1 |2 |3 |4 |5 |9 INT24_75

30. felt nervous or "stressed"? |1 |2 |3 |4 |5 |9 INT24_76
Not at all Rarely Sometimes Often Most of Not sure
the time
31. dealt with irritating life hassles? |1 |2 |3 |4 |5 |9 INT24_77
32. felt that things were going
your way? |1 |2 |3 |4 |5 |9 INT24_78
33. felt unable to control irritations
in your life? |1 |2 |3 |4 |5 |9 INT24_79
34. felt that you were on the top
of things? |1 |2 |3 |4 |5 |9 INT24_80
35. felt difficulties or problems
were piling up so high that
you could not handle them? |1 |2 |3 |4 |5 |9 INT24_81
36. On the average, how much time per day do you watch TV? ||:|| INT24_82
hours minutes

G. ADMINISTRATIVE INFORMATION:

37. How reliable was the participant in completing the questionnaire?
Very reliable |1 Reliable |2 Unreliable |3 INT24_83
Very unreliable |4 Uncertain |5
38. Did the participant complete the interview? **INT_STAT**
Yes, completed the interview |1
No, refused all questions |2
39. Interviewer: ||| INT_CODE
40. Date of interview: ||/||/||| INT_DATE
mo day yr

**THE STRONG HEART — FAMILY STUDY
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MEDICAL HISTORY FORM

SHS Family I.D. F A M I L Y I D _____

SHS. I.D.: I D N O _____

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 **MED4_1**
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 ||| **MED4_2**

YES NO UNKNOWN

2. Arthritis? |1 |2 |9 **MED4_3**

3. Any fractures associated with brittle bone disease or osteoporosis? |1 |2 |9 **MED4_4**

If YES,” where? _____ **MED4_4A**

4. Rheumatic heart disease? |1 |2 |9 **MED4_5**

5. Gallstones? |1 |2 |9 **MED4_6**

6. Cancer, including leukemia and lymphoma? |1 |2 |9 **MED4_7**

If YES,” specify type of cancer: _____ **MED4_7A**

7. Diabetes? Yes |1 No |2 Only during pregnancy |3 Unknown |9 **MED4_8**
(if No or Unknown, skip to Q8)

a) 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* ||| **MED4_10**

b) What type of treatment are you taking for your diabetes? *(Check appropriate answer)*

YES NO

i) insulin |1 |2 **MED4_11**

ii) oral hypoglycemic agent |1 |2 **MED4_12**

iii) by dietary control |1 |2 **MED4_13**

- | | | | | |
|-----|--------------|------|------|----------------|
| | | YES | NO | |
| iv) | by exercise | __ 1 | __ 2 | MED4_14 |
| v) | do nothing | __ 1 | __ 2 | MED4_15 |
| vi) | other: _____ | __ 1 | __ 2 | MED4_16 |

YES NO UNKNOWN

8. Has a medical person ever told you that you had kidney failure? |__|1 |__|2 |__|9 **MED4_17**
(if No or Unknown, skip to Q11)

a) If Yes, are one or both working well now? |__|1 |__|2 |__|9 **MED4_18**

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 |__|__|__| **MED4_19**

YES NO UNKNOWN

9. Are you currently on renal dialysis? |__|1 |__|2 |__|9 **MED4_20**

10. Have you ever had kidney transplant? |__|1 |__|2 |__|9 **MED4_21**

a) If Yes, is the new kidney working well? |__|1 |__|2 |__|9 **MED4_22**

b) If No, are you waiting for a kidney transplant? |__|1 |__|2 |__|9 **MED4_23**

11. Cirrhosis of the liver? |__|1 |__|2 |__|9 **MED4_24**

HEART PROBLEMS:

12. Have you had a heart catheterization? Yes |__|1 No |__|2 Unknown |__|9 **MED4_29**

(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 (*most recent*)? |__|_|__|_|/|__|_|__|_|/|__|_|__|_|__|_| **MED4_29D**
mo day yr

hospital/clinic: _____ **MED4_29P**

13. Have you ever had an angioplasty (balloon, PCTA, or Stent procedure)?

Yes |1 No |2 Unknown |9 **MED4_30**

a) If "YES," when and where (*most recent*)? ||||||||||| **MED4_30D**
mo day yr

hospital/clinic: _____ **MED4_30P**

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

Yes |1 No |2 Unknown |9 **MED4_31**

a) If "YES," when and where? ||||||||||| **MED4_31D**
mo day yr

hospital/clinic: _____ **MED4_31P**

Has a doctor ever told you that you had any of the following conditions?

(If more than one episode, enter information for the MOST RECENT)

15. Congestive heart failure? Yes |1 No |2 Unknown |9 **MED4_32**

a) If YES," when and where? ||||||||||| **MED4_32D**
mo day yr

hospital/clinic: _____ **MED4_32P**

b) If YES," do you still have heart failure now ? Yes |1 No |2 Unknown |9 **MED4_32N**

16. Heart attack? Yes |1 No |2 Unknown |9 **MED4_33**

a) If YES," when and where? ||||||||||| **MED4_33D**
mo day yr

hospital/clinic: _____ **MED4_33P**

17. Any other heart trouble? Yes |1 No |2 Unknown |9 **MED4_34**

If "YES," please specify type: _____ **MED4_34A**

a) If YES," when and where ||||||||||| **MED4_34D**
mo day yr

hospital/clinic: _____ **MED4_34P**

18. Stroke? Yes |__|1 No |__|2 Unknown |__|9 **MED4_35**

a) If "YES," when and where? |__|_|__|_|/|_|_|_|_|_|/|_|_|_|_|_| **MED4_35D**
mo day yr

hospital/clinic: _____ **MED4_35P**

19. Have you ever had surgery on your chest? Yes |__|1 No |__|2 (*skip to Q20*) **MED4_36**

a) Was it heart surgery? Yes |__|1 No |__|2 (*skip to Q20*) **MED4_37**

If "Yes," which surgery have you had?

i) Bypass? Yes |__|1 No |__|2 **MED4_38**

If "Yes," when and where (*most recent*)? |__|_|__|_|/|_|_|_|_|_|/|_|_|_|_|_| **MED4_38D**
mo day yr

hospital/clinic: _____ **MED4_38P**

ii) Valvular repair/replacement? Yes |__|1 No |__|2 **MED4_39**

If "Yes," when and where (*most recent*)? |__|_|__|_|/|_|_|_|_|_|/|_|_|_|_|_| **MED4_39D**
mo day yr

hospital/clinic: _____ **MED4_39P**

iii) Pacemaker? Yes |__|1 No |__|2 **MED4_40**

If "Yes," when and where (*most recent*)? |__|_|__|_|/|_|_|_|_|_|/|_|_|_|_|_| **MED4_40D**
mo day yr

hospital/clinic: _____ **MED4_40P**

iv) Other? Yes |__|1 No |__|2 **MED4_41**

If "Yes," when and where (*most recent*)? |__|_|__|_|/|_|_|_|_|_|/|_|_|_|_|_| **MED4_41D**
mo day yr

Please specify: _____ **MED4_41A**

hospital/clinic: _____ **MED4 41P**

20. Did the participant complete the interview? **MED_STAT**

Yes, completed the interview |__|1

No, some questions refused |__|2

No, refused all questions |__|3

IS THE PARTICIPANT FEMALE? Yes |__|1 (**go to next page**) No |__|2 **GENDER**

IF THE PARTICIPANT IS **MALE**, GO TO ROSE QUESTIONNAIRE

21. Interviewer: |__|_|__|_|__| **INT_CODE**

22. Date of interview: |__|_|__|_|/|__|_|__|_|/|__|_|__|_|__| **INT_DATE**
mo day yr

THE STRONG HEART — FAMILY STUDY

REPRODUCTION AND HORMONE USE (WOMEN ONLY)

SHS Family I.D. | F | A | M | I | D | | | |

SHS. I.D.: | I | D | N | O | | | |

“The following questions are related to your childbearing history and childbearing organs”.
(For Q1 - Q4, use 999 for Unknown)

1. How many times have you been pregnant? (gravidity) | | | | | **REP4_1**
(If never pregnant, skip to Q5)
2. How many of your pregnancies resulted in a live birth (parity)? | | | | | **REP4_2**
3. How many living children do you have? | | | | | **REP4_3**
4. How many pregnancies did you lose (including miscarriage or stillbirth)? | | | | | **REP4_4**
5. Have you ever used birth control pills? Yes | | |1 No | | |2 Not sure | | |3 **REP4_5**
(if NO or NOT SURE, go to Q6)
- a) Are you still using birth control pills? Yes | | |1 No | | |2 **REP4_6**
- b) How old were you when you started to use birth control pills?
 Indicate the age in years. 999=unknown | | | | | **REP4_7**
- c) How many years altogether did you use them? | | | | | **REP4_8**
Specify the duration in years. 0=less than 6 months, 1=6-12 months, 999=unknown.
6. Have you ever had a birth control implant (such as Norplant)?
 Yes | | |1 No | | |2 Not sure | | |3 **REP4_9**
(if NO or NOT SURE, go to Q7)
- a) Are you still using a birth control implant? Yes | | |1 No | | |2 **REP4_10**
- b) How old were you when you started to use a birth control implant?
 Indicate the age in years. 999=unknown, can't remember | | | | | **REP4_11**
- c) How many years altogether did you use it? | | | | | **REP4_12**
Specify the duration in years. 0=less than 6 months, 1=6-12 months, 999=unknown.
7. Have you ever used birth control shots (such as Depo Provera)?
 Yes | | |1 No | | |2 Not sure | | |3 **REP4_42**

(if NO or NOT SURE, go to Q8)

- a) Are you still using birth control shots? Yes |1 No |2 **REP4_42A**
- b) How old were you when you started to use birth control shots?
Indicate the age in years. 999=unknown, can't remember ||| **REP4_42B**
- c) How many years altogether did you use them? || **REP4_42C**
Specify the duration in years. 0=less than 6 months, 1=6-12 months, 999=unknown.
8. How old were you when you started to have regular menstrual cycles (periods)?
Indicate the age in years. 999=unknown ||| **REP4_13**
9. Have your menstrual cycles (periods) stopped? Yes |1 No |2 (*go to Q11*) **REP4_14**
10. If 'YES', have they stopped for 12 months or more? Yes |1 No |2 (*go to Q11*) **REP4_15**
- a) How old were you when your periods stopped completely?
Indicate the age in years. 999=unknown, can't remember ||| **REP4_16**
- b) Did your periods stop naturally, or because of surgery or hormone use, or for some other reason? Natural |1 (*go to Q11*) **REP4_17**
Surgery |2
Hormonal |3 (*go to Q11*)
Other, specify: _____ **REP 17A** |4 (*go to Q11*)
- c) If **SURGERY**, were both of your ovaries removed?
Yes |1 No |2 Unknown |9 **REP4_18**

“ESTROGEN and PROGESTERONE are types of female hormones that may be taken for many reasons, including after a hysterectomy or the menopause, to regulate your periods or for other reasons.”

11. Except for birth control pills, have you ever taken estrogen - either pills, as a patch or by shot - for any reason? Yes |1 No |2 Not sure |3 **REP4_19**
(if NO or NOT SURE, go to Q19)
12. How old were you when you started using estrogen? *Indicate age in years.* ||| **REP4_20**
13. How many years altogether did you take estrogen? *Specify duration in years.* ||| **REP4_21**

(If less than 3 months, record 0. If more than 3 months but less than 1 year, record 1)

14. Do/Did you use estrogen for (answer all applicable) YES NO NOT SURE
- a) post surgery (hysterectomy and removal of ovaries) |1 |2 |3 **REP4_22**
- b) relief of menopause symptoms |1 |2 |3 **REP4_23**
- c) prevent bone loss |1 |2 |3 **REP4_24**
- d) protect against heart disease |1 |2 |3 **REP4_25**
- e) doctor's advice |1 |2 |3 **REP4_26**
- f) other: _____ **REP4_26B** |1 |2 |3 **REP4_26A**
15. Do/Did you take progesterone in addition to, or in combination with, your estrogen treatment?
Yes |1 No |2 Not sure |3 **REP4_26C**
16. What form of estrogen are you taking? Is it a pill, patch, shot or other type?
pill |1 patch |2 shot |3 other |4 Not sure |5 **REP4_27**
17. Are you still taking estrogen? Yes |1 (**go to Q19**) No |2 (**go to Q18**) **REP4_28**
18. Why did you stop taking estrogen? YES NO UNKNOWN
- a) Caused Bleeding |1 |2 |9 **REP4_29**
- b) Made breasts tender |1 |2 |9 **REP4_30**
- c) Made you feel bloated |1 |2 |9 **REP4_31**
- d) Made you feel "funny," didn't like the way you felt |1 |2 |9 **REP4_32**

- e) Do not like taking any medicines |__|1 |__|2 |__|9 **REP4_33**
- YES NO UNKNOWN
- f) Too expensive |__|1 |__|2 |__|9 **REP4_34**
- g) Doctor's advice |__|1 |__|2 |__|9 **REP4_35**
- h) Concerned about long-term side effects |__|1 |__|2 |__|9 **REP4_36**
- i) Other: _____ **REP4_37A** |__|1 |__|2 |__|9 **REP4_37**

19. Other than in combination with estrogens, have you ever taken progesterone by itself for any reason? Yes |__|1 No |__|2 Not sure |__|3 **REP4_38**
(if NO or NOT SURE, go to Q23)
20. How old were you when you started using progesterone?
Indicate age in years. |__|__|__| **REP4_39**
21. How many years altogether did you take progesterone? *Specify duration in years.*
|__|__|__| **REP4_40**
(If less than 3 months, record 0. If more than 3 months but less than 1 year, record 1)
22. Are you still taking progesterone? Yes |__|1 No |__|2 **REP4_41**

23. Did the participant complete the interview? **REP_STAT**
- Yes, completed the interview |__|1
- No, refused all questions |__|2
24. Interviewer: |__|__|__| **INT_CODE**
25. Date of interview: |__|_|_|/|__|_|_|/|__|_|_|_|_| **INT_DATE**
mo day yr

THE STRONG HEART — FAMILY STUDY

ROSE QUESTIONNAIRE FOR ANGINA AND INTERMITTENT CLAUDICATION

SHS Family I.D. | F | A | M | I | D | | |

SHS. I.D.: | I | D | N | O | | |

Section A: Chest Pain on Effort

1. Have you ever had any pain or discomfort in your chest? Yes | | |1 No | | |2 ROSE4_1

(go to Section C)

2. Do you get it when you walk uphill, upstairs or hurry? Yes | | |1 ROSE4_2

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 ROSE4_3

4. What do you do if you get it while you are walking? Stop or slow down | | |1 ROSE4_4

(Record "stop or slow down" if subject carries on after taking nitroglycerine.)

Carry on | | |2 (go to Section B)

5. If you stand still, what happens to it? Relieved | | |1 Not relieved | | |2 ROSE4_5

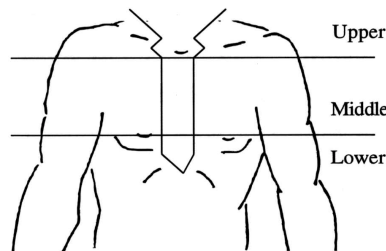
(go to Section B)

6. How soon? 10 minutes or less | | |1 More than 10 minutes | | |2 ROSE4_6

(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.)

YES NO



Sternum (upper or middle) | | |1 | | |2 ROSE4_7A

Sternum (lower) | | |1 | | |2 ROSE4_7B

Left anterior chest | | |1 | | |2 ROSE4_7C

Left arm | | |1 | | |2 ROSE4_7D

Other: ROSE4_7EA | | |1 | | |2 ROSE4_7E

8. Do you feel it anywhere else? Yes | | |1 No | | |2

If "YES," record additional information : ROSE4_8A

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 **ROSE4_9**

Section C: Intermittent Claudication

10. Do you get pain in either leg on walking? Yes |1 **ROSE4_10**
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 **ROSE4_11**
12. In what part of your leg did you feel it? Pain includes calf/calves |1 **ROSE4_12**
Pain does not include calf/calves |2 (*go to Q19*)
If calves not mentioned, ask: "Anywhere else?" *Please specify:* _____ **ROSE4_12A**
-
13. Do you get it if you walk uphill or hurry? Yes |1 **ROSE4_13**
No |2 (*go to Q19*)
Never hurries or walks uphill |3
14. Do you get it if you walk at an ordinary pace on the level? Yes |1 No |2 **ROSE4_14**
15. Does the pain ever disappear while you are walking? Yes |1 (*go to Q19*) No |2 **ROSE4_15**
16. What do you do if you get it when you are walking? Stop or slow down |1 **ROSE4_16**
Carry on |2 (*go to Q19*)
17. What happens to it if you stand still? Relieved |1 **ROSE4_17**
Not Relieved |2 (*go to Q19*)
18. How soon? 10 minutes or less |1 More than 10 minutes |2 **ROSE4_18**
- END OF ROSE QUESTIONNAIRE**

19. Did the participant complete the interview? **RS_STAT**
Yes, completed the interview |1
No, refused all questions |2
20. Interviewer: |||| **INT_CODE**
21. Date of interview: |||/||||/||||| **INT_DATE**
mo day yr

**THE STRONG HEART — FAMILY STUDY
GENETICS OF CARDIOVASCULAR DISEASE IN AMERICAN INDIANS**

RESPIRATORY QUESTIONS

SHS Family I.D.: F A M I D

SHS. I.D.: I D N O

1. a) Do you usually have a cough? Yes |1 No |2 (skip to Q3) **RESP4_1**
- b) Do you usually cough as much as 4 to 6 times a day, 4 or more days out of the week? Yes |1 No |2 **RESP4_2**
- c) Do you usually cough at all on getting up, or first thing in the morning? Yes |1 No |2 **RESP4_3**
- d) Do you usually cough like this on most days for 3 consecutive months or more during the year? Yes |1 No |2 **RESP4_4**
- e) How long have you had this cough? **RESP4_5Y** |/| | **RESP4_5M**
years months
2. Do you usually bring up phlegm from your chest when you cough? **RESP4_6**
 Yes |1 No |2
3. Does your chest ever sound wheezy or whistling : Yes No
- a) when you have a cold? |1 |2 **RESP4_7**
- b) occasionally apart from colds? |1 |2 (go to Q4) **RESP4_8**
- c) most days? |1 |2 **RESP4_9**
- d) most nights? |1 |2 **RESP4_10**
4. Have you ever had an attack of wheezing that has made you feel short of breath? Yes |1 No |2 **RESP4_11**
5. Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill
 Yes |1 **RESP4_12**
 No |2 (go to Q10)
 Unable to walk |4 (go to Q10)
6. Do you have to walk slower on level ground than people of your age due to breathlessness? Yes |1 No |2 **RESP4_13**
7. Do you ever have to stop for breath when walking at your own pace on level ground? Yes |1 No |2 **RESP4_14**
8. Do you ever have to stop for breath after walking 100 yards (the length of a football field) or after a few minutes on level ground? Yes |1 No |2 **RESP4_15**

- 9. Are you too breathless to leave the house or breathless after dressing or undressing? Yes |1 No |2 **RESP4_16**
- 10. Did you have any lung trouble before the age of 16? Yes |1 No |2 **RESP4_17**
- 11. Have you ever been told you snore? Yes |1 No |2 **RESP4_18**

12. LUNG PROBLEMS

Has a medical person ever told you that you had any of the following conditions?

- | | YES | NO | UNKNOWN | |
|---|-----------------------------|-----------------------------|-----------------------------|-----------------|
| a. Emphysema? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 9 | RESP4_19 |
| b. Hay fever? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 9 | RESP4_20 |
| c. Chronic bronchitis? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 9 | RESP4_21 |
| d. Asthma? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 9 | RESP4_22 |
| If "YES" for asthma, do you still have it now? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 9 | RESP4_23 |
| e. At any time during the last 12 months, have you had Wheezing or whistling in your chest? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 9 | RESP4_24 |

- 13. Did the participant complete the interview? **RES_STAT**
 Yes, completed the interview |1
 No, refused all questions |2
- 14. Interviewer: **INT_CODE**
||||
- 15. Date of interview: **INT_DATE**
|||/||||/|||||
mo day yr

THE STRONG HEART — FAMILY STUDY
GENETICS OF CARDIOVASCULAR DISEASE IN AMERICAN INDIANS
PHYSICAL EXAMINATION

SHS Family I.D. | F | A | M | I | D | | | |

SHS. I.D.: | I | D | N | O | | | |

I. EXAMINATION OF EXTREMITIES FOR AMPUTATIONS

1. Are any extremities missing? Yes |__|₁ No |__|₂ (*Skip to next Section*) **EX4_9**

If "YES" to amputation, Please code the cause of amputation:

1 = Diabetes

4 = Other, please specify

2 = Trauma

9 = Unknown

3 = Congenital

Extremities	Check if Missing	Cause
a. Right arm	EX4_10	EX4_11 <u>EX4_11A</u>
b. Right hand	EX4_12	EX4_13 <u>EX4_13A</u>
c. Right finger(s)	EX4_14 <u>EX4_15</u> # missing	EX4_16 <u>EX4_16A</u>
d. Left arm	EX4_17	EX4_18 <u>EX4_18A</u>
e. Left hand	EX4_19	EX4_20 <u>EX4_20A</u>
f. Left fingers	EX4_21 <u>EX4_22</u> # missing	EX4_23 <u>EX4_23A</u>
g. Right leg above knee	EX4_24	EX4_25 <u>EX4_25A</u>
h. Right leg below knee	EX4_26	EX4_27 <u>EX4_27A</u>
i. Right foot	EX4_28	EX4_29 <u>EX4_29A</u>
j. Right toe(s)	EX4_30 <u>EX4_31</u> # Missing	EX4_32 <u>EX4_32A</u>
k. Left leg above knee	EX4_33	EX4_34 <u>EX4_34A</u>
l. Left leg below knee	EX4_35	EX4_36 <u>EX4_36A</u>
m. Left foot	EX4_37	EX4_38 <u>EX4_38A</u>
n. Left toe(s)	EX4_39 <u>EX4_40</u> # Missing	EX4_41 <u>EX4_41A</u>

II. BLOOD PRESSURE

2. Right arm circumference, measured in centimeters (cm) |__| |__| |__| **EX4_42**
Midway between acromium and olecranon

3. Cuff size (arm circumference in brackets) Pediatric (under 24cm) |__|₁ **EX4_43**
 Regular arm (24-32cm) |__|₂
 Large arm (33-41cm) |__|₃
 Thigh (>41cm) |__|₄

4. Pulse obliteration pressure ||| EX4_44
5. Seated Blood Pressure: **Systolic BP** **Diastolic BP**
- a) **First** Blood Pressure Measurement ||| EX4_45 ||| EX4_46
- b) **Second** Blood Pressure Measurement ||| EX4_47 ||| EX4_48
- c) **Third** Blood Pressure Measurement ||| EX4_49 ||| EX4_50
6. Were the above blood pressures taken from RIGHT arm? Yes ||¹ EX4_51
 No ||²
- Specify: _____ EX4_51A
7. Recorder ID (For the SHS staff who took BP): ||| EX4_52

III. ANTHROPOMETRIC MEASUREMENTS:
 (Take off shoes and remove heavy objects from pockets.)

METRIC SYSTEM
 (centimeters/cm/kg)

8. Height (Standing) ||| cm EX4_53
9. Weight(Standing) ||| kg EX4_55
10. Hip circumference (Standing) ||| cm EX4_57
11. Waist measurement at umbilicus (Supine) ||| cm EX4_59

IV. PEDAL PULSES AND EDEMA

- | | | PRESENT | ABSENT | MISSING LIMBS | UNABLE TO ASSESS |
|----------------------------------|--|--|--|-------------------------------------|------------------|
| 12. Right posterior tibial pulse | <input type="text"/> ¹ | <input type="text"/> ² | <input type="text"/> ³ | <input type="text"/> ⁹ | EX4_61 |
| 13. Right dorsalis pedis pulse | <input type="text"/> ¹ | <input type="text"/> ² | <input type="text"/> ³ | <input type="text"/> ⁹ | EX4_62 |
| 14. Left posterior tibial pulse | <input type="text"/> ¹ | <input type="text"/> ² | <input type="text"/> ³ | <input type="text"/> ⁹ | EX4_63 |
| 15. Left dorsalis pedis pulse | <input type="text"/> ¹ | <input type="text"/> ² | <input type="text"/> ³ | <input type="text"/> ⁹ | EX4_64 |
| 16. Pedal edema | Absent <input type="text"/> ¹ | Mild <input type="text"/> ² | Marked <input type="text"/> ³ | | EX4_65 |

V. IMPEDANCE MEASUREMENT

17. a) Was impedance taken? Yes |1 No |2 **EX4_66**
(go to b)
- if No, due to:* Amputation |1 **EX4_66A**
(go to Q18) Wound/dressing |2
Cast |3
Dialysis shunt |4
Refusal |8
- b) Taken on right side? Yes |1 No |2 **EX4_67**
(go to c)
- if No, due to:* Amputation |1 **EX4_67A**
Wound/dressing |2
Cast |3
Dialysis shunt |4
Refusal |8
- c) Resistance|||| **EX4_68**
- d) Reactance|||| **EX4_69**

VI. 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 obliterate (over 250 mmHg).*

- | | | Right arm | Right ankle | Left ankle |
|--------|----------------------|--|--|------------|
| 18. a) | First systolic B.P. | EX4_70 | EX4_71 | EX4_72 |
| b) | Second systolic B.P. | EX4_73 | EX4_74 | EX4_75 |
| c) | Location | Posterior tibial EX4_76 ₁ | Posterior tibial EX4_77 ₁ | |
| | | Dorsalis pedis EX4_76 ₂ | Dorsalis pedis EX4_77 ₂ | |

VII. ACANTHOSIS NIGRICANS

19. Acanthosis Nigricans in the back of neck: Not Present |__|0 **EX4_78**
Grade 1 |__|1
Grade 2 |__|2
Grade 3 |__|3
Grade 4 |__|4
-

VIII. ADMINISTRATIVE INFORMATION

20. Did the participant complete this examination? **EX4_STAT**
Yes, completed the examination |__|1
No, refused all questions |__|2
21. SHS Code of person completing this form |_|_|_|_| **INT_CODE**
22. Date of Examination: |_|_|_|_|/|_|_|_|_|/|_|_|_|_| **INT_DATE**
mo day yr

**THE STRONG HEART — FAMILY STUDY
GENETICS OF CARDIOVASCULAR DISEASE IN AMERICAN INDIANS**

SAMPLE COLLECTION CHECKLIST

SHS Family I.D. F A M I D

SHS. I.D.: I D N O

1. Fasting One Touch glucose result. 999= *not done* |_|_|_| **GTT4_1**

2. Is **FASTING** blood sample taken?
 - Yes, and participant has been fasting |_|1 **GTT4_2**
 - Yes, but participant has NOT been fasting |_|2
 - No, participant has not been fasting |_|3
 - Other, specify: _____ **GTT4_2A** _____ |_|4
 - No, participant refused |_|8

3. When was the last time you ate (*use military time*) |_|_|:|_|_| **GTT4_3**

4. Time of collection of fasting samples |_|_|:|_|_| **GTT4_4**

5. Is urine sample taken? Yes |_|1 (**go to Q7**) No |_|2 **GTT4_5**

6. If no, why?
 - On dialysis. |_|1 **GTT4_6**
 - Cannot urinate. |_|2
 - Other, specify: _____ **GTT4_6A** _____ |_|3

7. Time of collection of urine sample |_|_|:|_|_| **GTT4_7**

8. Blood Samples/Urine Checklist. Check the box(es) if samples were collected

<u>Item</u>	<u>Purpose</u>	<u>Type</u>	<u>Check</u>
One 10 ml SST	Chem Profile, Lipids, Insulin	Serum	<input type="checkbox"/> GTT4_8A
One 4.5 ml Lt Blue	PAI-1, Fibrinogen	Plasma	<input type="checkbox"/> GTT4_8B
One 7 ml Gray	Fasting glucose	Plasma	<input type="checkbox"/> GTT4_8C
One 10 ml Green	Heparin storage	Plasma/Buffy coat	<input type="checkbox"/> GTT4_8D
One 10 ml Purple	HbA1c	Whole blood	<input type="checkbox"/> GTT4_8E
One 10 ml Purple	DNA	Buffy coat	<input type="checkbox"/> GTT4_8F
One 10 ml Purple	LDL size, ApoE	Serum	<input type="checkbox"/> GTT4_8G
Urine	Albumin/creatinine	Urine	<input type="checkbox"/> GTT4_8H

9. Is this participant also a volunteer for blood/urine QC? Yes ₁ No ₂ **GTT4_9**

If the participant is NOT a QC volunteer, skip to Q12.

10. QC ID (second digit is "3"): **GTT4_10**

11. QC samples checklist. Check the box(es) if samples were collected

<u>Item</u>	<u>Purpose</u>	<u>Type</u>	<u>Check</u>
One 10 ml SST	Chem Profile, Lipids, Insulin	Serum	<input type="checkbox"/> GTT4_11A
One 4.5 ml Lt Blue	PAI-1, Fibrinogen	Plasma	<input type="checkbox"/> GTT4_11B
One 7 ml Gray	Fasting glucose	Plasma	<input type="checkbox"/> GTT4_11C
One 10 ml Purple	LDL size, ApoE	Serum	<input type="checkbox"/> GTT4_11D
Urine	Albumin/creatinine	Urine	<input type="checkbox"/> GTT4_11E

Instructions:

“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.”

12. If you did, when and what: **GTT4_CHK**

13. SHS Code of person completing this form **INT_CODE**

14. Today's Date / / **INT_DATE**
mo day yr

THE STRONG HEART— FAMILY STUDY
GENETICS OF CARDIOVASCULAR DISEASE IN AMERICAN INDIANS
CBC Results

SHS Family I.D. SHS. I.D.:

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

- | | | | |
|-----|--|---|-------|
| 1. | WBC (10 ⁹ /L) | <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> | WBC4 |
| 2. | RBC (10 ¹² /L) | <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> | RBC4 |
| 3. | HGB (g/dL) | <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> | HGB4 |
| 4. | HCT (%) | <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> | HCT4 |
| 5. | MCV (fL) | <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> | MCV4 |
| 6. | MCH (pg) | <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> | MCH4 |
| 7. | MCHC (g/dL) | <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> | MCHC4 |
| 8. | RDW (%) | <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> | RDW4 |
| 9. | Platelet count (PLT .. 10 ⁹ /L) | <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> | PLT4 |
| 10. | MPV (fL) | <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> | MPV4 |

DIFFERENTIAL

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

- | | | | |
|-----|--|---|----------|
| 11. | NEUT (%) | <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> | NEUT4 |
| 12. | LYMPH (%) | <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> | LYMPH4 |
| 13. | MONO (%) | <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> | MONO4 |
| 14. | EOS (%) | <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> | EOS4 |
| 15. | BASO (%) | <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> | BASO4 |
| 16. | Did the participant have a CBC? | Yes <u> </u> 1 No <u> </u> 2 | CBC_STAT |
| 17. | Code number of person completing this form | <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> | INT_CODE |
| 18. | Date of data collection | <u> </u> <u> </u> <u> </u> / <u> </u> <u> </u> <u> </u> / <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> | INT_DATE |
| | | <small>mo day yr</small> | |

**THE STRONG HEART — FAMILY STUDY
GENETICS OF CARDIOVASCULAR DISEASE IN AMERICAN INDIANS**

QUALITY OF LIFE ¹

SHS Family I.D. F A M I L Y I D

SHS. I.D.: I D N O

How is this questionnaire administered? By interviewer |1 By self |2 Refused |8
QUA4_0

1. In general, would you say your health is: **(Please Check Only One)**

- Excellent. |1 **QUA4_1**
- Very good. |2
- Good. |3
- Fair. |4
- Poor. |5

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 Number Per Line)

- | | <u>Yes,
Limited
a Lot</u> | <u>Yes
Limited
a Little</u> | <u>No
Not Limited
at All</u> | |
|--|-----------------------------------|-------------------------------------|--------------------------------------|---------------|
| 2. Moderate activities , such as moving a table, pushing a vacuum cleaner, bowling or playing golf..... | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | QUA4_4 |
| 3. Climbing several flights of stairs..... | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | QUA4_6 |

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)

- | | <u>Yes</u> | <u>No</u> | |
|--|-----------------------------|-----------------------------|----------------|
| 4. Accomplish less than you would like. | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | QUA4_14 |
| 5. Were limited in the kind of work or other activities. | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | QUA4_15 |

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)

- | | <u>Yes</u> | <u>No</u> | |
|--|-----------------------------|-----------------------------|----------------|
| 6. Accomplish less than you would like | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | QUA4_18 |
| 7. Didn't do work or other activities as carefully as usual. | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | QUA4_19 |

8. **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 **QUA4_22**
- Slightly |__|2
- Moderately |__|3
- Quite a bit. |__|4
- Extremely. |__|5

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 Number Per Line)

<u>All of the Time</u>	<u>Most of the Time</u>	<u>a Good Bit of the Time</u>	<u>Some of the Time</u>	<u>a Little of the Time</u>	<u>None of the Time</u>
--------------------------------	---------------------------------	---------------------------------------	---------------------------------	-------------------------------------	---------------------------------

- 9. Have you felt calm and peaceful? |__|1 |__|2 |__|3 |__|4 |__|5 |__|6 **QUA4_26**
- 10. Did you have a lot of energy? . |__|1 |__|2 |__|3 |__|4 |__|5 |__|6 **QUA4_27**
- 11. Did you feel downhearted and blue? |__|1 |__|2 |__|3 |__|4 |__|5 |__|6 **QUA4_28**

12. **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 Circle One Number)

- All the time. |__|1 **QUA4_32**
- Most of the time |__|2
- Some of the time. |__|3
- A Little of the time. |__|4
- None of the time. |__|5

13. Interviewer/Reviewer: |__| |__| |__| |__| **INT_CODE**

14. Date of interview: |__| |__| / |__| |__| / |__| |__| |__| |__| **INT_DATE**
mo day yr

**THE STRONG HEART – FAMILY STUDY
GENETICS OF CARDIOVASCULAR DISEASE IN AMERICAN INDIANS**

CES-D SCALE

SHS Family I.D. **F** **A** **M** **I** **D** SHS. I.D.: **I** **D** **N** **O** How is this questionnaire administered? 1=By interviewer 2=By self 8=Refused**CES_STAT**

Here are some questions (Q2-Q22) about your feelings during the past week. For each of the following statements, please respond as to whether you felt that way: Rarely or Not At All, Some of the time, Often, or Most of the time.

During the **past week** . . .

	Rarely or Not at ALL < 1 day 1	Some 1-2 days 2	Often 3-4 days 3	Most of the Time 5-7 days 4	Not Applicable 9	
1. I was bothered by things that don't usually bother me.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 9	CES4_1
2. I did not feel like eating; my appetite was poor.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 9	CES4_2
3. I felt that I could not shake the blues even with help from my family or friends.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 9	CES4_3
4. I felt that I was just as good as other people.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 9	CES4_4
5. I had trouble keeping my mind on what I was doing.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 9	CES4_5
6. I felt depressed	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 9	CES4_6
7. I felt that everything I did was an effort.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 9	CES4_7
8. I felt hopeful about the future.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 9	CES4_8
9. I thought my life had been a failure.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 9	CES4_9
10. I felt fearful.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 9	CES4_10
11. My sleep was restless.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 9	CES4_11
12. I was happy.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 9	CES4_12

For each of the following statements, please respond as to whether you felt that way: Rarely or Not At All, Some of the time, Often, or Most of the time.

During the past week . . .	Rarely or	Some	Often	Most of	Not	
	Not at AL	1-2 days	3-4 days	the Time	Applicable	
	< 1 day			5-7 days		
	1	2	3	4	9	
13. I talked less than usual.	__ 1	__ 2	__ 3	__ 4	__ 9	CES4_13
14. I felt lonely.	__ 1	__ 2	__ 3	__ 4	__ 9	CES4_14
15. People were unfriendly.	__ 1	__ 2	__ 3	__ 4	__ 9	CES4_15
16. I enjoyed life.	__ 1	__ 2	__ 3	__ 4	__ 9	CES4_16
17. I had crying spells.	__ 1	__ 2	__ 3	__ 4	__ 9	CES4_17
18. I felt sad.	__ 1	__ 2	__ 3	__ 4	__ 9	CES4_18
19. I felt that people disliked me.	__ 1	__ 2	__ 3	__ 4	__ 9	CES4_19
20. I felt like I couldn't do what I needed to do.	__ 1	__ 2	__ 3	__ 4	__ 9	CES4_20

For Question 21, please use the following scale: Rarely or Not at ALL, Some, Often, Most of the Time, Not Applicable

< 1 day	1-2 days	3-4 days	5-7 days	
1	2	3	4	9

21. I have felt depressed or sad in this **past year**. |__|1 |__|2 |__|3 |__|4 |__|9 **CES4_21**

22. Interviewer/Reviewer: |__|__|__| **INT_CODE**

23. Date of interview: |__|__|/|__|__|/|__|__|__|__| **INT_DATE**
mo day yr

**THE STRONG HEART STUDY – FAMILY STUDY
GENETICS OF CARDIOVASCULAR DISEASE IN AMERICAN INDIANS**

MHLC SCALE

SHS Family I.D.

SHS. I.D.:

How was the questionnaire administered? 1=By interviewer 2=By self 8=Refused

MHL_STAT

Each item below is a belief statement about your medical condition with which you may agree or disagree. Each statement is a scale which ranges from strongly disagree (0) to strongly agree (3). For each item we would like you to write the number that represents the extent to which you agree or disagree with that statement. The more you agree with a statement, the higher will be the number you write. This is a measure of your personal beliefs; obviously, there are no right or wrong answers.

	Strongly Disagree 0	Disagree 1	Agree 2	Strongly Agree 3	
1. If I become sick, I have the power to make myself well again.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	MHLC4_1
2. Often I feel that no matter what I do, if I am going to get sick, I will get sick.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	MHLC4_2
3. If I see an excellent doctor regularly, I am less likely to have health problems.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	MHLC4_3
4. Most things that affect my health happen by accidental happenings.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	MHLC4_4
5. I can only maintain my health by consulting health professionals.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	MHLC4_5
6. I am directly responsible for my health.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	MHLC4_6
7. Other people play a big part in whether I stay healthy or become sick.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	MHLC4_7
8. Whatever goes wrong with my health is my own fault	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	MHLC4_8
9. When I am sick, I just have to let nature run its course.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	MHLC4_9
10. Health professionals keep me healthy.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	MHLC4_10
11. When I stay healthy, I'm just plain lucky.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	MHLC4_11

	Strongly Disagree 0	Disagree 1	Agree 2	Strongly Agree 3	
12. My physical well-being depends on how well I take care of myself.	_ 0	_ 1	_ 2	_ 3	MHLC4_12
13. When I feel ill, I know it is because I have not been taking care of myself properly.	_ 0	_ 1	_ 2	_ 3	MHLC4_13
14. The type of care I receive from other people is what is responsible for how well I recover from an illness.	_ 0	_ 1	_ 2	_ 3	MHLC4_14
15. Even when I take care of myself, it's easy to get sick.	_ 0	_ 1	_ 2	_ 3	MHLC4_15
16. When I become ill, it's a matter of fate.	_ 0	_ 1	_ 2	_ 3	MHLC4_16
17. I can pretty much stay healthy by taking good care of myself.	_ 0	_ 1	_ 2	_ 3	MHLC4_17
18. Following doctor's orders to the letter is the best way for me to stay healthy.	_ 0	_ 1	_ 2	_ 3	MHLC4_18
19. Interviewer/ Reviewer:				_ _ _ _	INT_CODE
20. Date of interview:				_ _ _ _ / _ _ _ _ / _ _ _ _	INT_DATE
	mo	day	yr		

**THE STRONG HEART-FAMILY STUDY
GENETICS OF CARDIOVASCULAR DISEASE IN AMERICAN INDIANS**

SOCIAL SUPPORT

SHS Family I.D.

SHS I.D.:

How was the questionnaire administered? 1=By interviewer 2=By self 8=Refused

AI4_STAT

This scale is an assessment of social support, and is made up of a list of statements, which may or may not be true about you. For each statement, check the response that best describes you.

1. How often do you talk on the phone or get together with friends or relatives who do not live with you? . . .
- | | | | |
|--------------------------------------|----|---|--------------|
| Every day | __ | 5 | AI4_1 |
| A few times a week | __ | 4 | |
| A few times a month | __ | 3 | |
| Once a month | __ | 2 | |
| Less than once a month, or | __ | 1 | |
| Never (IF VOL.) | __ | 0 | |

NOT MUCH			
AT ALL	SOME	A LOT	
1	2	3	

- | | | | | | | | | |
|----|---|----|---|----|---|----|---|--------------|
| 2. | How much do your friends or relatives really care about you-- a lot, some, or not much at all? | __ | 1 | __ | 2 | __ | 3 | AI4_2 |
| 3. | How much do they understand the way you feel about things? | __ | 1 | __ | 2 | __ | 3 | AI4_3 |
| 4. | How much do they appreciate you? | __ | 1 | __ | 2 | __ | 3 | AI4_4 |
| 5. | How much can you rely on them for help if you have a serious problem? | __ | 1 | __ | 2 | __ | 3 | AI4_5 |
| 6. | How much can you talk to them about your worries? | __ | 1 | __ | 2 | __ | 3 | AI4_6 |
| 7. | How much can you relax and be yourself around them? | __ | 1 | __ | 2 | __ | 3 | AI4_7 |

RARELY

- | | | NEVER
0 | SOMETIMES
1 | OFTEN
2 | |
|-----|---|------------|----------------|------------|---------------|
| 8. | How often do your friends or relatives make too many demands on you-- often, sometimes, rarely or never? | __ 0 | __ 1 | __ 2 | AI4_8 |
| 9. | How often do they argue with you? | __ 0 | __ 1 | __ 2 | AI4_9 |
| 10. | How often do they criticize you? | __ 0 | __ 1 | __ 2 | AI4_10 |
| 11. | How often do they let you down when you are counting on them? | __ 0 | __ 1 | __ 2 | AI4_11 |
| 12. | How often do they get on your nerves? | __ 0 | __ 1 | __ 2 | AI4_12 |

- | | | RARELY
NEVER
0 | SOMETIMES
1 | OFTEN
2 | |
|-----|--|----------------------|----------------|------------|---------------|
| 13. | How often do they drink or use drugs too much? | __ 0 | __ 1 | __ 2 | AI4_13 |

Among the people you know, is there someone . . .

- | | | NO
0 | YES
1 | |
|-----|--|---------|----------|---------------|
| 14. | you can go with to play cards, or go to bingo, a powwow, or a community meeting? | __ 0 | __ 1 | AI4_14 |
| 15. | who would lend you money if you needed it in an emergency? | __ 0 | __ 1 | AI4_15 |
| 16. | who would lend you a car or drive you somewhere else if you really needed it? | __ 0 | __ 1 | AI4_16 |
| 17. | you could call who would bail you out if you were arrested and put in jail? | __ 0 | __ 1 | AI4_17 |
| 18. | you could count on to check in on you regularly? | __ 0 | __ 1 | AI4_18 |

19. How isolated do you feel? . . .
- | | | |
|------------------------------------|------|---------------|
| Very isolated | __ 3 | AI4_19 |
| Somewhat isolated | __ 2 | |
| Not very isolated at all | __ 1 | |

20. How often do you purposefully avoid family gatherings? . . .

A lot |__|3 **AI4_20**
 Sometimes, or |__|2
 Not very much at all |__|1

21. Of those family gatherings you go to, how likely are you to leave early? . . .

Very likely |__|3 **AI4_21**
 Somewhat likely, or |__|2
 Not at all likely |__|1

22. Interviewer/Reviewer: |__|__|__| **INT_CODE**

23. Date of interview: |__|__|/|__|__|/|__|__|__|__| **INT_DATE**
mo day yr

	Or Never 0	Sometimes 1	or Always 2	Always 3	
14. I am more critical of (judge or find fault with) others than I let people know.	__ 0	__ 1	__ 2	__ 3	SPIE4_14
15. I get angrier than I usually admit.	__ 0	__ 1	__ 2	__ 3	SPIE4_15
16. I calm down faster than most people.	__ 0	__ 1	__ 2	__ 3	SPIE4_16
17. I say mean things.	__ 0	__ 1	__ 2	__ 3	SPIE4_17
18. I am irritated (frustrated, annoyed) much more than people are aware of.	__ 0	__ 1	__ 2	__ 3	SPIE4_18
19. I lose my temper.	__ 0	__ 1	__ 2	__ 3	SPIE4_19
20. If someone bothers (frustrates, irritates) me, I am likely to tell him/her.	__ 0	__ 1	__ 2	__ 3	SPIE4_20

These next questions (Q21- Q28) are about how you think about other people. Although we cannot really know what people would think or do unless they tell us, we would like to know your opinion as to whether you think each of the following statements is "True or False". Once again, this is your opinion, so there is no right or wrong answer.

	True 0	False 1	
21. No one cares much about what happens to me.	__ 0	__ 1	COOK4_1
22. It is safer to trust nobody.	__ 0	__ 1	COOK4_2
23. Most people would lie to get ahead.	__ 0	__ 1	COOK4_3
24. Most people inwardly dislike putting themselves out to help other people.	__ 0	__ 1	COOK4_4
25. Most people will use unfair means to gain an advantage rather than lose it.	__ 0	__ 1	COOK4_5
26. Most people are honest mainly through fear of being caught.	__ 0	__ 1	COOK4_6
27. I often wonder what hidden reason another person may have for doing something nice for me.	__ 0	__ 1	COOK4_7
28. Most people make friends because friends are likely to be useful to them.	__ 0	__ 1	COOK4_8
29. Interviewer/Reviewer:	_ _ _ _		INT_CODE
30. Date of interview:	_ _ _ _ / _ _ _ _ / _ _ _ _		INT_DATE
	mo	day	yr

**THE STRONG HEART – FAMILY STUDY
GENETICS OF CARDIOVASCULAR DISEASE IN AMERICAN INDIANS**

**DIRECTIONS TO PARTICIPANTS FOR USING THE ACTIVITY METER
(PEDOMETER)**

The Accusplit Activity Meter (pedometer) counts the number of steps taken while walking. You have been requested to wear this meter EVERY DAY for a seven day period from _____ to _____. The pedometer is to be clipped at the waist to your clothes, underwear, or on a belt and worn on the _____ hip and must be kept in an upright position. Please keep the pedometer firmly against your body so it does not move around freely. You can use a belt or elastic strap to keep it in place on your hip. Please DO NOT LET THE PEDOMETER GET WET by wearing it in the rain or while bathing or swimming. Please remember to reset the pedometer to “0” (zero) when you put it on in the morning and to record the pedometer number in your activity record when you take it off at night.

If you have any questions, please contact:

_____ at
_____.

Specific Instructions

1. Every morning, just before you put the pedometer on, push the reset button to read “0”.
2. Record the time you reset the pedometer on the activity record page.
3. ***Wear the pedometer all day except for bathing, swimming or in the rain (unless you can keep it dry). If you take it off, record the length of time it was off (minutes or hours) on your activity record page.***
4. At bedtime, take off the pedometer. Record on your activity record page (a) the pedometer number (the number of steps taken), and (b) the time you removed the pedometer.
5. Please do not touch the reset button during the day or you will erase your activity numbers.
6. Wear the pedometer on your dominant hip (right hip for right handed people and left hip for left handed people), keep it upright, and make sure it fits firmly against your body so it does not move around.
7. ***Keep the cover closed or it will not record your steps.***
8. The pedometer will not work correctly if it is in a pants, coat, or shirt pocket. It will not work correctly if it is sideways either.
9. Please mail the activity record to us in the self-addressed stamped envelope after you complete your week.
10. Please keep the pedometer as a token of our appreciation of your participation in the Strong Heart Family Study.

Thank you very much for your time and effort!

SHS Family Study – Cardiovascular Disease in American Indians
National Heart, Lung, and Blood Institute

ACTIVITY METER SEVEN-DAY RECORD

ACT_STAT

Name: _____

Strong Heart Study ID No: **IDNO** _____

Family Study ID No: **FAMID** _____

Reminder: Reset the Activity Meter (pedometer) to “0” every morning

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Date	ACT4_1A	ACT4_2A	ACT4_3A	ACT4_4A	ACT4_5A	ACT4_6A	ACT4_7A
Day of week	ACT4_1B	ACT4_2B	ACT4_3B	ACT4_4B	ACT4_5B	ACT4_6B	ACT4_7B
Time attached	ACT4_1C	ACT4_2C	ACT4_3C	ACT4_4C	ACT4_5C	ACT4_6C	ACT4_7C
Meter number at bedtime	ACT4_1D	ACT4_2D	ACT4_3D	ACT4_4D	ACT4_5D	ACT4_6D	ACT4_7D
Time removed	ACT4_1E	ACT4_2E	ACT4_3E	ACT4_4E	ACT4_5E	ACT4_6E	ACT4_7E
Did you take off the meter for any reason?	ACT4_1F	ACT4_2F	ACT4_3F	ACT4_4F	ACT4_5F	ACT4_6F	ACT4_7F
If yes, for how long?	ACT4_1G ACT4_1H	ACT4_2G ACT4_2H	ACT4_3G ACT4_3H	ACT4_4G ACT4_4H	ACT4_5G ACT4_5H	ACT4_6G ACT4_6H	ACT4_7G ACT4_7H

Complete this question after completing this journal.

Has your physical activity in the past seven (7) days been typical for you compared to your regular activity level? Yes |1 No |2 **ACT4_8**

**THE STRONG HEART STUDY III
CARDIOVASCULAR DISEASE IN AMERICAN INDIANS**

MEDICATION CHECKLIST

SHS Family I.D.

SHS I.D.:

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, eyedrops, 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 |4 *(Cite reasons for refusal in the space below)*

Reasons for refusal: _____ : Go to Section C

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?

Medication Name <i>Print the first 20 letters only. Please print clearly.</i>	Strength (mg) <i>Write the decimal as one of the digits.</i>	Number Prescribed <i>Circle: day, week, month</i>	PRN Medicine?
1 _____	_____	— D W M	Y N — D W M
2 _____	_____	— D W M	Y N — D W M
3 _____	_____	— D W M	Y N — D W M
4 _____	_____	— D W M	Y N — D W M
5 _____	_____	— D W M	Y N — D W M
6 _____	_____	— D W M	Y N — D W M
7 _____	_____	— D W M	Y N — D W M
8 _____	_____	— D W M	Y N — D W M

PRESCRIPTION MEDICATIONS (cont.)

Medication Name <i>Print the first 20 letters only. Please print clearly.</i>	Strength (mg) <i>Write the decimal as one of the digits.</i>	Prescribed <i>Circle: day, week, month</i>	PRN Medicine?
9 _____	_____	___ D W M	Y N ___ D W M
10 _____	_____	___ D W M	Y N ___ D W M
11 _____	_____	___ D W M	Y N ___ D W M
12 _____	_____	___ D W M	Y N ___ D W M
13 _____	_____	___ D W M	Y N ___ D W M
14 _____	_____	___ D W M	Y N ___ D W M
15 _____	_____	___ D W M	Y N ___ D W M

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)

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

Medication Name <i>Print the first 20 letters. Please print clearly.</i>	Strength (mg) <i>Write the decimal as one of the digits.</i>	Circle: day week, month
1 _____	_____	___ D W M
2 _____	_____	___ D W M
3 _____	_____	___ D W M
4 _____	_____	___ D W M
5 _____	_____	___ D W M
6 _____	_____	___ D W M
7 _____	_____	___ D W M
8 _____	_____	___ D W M
9 _____	_____	___ D W M

OVER-THE-COUNTER MEDICATIONS (cont.)

Medication Name	Strength (mg)	Circle: day week, month
<i>Print the first 20 letters. Please print clearly.</i>	<i>Write the decimal as one of the digits.</i>	
10 _____	_____	_____ D W M
11 _____	_____	_____ D W M
12 _____	_____	_____ D W M
13 _____	_____	_____ D W M
14 _____	_____	_____ D W M
15 _____	_____	_____ D W M

Comments: _____

5. Interviewer: _____

6. Date of interview: _____/_____/_____

mo day yr

7.Height(Standing) |__|__|__| cm **SQC4_53** 8.Weight (Standing)|__|__|__| kg **SQC4_55**

9.Hip circumference (Standing) |__|__|__| cm **SQC4_57** 10.Waist (Supine)|__|__|__| cm **SQC4_59**

III. IMPEDANCE MEASUREMENT

9. a) Was impedance taken? Yes |__|1 **(Go to b)** No |__|2 **SQC4_66**

If NO, due to: Amputation |__|1 Wound/dressing |__|2 Cast |__|3 Refusal |__|8 **SQC4_66A**

b) Taken on RIGHT side? Yes |__|1 No |__|2 **SQC4_67**

If NO, due to: Amputation |__|1 Wound/dressing |__|2 Cast |__|3 Refusal |__|8 **SQC4_67A**

c) Resistance |__|__|__|

d) Reactance |__|__|__|

IV. ACANTHOSIS NIGRICANS

10. Acanthosis Nigricans in the back of neck: Not Present |__|0 **SQC4_78**

Grade 1 |__|1

Grade 2 |__|2

Grade 3 |__|3

Grade 4 |__|4

V. ADMINSTRATIVE INFORMATION

11. Code number of person completing this form |__|__|__| **INT_CODE**

12. Date of data collection |__|__|__|/|__|__|__|/|__|__|__|__|__| **INT_DATE**
mo day yr