THE STRONG HEART STUDY VII
CARDIOVASCULAR DISEASE IN AMERICAN INDIANS

PARTICIPANT VISIT CHECKLIST (CENTER-SPECIFIC)

SHS I.D.: |___|___|___|___|___|___|___| SHS Family I.D.: |___|___|___|___|___|___|___|___|

Interview date: |___|___|/|___|___|/|___|___|___|___|
Month day year

|___| Screenings for COVID-19 & Pregnancy Completed
|___| Consent Form & HIPAA Forms Completed – Boxes Checked, Printed name, Signature, Date, Person Obtaining Consent
|___| IHS & Area Healthcare Facility Release of Information Forms Completed
|___| Lab Samples Collected
|___| Personal Interview I Completed
|___| Montreal Cognitive Assessment (MOCA)
|___| NIH Toolbox Completed
|___| Personal Interview II Completed
|___| Medical History Completed
|___| Reproduction and Hormone use (Women only)
|___| Rose questionnaire for Angina & Intermittent Claudication
|___| Medication Reception Completed
|___| Perceived Stress
|___| Quality of Life
|___| CES-D-Scale
|___| MHLC Scale
|___| Other Questions about your Life
|___| Resilience study Questionnaire
|___| 14-Item Resilience Scale (Rs-14)
|___| Multidimensional & Interpersonal Resilience Measure (MIRM)
|___| Revised Multigroup Ethic Identity Scale (MEIRM-R)
|___| Orthogonal Cultural Identity Scale (OCIS)
|___| Rosenberg Self Esteem Scale (R-SES)
|___| Social Support & Social Undermining Items (SS/U)
|___| Social Network Index (SNI)

|___| Functional Activities Questionnaire (FAQ)

|___| Food assistance & food security.

|___| Physical Examination

|___| Physical Examination- Qc Duplicate Measurement

|___| Sample Collection Checklist

|___| CBC Results

|___| Copies of Consent Form and HIPAA Forms Given to Participant

THE STRONG HEART STUDY VII
CARDIOVASCULAR DISEASE IN AMERICAN INDIANS

SCREENING FOR COVID-19 AND PREGNANCY

SHS I.D.: |___|___|___|___|___|___|___| SHS Family I.D.: |___|___|___|___|___|___|___|___|

Screening for COVID-19 (Field staff should refer to SHS MOOP Vol 3 for guidelines for in-person contact with participants)

1. Are you currently experiencing, or have you experienced in the past 14 days, any of the following symptoms? (***Please take your temperature before you answer this question.)***

   Yes ☐ N o ☐ Fever (100.4° F or greater)
   Yes ☐ No ☐ Cough
   Yes ☐ N o ☐ Shortness of breath or difficulty breathing
   Yes ☐ N o ☐ Sore throat
   Yes ☐ No ☐ New loss of taste or smell
   Yes ☐ No ☐ Chills
   Yes ☐ N o ☐ Head or muscle aches
   Yes ☐ No ☐ Nausea, diarrhea, vomiting

2. In the past 14 days, have you been in close proximity to anyone who was experiencing any of the above symptoms or has experienced any of the above symptoms since your contact?

   Yes ☐ No☐ Not sure/I don't know☐

3. In the past 14 days, have you been in close proximity to anyone who has tested positive for COVID-19?

   Yes ☐ No☐ Not sure/I don't know☐

4. Have you been tested for COVID-19 and are waiting to receive test results?

   Yes ☐ No☐

5. Have you have tested positive for COVID-19, or are you presumptively positive for COVID-19 based on your health care provider's assessment or your symptoms?

   Yes ☐ No☐

Screening for Pregnancy:

6. Are you Currently Pregnant? Yes |___| No |___| (If Yes, field staff should schedule participant's visit six weeks postpartum)

THE STRONG HEART STUDY VII
CARDIOVASCULAR DISEASE IN AMERICAN INDIANS

PERSONAL INTERVIEW I

SHS I.D.: |___|___|___|___|___|___| SHS Family I.D.: |___|___|___|___|___|___|___|

Date of Birth: |___|___|/|___|___|/|___|___|___|___|
month day year

DEMOGRAPHIC INFORMATION:

1. Your Name:

a. Last: |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

b. First: |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

c. Middle: |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

d. Nickname/Other Name: |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

2. If ever married, what was your maiden name?

|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

3. If married, what is your spouse's name? ***(if not married, go to Q4)***

____
Last First Middle

4. 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.*

	Hospital	Chart number	IHS 1=yes, 2=no
a.	________________	__________	______
b.	________________	__________	______

5. What is your current mailing address?

a. |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|
Street/P.O. Box

b. |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|
City/town

c. |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|
County

d. State and zip code: |___|___|—|___|___|___|___|___|

6. Is your residential address the same as above?

Yes |___|1 No |___|2 ***If no, what is your current residential address?***
If yes, skip to Q6e

a. |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|
Street

b. |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|
City/town

c. |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|
County

d. State and zip code: |___|___|—|___|___|___|___|___|

e. Geo codes for the residential address **(To be filled-in by SHS staff by using Google Satellite Maps. Locate the participant's home, click right on that location to identify the global position system (GPS) code. Be sure to include all decimals and positive or negative symbols as indicated on the map.)**

Latitude: _______________

Longitude: _______________

7. For how long have you being living at the residential address above? _____ months ______ years

8. Is the residential address above where you have lived the longest?

Yes |___|1 No |___|2 ***If no, provide the address where you have lived the longest***
If yes, skip to Q8

a. |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|
Street

b. |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|
City/town

c. |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|
County

d. State and zip code: |___|___|—|___|___|___|___|___|

e. Geo codes for the residential address where you have lived the longest **(to be filled-in by SHS staff)**

Latitude: _______________

Longitude: _______________

9. Is your current residence or the residence where you have lived the longest located in the same city/town where you lived

When you were born?	Yes |___|1	No |___|2
During childhood?	Yes |___|1	No |___|2
During adolescence?	Yes |___|1	No |___|2

If YES to these 3 questions, skip the next 3 questions. If NO to one or more of these 3, ask the corresponding question(s):

Can you provide the name of the city/town, county, state (and zip code if possible) where you lived for the following periods?

10. First year of life (<1 year):

a. |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

City/town

b. |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

County

c. State and zip code: |___|___|—|___|___|___|___|___|

11. During childhood (1 to 11 years):

a. |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

City/town

b. |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

County

c. State and zip code: |___|___|—|___|___|___|___|___|

12. During adolescence (12 to 17 years):

a. |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

City/town

b. |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

County

c. State and zip code: |___|___|—|___|___|___|___|___|

If you lived in multiple places within each of those periods, tell us the location where you lived the longest.

13. What is your home telephone number or at what telephone number can we reach you or leave a message? |___|___|___|—|___|___|___|—|___|___|___|___|
area code
0 = If unlisted 9 = If no phone

14. What is your work or other contact telephone number? |___|___|___|—|___|___|___|—|___|___|___|___|
area code
0 = If same as home phone 9 = If not applicable or unknown

15. Please list two of your relatives or friends not living with you who would be able to help us find you in the future:

Contact #1: _____
Name

_____
PO Address Residential (Physical) Address

_____
City/Town State, ZIP code

_____
Phone with area code Cell e-mail address

Contact #2: _____
Name

_____
PO Address Residential (Physical) Address

_____
City/Town State, ZIP code

_____
Phone with area code Cell e-mail address

ADMINISTRATIVE INFORMATION:

16. Interviewer code: |___|___|___|

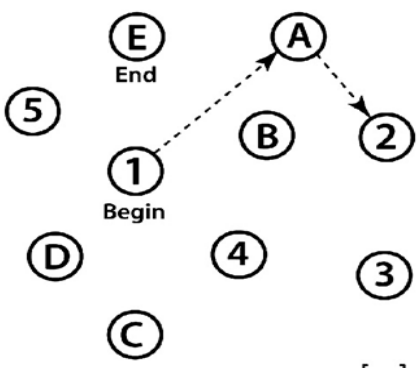
17. Interview date: |___|___|/|___|___|/|___|___|___|___|
Month day year

Montreal Cognitive Assessment (MOCA) *[To be administered by trained personnel]*

SHS I.D.: |___|___|___|___|___|___|___| Interviewer code: |___|___|___|

Interview date: |___|___|/|___|___|/|___|___|___|___|

VISUOSPATIAL / EXECUTIVE



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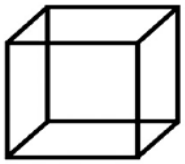
Copy cube

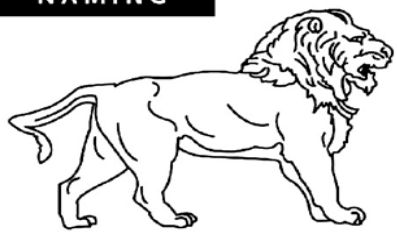


Draw CLOCK (Ten past eleven) (3 points)

[ ] Contour [ ] Numbers [ ] Hands

POINTS ___/5

NAMING



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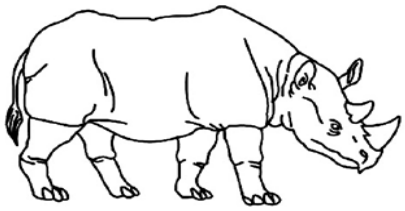

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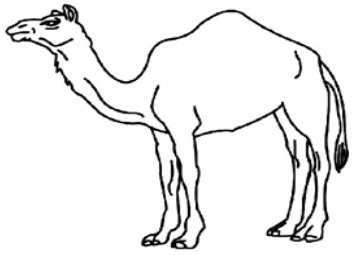


[ ]

___/3

MEMORY

Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes.

	FACE	VELVET	CHURCH	DAISY	RED
1st trial					
2nd trial					

No points

ATTENTION

Read list of digits (1 digit/ sec.).

Subject has to repeat them in the forward order [ ] 2 1 8 5 4

Subject has to repeat them in the backward order [ ] 7 4 2

___/2

Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors

[ ] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B

___/1

Serial 7 subtraction starting at 100 [ ] 93 [ ] 86 [ ] 79 [ ] 72 [ ] 65

4 or 5 correct subtractions: **3 pts**, 2 or 3 correct: **2 pts**, 1 correct: **1 pt**, 0 correct: **0 pt**

___/3

LANGUAGE

Repeat : I only know that John is the one to help today. [ ]

The cat always hid under the couch when dogs were in the room. [ ]

___/2

Fluency / Name maximum number of words in one minute that begin with the letter F [ ] _____ (N ≥ 11 words)

___/1

ABSTRACTION

Similarity between e.g. banana - orange = fruit [ ] train – bicycle [ ] watch - ruler

___/2

DELAYED RECALL

	Has to recall words WITH NO CUE	FACE [ ]	VELVET [ ]	CHURCH [ ]	DAISY [ ]	RED [ ]	Points for UNCUED recall only
Optional	Category cue						
	Multiple choice cue						

___/5

ORIENTATION

[ ] Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City

___/6

© Z.Nasreddine MD **www.mocatest.org** Normal ≥ 26 / 30

TOTAL ___/30

Add 1 point if ≤ 12 yr edu

MOCA Continued: *Scratch page for interviewer*

Attention-Digits: _____

Attention-Subtraction (Serial 7): ____ _____ _____ _____ _____

Language Fluency - F test:

1. _____	11. _____	21. _____
2. _____	12. _____	22. _____
3. _____	13. _____	23. _____
4. _____	14. _____	24. _____
5. _____	15. _____	25. _____
6. _____	16. _____	26. _____
7. _____	17. _____	27. _____
8. _____	18. _____	28. _____
9. _____	19. _____	29. _____
10. _____	20. _____	30. _____

Abstraction- train/bicycle: _____

Abstraction- watch-ruler: _____

Orientation-Date: _____

Orientation-Month: _____

Orientation-Year: _____

Orientation-Day: _____

Orientation-Place: _____

Orientation-City: _____

Other Notes: _____

THE STRONG HEART STUDY VII
CARDIOVASCULAR DISEASE IN AMERICAN INDIANS

PERSONAL INTERVIEW II

SHS I.D.: |___|___|___|___|___|___|___| SHS Family I.D.: |___|___|___|___|___|___|___|

BASIC INFORMATION:

1. Gender:

1. Sex Assigned at Birth:

|___| Male

|___| Female

|___| Intersex (born with reproductive or sexual anatomy that doesn't fit the boxes of "female" or "male.")

|___| Don't know/Not Sure

|___| Prefer not to answer

|___| Other (please specify): _____

2. As you know, not everyone identifies with a gender that's consistent with their sex assigned at birth, so which of the following best describes your gender identity? **(Give participants a chance to offer the information on their own, then read response options, and provide the explanations of each category if the participants ask)**.

|___| Male- current gender identity matches sex assigned at birth.

|___| Female- current gender identity matches sex assigned at birth.

|___| Transgender- current gender identity differs from sex assigned at birth

|___| Gender non-conforming– a term used to describe gender identities that fall outside the defined categories of male and female.

|___| Two-spirit- an umbrella term used to describe gender roles and sexual identities that existed prior to colonization.

|___| Don't know/Not Sure

|___| Prefer not to answer

|___| Other (please specify): _____

3. What is your marital status? |___|
Current

1 = Never married
2 = Currently married
3 = Divorced
4 = Separated
5 = Widowed
6 = Adult roommate/partner/significant other

Since we know the years of education may be a risk factor for some diseases, we need to ask about the years of education you have completed.

4. How many years of education have you completed? (start with the first grade) |___|___|___|
   0-12 = Vo-tech or years of school (Vo-tech/GED = 12)
   14 = Junior college 16 = Bachelors
   18 = Masters 19 = Law Degree
   20 = Doctorate 999 = Unknown

5. Did you attend preschool, or kindergarten, or participate in Head Start Program?

   Yes |___| 1 No |___| 2 Unsure |___| 9

FAMILY INCOME:

6. Does your household income meet your family's needs?

   Yes |___| 1 No |___| 2 Unsure |___| 9

7. Are you going to school? Yes |___| 1 No |___| 2

8. 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)* |___|___|___|

9. Which of the following categories best describes your annual **household** income from all sources? *Please show a list.*

Less than 5,000	|___| 1	20,000 to 24,999	|___| 5	Don't know/not sure	|___| 9
5,000 to 9,999	|___| 2	25,000 to 34,999	|___| 6	Refused	|___| 0
10,000 to 14,999	|___| 3	35,000 to 50,000	|___| 7		
15,000 to 19,999	|___| 4	Over 50,000	|___| 8		

TOBACCO:

10. During your lifetime have you smoked 100 cigarettes or more total?

Yes |___| 1 No |___| 2 (***go to Q18)***

11. How old were you when you first started smoking regularly? |___|___|___|
(Indicate age at which you started smoking)
0 = Never smoked regularly 999 = Unknown

12. Did you quit smoking? Yes |___| 1 No |___| 2 (***go to Q13)***

a) If you quit, when did you last smoke?
(Just the year, please) |___|___|___|___|

b) What reason(s) did you have for quitting?
Please check *all that apply:*

		Yes	No
i)	Doctor's advice	|___| 1	|___| 2
ii)	Health concerns	|___| 1	|___| 2
iii)	Expenses	|___| 1	|___| 2
iv)	Family pressure	|___| 1	|___| 2
v)	Peer pressure	|___| 1	|___| 2
vi)	Other	|___| 1	|___| 2

specify: _____

13. On the average, how many cigarettes do/did you usually smoke per day? |___|___|___|
(Please give an average for a typical week)
0 = Less than one cigarette per day

a) If the average is less than one cigarette per day,
number of cigarettes per month? |___|___|___|

14. 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	|___| 1	|___| 2
b)	casinos	|___| 1	|___| 2
c)	wakes/funerals	|___| 1	|___| 2
d)	when drinking alcohol	|___| 1	|___| 2
e)	social meetings	|___| 1	|___| 2
f)	when you have extra money	|___| 1	|___| 2
g)	bingo	|___| 1	|___| 2
h)	school	|___| 1	|___| 2
i)	other, specify: _____	|___| 1	|___| 2

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

16. Do you smoke cigarettes now? Yes |___| 1 No |___| 2
(If No, go to Q18)

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

Yes |___| 1 No |___| 2
(If No, go to Q18)

a) If yes, would you prefer to…		Yes	No
i)	Reduce the number of cigarettes per day	|___| 1	|___| 2
ii)	Switch to lower "tar" or "nicotine" cigarettes	|___| 1	|___| 2
iii)	Use nicotine patch/chewing gum/medications	|___| 1	|___| 2
iv)	Quit	|___| 1	|___| 2
v)	Other, specify: _____	|___| 1	|___| 2

18. Do you use chewing tobacco/snuff now? Yes |___| 1 No |___| 2
(If No, go to Q20)

19. If yes, how many times a day do you use it? _____ times/day. (Enter 0 if less than once a day or used sporadically.)

PASSIVE SMOKING:

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

E-CIGARETTE OR OTHER ELECTRONIC VAPING PRODUCT

21. Have you ever used an e-cigarette or other electronic vaping product, even just one time in your entire life?

Yes |___| 1 No |___| 2 Don't know/Unsure |___| 9 ***if "NO" or "Don't know/Unsure, go to next section***

22. During the past 30 days, on how many days did you use e-cigarettes or other electronic vaping products? (0 – 30)

|___|___|
# of days

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 whiskey = 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 ever clear in punch = 1 drink

23. Have you ever consumed alcoholic beverages?

Yes |___| 1 No |___| 2 ***(go to Q30)***

a) If "YES," when was your last drink? *(Choose only one)*

|___| 1 Within the last week

|___| 2 Within the last month

|___| 3 Within the last year. Number of months |___|___|___|

|___| 4 More than a year ago ***(go to Q30)***

24. How many alcoholic drinks do you have in a typical week? |___|___|___|

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

26. 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.)* |___|___|___| (# of Drinks)

27. When you drink more than your usual amount, how many **total** drinks do you have? |___|___|___| (# of Drinks)

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

29. How many times during the **PAST YEAR** did you have 5 or more |___|___|___|

drinks on an occasion?

30. Is your current residence or the residence where you have lived the longest located in the same city/town where you lived

When you were born? Yes |___|1 No |___|2

During childhood? Yes |___|1 No |___|2

During adolescence? Yes |___|1 No |___|2

If YES to these 3 questions, skip the next 3 questions. If NO to one or more of these 3, ask the corresponding question(s):

Can you provide the name of the city/town, county, state (and zip code if possible) where you lived for the following periods?

31. First year of life (<1 year):

b. |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|
City/town

c. |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|
County

d. State and zip code: |___|___|—|___|___|___|___|___|

32. During childhood (1 to 11 years):

b. |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|
City/town

c. |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|
County

d. State and zip code: |___|___|—|___|___|___|___|___|

33. During adolescence (12 to 17 years):

b. |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|
City/town

c. |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

County

d. State and zip code: |___|___|—|___|___|___|___|___|

If you lived in multiple places within each of those periods, tell us the location where you lived the longest.

Water Questions:

34. What is the source of drinking water in your home that is used for drinking and/or cooking? (mark all options that apply)

Drilled or dug well |___|

Public or community system |___| Name of the system: _____

Spring |___|

Cistern |___|

Hauling water |___|

Bottled or other purchased water |___|

Other |___| Please specify: _____

Don't Know |___|

35. Do you treat or filter the drinking water in your home??

Yes |___|

No |___|

Don't Know |___|

If yes, which of these water treatment systems do you use? (mark all option that apply)

Softener |___|

Sediment filter |___|

UV Ultraviolet light |___|

RO Reverse Osmosis |___|

Pitcher or faucet filter (example: Brita, Aquagear, Zero Water) |___|

Other |___| Specify: _____

Don't know |___

36. In a typical day, approximately what percentage of the water that you drink is tap water vs. bottled water? (please note: total should add up to 100%)

Tap water _____%

Bottled water _____%

LANGUAGE QUESTIONS

37. Can you speak your native language? (interviewer should specify the language)?

Yes, fluently |___|1 Yes, but not fluently |___|2 No |___|3 (**If no Skip to Q32)**

38 How often do you speak your native language? (Please read options)

Always |___|1 Almost always |___|2 Often |___|3

Seldom|___|4 Never |___| 5 Not applicable |___| 6

US MILITARY OR ARMED FORCES SERVICE

39. Have you ever served or are you currently serving in the US military or Armed Forces? ***(If yes, answer 31 &32. If no, skip to next section)***

Yes |___| 1 No |___| 2

40. If "YES," in which branch of the military did you serve?

|___| 1 Air Force

|___| 2 Army

|___| 3 Marines

|___| 4 Navy

|___| 5 Coast Guard

|___| 6 National Guard

41. For how long did you serve in the military? |___|___| |___|___|
years months

ADMINISTRATIVE INFORMATION:

42. Interviewer code: |___|___|___|

43. Interview date: |___|___|/|___|___|/|___|___|___|___|
month day year

HE STRONG HEART STUDY VII
CARDIOVASCULAR DISEASE IN AMERICAN INDIANS

MEDICAL HISTORY

SHS I.D.: |___|___|___|___|___|___|___| SHS Family I.D.: |___|___|___|___|___|___|___|___|

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. a) High blood pressure?

   Yes |___| 1 No |___| 2 Only during pregnancy |___| 3 Unknown |___| 9

   b) 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 |___|___|___|

   c) If "YES," are you taking any medication to control your blood pressure?

   Yes |___| 1 No |___| 2 Unknown |___| 9

		YES	NO	UNKNOWN
2.	Arthritis?	|___| 1	|___| 2	|___| 9
3.	Any fractures associated with brittle bone disease or osteoporosis?	|___| 1	|___| 2	|___| 9
	a) If "YES," where? _____			
4.	Rheumatic heart disease?	|___| 1	|___| 2	|___| 9
5.	Gallstones?	|___| 1	|___| 2	|___| 9
6.	Cancer, including leukemia and lymphoma?	|___| 1	|___| 2	|___| 9
	a) If "YES," specify type of cancer: _____			

7. Diabetes? Yes |___| 1 No |___| 2 Only during pregnancy |___| 3 Unknown |___| 9
(If No or Unknown, go 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 |___|___|___|

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

		YES	NO
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

	YES	NO	UNKNOWN
8. Has a medical person ever told you that you had kidney failure?	|___| 1	|___| 2	|___| 9

(If No or Unknown, go to Q11)

a) If "YES," are one or both working well now? |___| 1 |___| 2 |___| 9

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 |___|___|___|

	YES	NO	UNKNOWN
9. Are you currently on renal dialysis?	|___| 1	|___| 2	|___| 9
10. Have you ever had a kidney transplant?	|___| 1	|___| 2	|___| 9
a) If "YES," is the new kidney working well?	|___| 1	|___| 2	|___| 9
b) If "NO," are you waiting for a kidney transplant?	|___| 1	|___| 2	|___| 9
11. Cirrhosis of the liver?	|___| 1	|___| 2	|___| 9

HEART PROBLEMS:

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

(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)*? |___|___|/|___|___|/|___|___|___|___|
month day year

i) hospital/clinic: _____

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

(Coronary angioplasty is a procedure used to open clogged heart arteries. It uses a tiny balloon catheter that is inserted in a blocked blood vessel to help widen it and improve blood flow to the heart.)

Yes |___| 1 No |___| 2 Unknown |___| 9

a) If "YES," when and where *(most recent)*? |___|___|/|___|___|/|___|___|___|___|
month day year

i) hospital/clinic: _____

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

Yes |___| 1 No |___| 2 Unknown |___| 9

a) If "YES," when and where? |___|___|/|___|___|/|___|___|___|___|
month day year

i) hospital/clinic: _____

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

a) If "YES," when and where? |___|___|/|___|___|/|___|___|___|___|
month day year

i) hospital/clinic: _____

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

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

a) If "YES," when and where? |___|___|/|___|___|/|___|___|___|___|
month day year

i) hospital/clinic: _____

17. Any other heart troubles? Yes |___| 1 No |___| 2 Unknown |___| 9

a) If "YES," please specify type: _____

b) If "YES," when and where? |___|___|/|___|___|/|___|___|___|___|
month day year

i) hospital/clinic: _____

18. Stroke? Yes |___| 1 No |___| 2 Unknown |___| 9

a) If "YES," when and where? |___|___|/|___|___|/|___|___|___|___|
month day year

i) hospital/clinic: _____

19. Have you ever had surgery on your chest? Yes |___| 1 No |___| 2
(go to Q20)

a) Was it heart surgery? Yes |___| 1 No |___| 2 Unknown |___| 9
(go to Q20)

If "YES," which surgery have you had?

i) Bypass? Yes |___| 1 No |___| 2 Unknown |___| 9

If "YES," when and where *(most recent)*? |___|___|/|___|___|/|___|___|___|___|
month day year

hospital/clinic: _____

ii) Valvular repair/replacement? Yes |___| 1 No |___| 2 Unknown |___| 9

If "YES," when and where *(most recent)*? |___|___|/|___|___|/|___|___|___|___|
Month day year

hospital/clinic: _____

iii) Pacemaker? Yes |___| 1 No |___| 2 Unknown |___| 9

If "YES," when and where *(most recent)*? |___|___|/|___|___|/|___|___|___|___|
month day year

hospital/clinic: _____

iv) Other? Yes |___| 1 No |___| 2

If "YES," when and where *(most recent)*? |___|___|/|___|___|/|___|___|___|___|
month day year

Please specify: _____

hospital/clinic: _____

20. Are you taking aspirin daily to prevent a heart attack or a stroke?

Yes |___| 1 No |___| 2 Unknown |___| 9

21. Has a medical person **ever** told you that you had COVID-19?

Yes |___| 1 Yes, probably or suspected |___| 2 No |___| 9

ORAL HEALTH QUESTION

22. How many natural teeth do you have?

a) All |___| Most |___| Some |___| None |___|

23. Describe how your chew your food? (please choose only one)

a) I use natural teeth to chew |___|
b) I use natural teeth with caps/crowns to chew |___|
c) I have natural teeth and a denture or partial. I use them both together to chew |___|
d) I use dentures to chew |___|
e) I chew with my gums |___|

24. Rate your ability to chew food (please choose only ONE)

a) Good |___| Fair |___| Poor |___|

25. Overall, how would you rate the health of your teeth and gums? (%)

a) Excellent |___|
b) Very good |___|
c) Good |___|
d) Fair |___|
e) Poor |___|

26 Have you ever had treatment for gum disease, such as scaling and root planning, (sometimes called "deep" cleaning?)

a) Yes |___| b. No |___| c. Unknown |___|

27 Have you ever been told by a dental professional that you lost bone around your teeth?

a) Yes |___| b. No |___| c. Unknown |___|

ADMINISTRATIVE INFORMATION:

28. Interviewer code: |___|___|___|

29. Interview date: |___|___|/|___|___|/|___|___|___|___|
Month day year

IF THE PARTICIPANT IS FEMALE GO TO REPRODUCTION AND HORMONE USE.

IF THE PARTICIPANT IS MALE GO TO ROSE QUESTIONNAIRE.

THE STRONG HEART STUDY VII
CARDIOVASCULAR DISEASE IN AMERICAN INDIANS

REPRODUCTION AND HORMONE USE (WOMEN ONLY)

SHS I.D.: |___|___|___|___|___|___| SHS Family I.D.: |___|___|___|___|___|___|___|

"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)? |___|___|___|
   (If never pregnant, go to Q25.)
2. How many of your pregnancies resulted in a live birth (parity)? |___|___|___|
3. How many living children do you have? |___|___|___|
4. How many pregnancies did you lose (including miscarriage or stillbirth)? |___|___|___|

Next set of questions (Q5 to Q14) pertain to the first pregnancy or pregnancy loss

5. Did your first pregnancy result in a live birth?
   Yes |___| 1 No |___| 2 Not sure |___| 3
6. What was the date of delivery or pregnancy loss for your first pregnancy?
   |___|___|/|___|___|/|___|___|___|___|
7. How many weeks pregnant were you when you delivered or lost your first pregnancy? (*full term pregnancy is about 40 weeks, use 999 for unknown)*?
   |___|___|___|
8. Hospital of delivery: _____ City: _____
9. During your first pregnancy, were you told you had high blood pressure for the first time? Please answer NO, if you were told before your first pregnancy you had high blood pressure.
   (If NO, go to Q11.)
   Yes |___| 1 No |___| 2 Not sure |___| 3
10. During your first pregnancy, how many weeks pregnant were you when you were first diagnosed with high blood pressure? (*full term pregnancy is about 40 weeks, use 999 for unknown)*?
    |___|___|___|

Preeclampsia (pree-i-CLAMP-see-ah), also called toxemia, is a condition that typically starts after the 20th week of pregnancy and is related to increased blood pressure and protein in the mother's urine.

11. During your first pregnancy, were you told you had preeclampsia, toxemia or protein in your urine? **(If NO, go to Q13)**
    Yes |___| 1 No |___| 2 Not sure |___| 3

12. During your first pregnancy, how many weeks pregnant were you when you were first diagnosed with preeclampsia, toxemia or protein in your urine? (*full term pregnancy is about 40 weeks, use 999 for unknown)*? |___|___|___|

13. During your first pregnancy, were you told for the first time that you had diabetes? Please answer NO, if you were told before your first pregnancy you had diabetes. **(If NO, go to Q15.)**

Yes |___| 1 No |___| 2 Not sure |___| 3

14. During your first pregnancy, how many weeks pregnant were you when you were first diagnosed with diabetes? (*full term pregnancy is about 40 weeks, use 999 for unknown)*?

|___|___|___|

<u>Questions 15 and 16 pertain to any other pregnancies</u>

15. Did you have preeclampsia, toxemia, or both hypertension and protein in your urine in one or more <u>later pregnancies</u>? **(If No, go to Q17)**

Yes |___| 1 No |___| 2 Not sure |___| 3

16. If yes, please answers questions below:

	Pre-eclampsia or toxemia?	Date and location of delivery or pregnancy loss	Number of weeks pregnant
pregnancy #2	Yes |___| 1 No |___| 2 Not sure |___| 3	|___|___|/|___|___|/|___|___|___|___| Hospital: _____ City:_____	|___|___|___|
pregnancy #3	Yes |___| 1 No |___| 2 Not sure |___| 3	|___|___|/|___|___|/|___|___|___|___| Hospital: _____ City:_____	|___|___|___|
pregnancy #4	Yes |___| 1 No |___| 2 Not sure |___| 3	|___|___|/|___|___|/|___|___|___|___| Hospital: _____ City:_____	|___|___|___|
pregnancy #5	Yes |___| 1 No |___| 2 Not sure |___| 3	|___|___|/|___|___|/|___|___|___|___| Hospital: _____ City:_____	|___|___|___|

17. Did you ever have eclampsia, i.e. a seizure (convulsion or “fit”) along with hypertension during a pregnancy or around the time of delivery?

Yes |___| 1 No |___| 2 Not sure |___| 3

18. Did your mother or sister ever have preeclampsia?

Yes |___| 1 No |___| 2 Not sure |___| 3

19. Did you have diabetes in one or more <u>later pregnancies</u>? **(If No, go to Q21)**

Yes |___| 1 No |___| 2 Not sure |___| 3

20. If yes, please answers questions below:

	Diabetes?	Date of delivery or pregnancy loss	Number of weeks pregnant
pregnancy #2	Yes |___| 1 No |___| 2 Not sure |___| 3	|___|___|/|___|___|/|___|___|___|___| Hospital: _____ City:_____	|___|___|___|
pregnancy #3	Yes |___| 1 No |___| 2 Not sure |___| 3	|___|___|/|___|___|/|___|___|___|___| Hospital: _____ City:_____	|___|___|___|
pregnancy #4	Yes |___| 1 No |___| 2 Not sure |___| 3	|___|___|/|___|___|/|___|___|___|___| Hospital: _____ City:_____	|___|___|___|
pregnancy #5	Yes |___| 1 No |___| 2 Not sure |___| 3	|___|___|/|___|___|/|___|___|___|___| Hospital: _____ City:_____	|___|___|___|

21. Approximately how many cigarettes/ day did you smoke during your first pregnancy *(enter "0" if you did not smoke, use 999 for unknown)*?

|___|___|___|

22. E-cigarettes are battery powered devices that provide inhaled doses of nicotine. Approximately how many e-cigarettes/ day did you use during your first pregnancy *(enter "0" if you did not smoke, use 999 for unknown)*?

|___|___|___|

23. Did you use chewing tobacco/snuff during your first pregnancy? Yes |___| 1 No |___| 2
(If NO, go to Q25.)

24. If yes, how many times a day did you use it? (Enter 0 if less than once a day or use sporadically.)

|___|___|___|

25. Have you ever used birth control pills? Yes |___| 1 No |___| 2 Not sure |___| 3
(If NO or NOT SURE, go to Q26.)

a) Are you still using birth control pills? Yes |___| 1 No |___| 2

b) How old were you when you started to use birth control pills?
Indicate the age in years. 999 = unknown |___|___|___|

c) How many years altogether did you use them? |___|___|
*Specify the duration **in years**. 0 = less than 6 months, 1 = 6–12 months, 99 = unknown.*

26. Have you ever had a birth control implant (such as Norplant)?

Yes |___| 1 No |___| 2 Not sure |___| 3
(If NO or NOT SURE, go to Q27.)

a) Are you still using a birth control implant? Yes |___| 1 No |___| 2

b) How old were you when you started to use a birth control implant?
Indicate the age in years. 999 = unknown, can't remember |___|___|___|

c) How many years altogether did you use it? |___|___|___|
*Specify the duration **in years**. 0 = less than 6 months, 1 = 6-12 months, 999 = unknown.*

27. Have you ever used birth control shots (such as Depo Provera)?

Yes |___| 1 No |___| 2 Not sure |___| 3
(If NO or NOT SURE, go to Q28.)

a) Are you still using birth control shots? Yes |___| 1 No |___| 2

b) How old were you when you started to use birth control shots?
Indicate the age in years. 999 = unknown, can't remember |___|___|___|

c) How many years altogether did you use them? |___|___|___|
*Specify the duration **in years**. 0 = less than 6 months, 1 = 6-12 months, 999 = unknown*

28. How old were you when you started to have regular menstrual cycles (periods)?
Indicate the age in years. 999 = unknown |___|___|___|

29. Have your menstrual cycles (periods) stopped? Yes |___| 1 No |___| 2
(go to Q30)

a) If "YES," have they stopped for 12 months or more? Yes |___| 1 No |___| 2
(go to Q30)

i) How old were you when your periods stopped completely?
Indicate the age in years. 999 = unknown, can't remember |___|___|___|

ii) Did your periods stop naturally, or because of surgery or hormone use, or for some other reason?
Natural |___| 1 ***(go to Q30)***
Surgery |___| 2
Hormonal |___| 3 ***(go to Q30)***
Other, specify: _____ |___| 4 ***(go to Q30)***

iii) If **SURGERY**, were <u>both</u> of your ovaries removed?

Yes |___| 1 No |___| 2 Unknown |___| 9

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

30. 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
(If NO or NOT SURE, go to Q38.)

31. How old were you when you started using estrogen? *Indicate age in years.*
|___|___|___|

32. How many years altogether did you take estrogen? *Specify duration in years.* |___|___|___|
(If less than 3 months, record 0. If more than 3 months but less than 1 year, record 1.)

33. Do/Did you use estrogen for (answer all applicable)		YES	NO	NOT SURE
a)	post-surgery (hysterectomy and removal of ovaries)	|___| 1	|___| 2	|___| 3
b)	relief of menopause symptoms	|___| 1	|___| 2	|___| 3
c)	prevent bone loss	|___| 1	|___| 2	|___| 3
d)	protect against heart disease	|___| 1	|___| 2	|___| 3
e)	doctor's advice	|___| 1	|___| 2	|___| 3
f)	other: _____	|___| 1	|___| 2	|___| 3

34. Do/Did you take progesterone in addition to, or in combination with, your estrogen treatment?

Yes |___| 1 No |___| 2 Not sure |___| 3

35. 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

36. Are you still taking estrogen? Yes |___| 1 ***(go to Q38)*** No |___| 2 ***(go to Q37)***

37. Why did you stop taking estrogen?		YES	NO	UNKNOWN
a)	Caused bleeding	|___| 1	|___| 2	|___| 9
b)	Made breasts tender	|___| 1	|___| 2	|___| 9
c)	Made you feel bloated	|___| 1	|___| 2	|___| 9
d)	Made you feel "funny," didn't like the way you felt	|___| 1	|___| 2	|___| 9
e)	Do not like taking any medicines	|___| 1	|___| 2	|___| 9
f)	Too expensive	|___| 1	|___| 2	|___| 9
g)	Doctor's advice	|___| 1	|___| 2	|___| 9
h)	Concerned about long-term side effects	|___| 1	|___| 2	|___| 9
i)	Other: _____	|___| 1	|___| 2	|___| 9

38. Other than in combination with estrogens, have you ever taken progesterone by itself for any reason?
Yes |___| 1 No |___| 2 Not sure |___| 3
(If NO or NOT SURE, go to Q42.)

39. How old were you when you started using progesterone? *Indicate age in years.* |___|___|___|

40. How many years altogether did you take progesterone? *Specify duration in years.* |___|___|___|
(If less than 3 months, record 0. If more than 3 months, but less than 1 year, record 1.)

41. Are you still taking progesterone? Yes |___| 1 No |___| 2 Not sure |___| 3

ADMINISTRATIVE INFORMATION:

42. Interviewer code: |___|___|___|

43. Interview date: |___|___|/|___|___|/|___|___|___|___|
Month day year

THE STRONG HEART STUDY VII
CARDIOVASCULAR DISEASE IN AMERICAN INDIANS

ROSE QUESTIONNAIRE FOR ANGINA AND INTERMITTENT CLAUDICATION

SHS I.D.: |___|___|___|___|___|___|___| SHS Family I.D.: |___|___|___|___|___|___|___|

Chest Pain on Effort

1. Have you ever had any pain or discomfort in your chest? Yes |___|1
   No |___|2 ***(go to Q10)***

2. Do you get it when you walk uphill, upstairs or hurry? Yes |___|1
   No |___|2 ***(go to Q9)***
   Never hurries or walks uphill or upstairs |___|3
   Unable to walk |___|4 ***(go to Q9)***

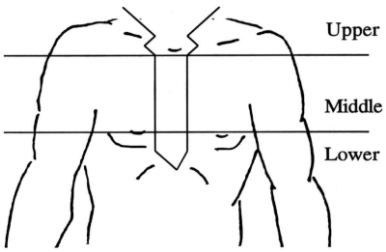
3. Do you get it when you walk at an ordinary pace on the level? Yes |___|1 No |___|2

4. What do you do if you get it while you are walking? Stop or slow down |___|1
   (*Record "stop or slow down" if participants carries on after taking nitroglycerine.*)
   Carry on |___|2 ***(go to Q9)***

5. If you stand still, what happens to it? Relieved |___|1 Not relieved |___|2 ***(go to Q9)***

6. How soon? 10 minutes or less |___|1 More than 10 minutes |___|2 ***(go to Q9)***

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
Sternum (lower)	|___|1	|___|2
Left anterior chest	|___|1	|___|2
Left arm	|___|1	|___|2
Other: _____	|___|1	|___|2

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

a) If "YES," record additional information: _____

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

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

a) If calves not mentioned, ask: "Anywhere else?" *Please specify*: _____
_____ ***(go to Q19)***

13. Do you get it if you walk uphill or hurry?
Yes |___|1
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

15. Does the pain ever disappear while you are walking? Yes |___|1 ***(go to Q19)*** 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

ADMINISTRATIVE INFORMATION:

19. Interviewer code: |___|___|___|

20. Interview date: |___|___|/|___|___|/|___|___|___|___|
Month day year

THE STRONG HEART STUDY VII
CARDIOVASCULAR DISEASE IN AMERICAN INDIANS

MEDICATION RECEPTION

SHS I.D.: |___|___|___|___|___|___| **SHS Family I.D.:** |___|___|___|___|___|___|___|

MEDICATION RECEPTION

As you know, the Strong Heart Study will be describing all medications its participants are using, both prescription and over- the-counter, and traditional remedies. These include pills, liquid medications, skin patches, eye drops, creams, salves, inhalers and injections, as well as cold or allergy medications, vitamins, herbal, homeopathic or traditional medicines and other supplements. Prior to your clinic visit we asked that you bring all your medications into the clinic in their original bottles.

1. **Have you brought your medications with you? Are these all the medications that you have taken in the past two weeks?**

   Yes |___| ***(May I see them?)***

   No |___| ***(Make arrangements to obtain)***

   Took no meds |___|

   Refused |___| ***(Cite reasons for refusal in the space below)***

   Reasons for refusal:_____

Interviewer, please observe:

2. Are there any prescription medications? Yes |___| No |___|
3. Are there any over the counter (OTC) medications? Yes |___| No |___|

MEDICATIONS (Prescription & Non-Prescription)

Copy the name of medicine, the strength (include units), and the total number of doses for prescription and non-prescription. Include all pills, skin patches, creams, salves, inhalers, nebulizers, injections, vitamins and supplements, cold and allergy medication, and any over-the-counter medications.

In the compliance column: In the last month, how much of the medication did you take approximately?

	Medication Name (Clearly print the first 20 letters only)	**Strength (mg IU, etc.)** (Include decimal)	**Frequency:** (Circle day, week, month)	**PRN** (Circle Y or N)	**Compliance: # of meds** (Circle day, week, month)
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
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: _____

TRADTIONAL REMEDIES, THERAPIES, & PRACTICES

Copy the name of the medicine, the strength (include units, if applicable), and total number of doses per day/week/month.

In the compliance column: In the last month, how many did you take approximately?

	Medication Name (Clearly print the first 20 letters only)	**Strength (mg IU, etc.)** (Include decimal)	**Frequency:** (Circle day, week, month)	**PRN** (Circle Y or N)	**Compliance: # of meds** (Circle day, week, month)
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
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: _____

4 . Who is the primary respondent? Study participant |___| Family member |___| Other |___|

ADMINISTRATIVE INFORMATION:

5. Interviewer/reviewer code: |___|___|___|

6 Interview/review date: |___|___|/|___|___|/|___|___|___|___|
Month day year

THE STRONG HEART STUDY VII
CARDIOVASCULAR DISEASE IN AMERICAN INDIANS

PERCEIVED STRESS

SHS I.D.: |___|___|___|___|___|___|___| SHS Family I.D.: |___|___|___|___|___|___|___|

Perceived stress refers to how much the everyday situations in life may be causing psychological distress or difficulty. Higher stress has been linked to higher risk of depression, mortality, and cardiovascular disease.

***Instructions**: For the following questions, please check the closest answer according to the following scales. **Mark only one answer for each question**.*

In the past month, how often have you (Q1- 7)

		Not at all	Rarely	Sometimes	Often	Most of the time	Not Sure
1.	been upset because of something that happened unexpectedly?	|___| 1	|___| 2	|___| 3	|___| 4	|___| 5	|___| 9
2.	felt nervous or "stressed"?	|___| 1	|___| 2	|___| 3	|___| 4	|___| 5	|___| 9
3.	dealt well with irritating life hassles?	|___| 1	|___| 2	|___| 3	|___| 4	|___| 5	|___| 9
4.	felt that things were going your way?	|___| 1	|___| 2	|___| 3	|___| 4	|___| 5	|___| 9
5.	felt unable to control irritations in your life?	|___| 1	|___| 2	|___| 3	|___| 4	|___| 5	|___| 9
6.	felt that you were on the top of things?	|___| 1	|___| 2	|___| 3	|___| 4	|___| 5	|___| 9
7.	felt difficulties or problems were piling up so high that you could not handle them?	|___| 1	|___| 2	|___| 3	|___| 4	|___| 5	|___| 9

Time Spent Watching TV/Social Media

8. On the average, how much time per day do you watch TV/Social Media? |___|___|: |___|___|
hours minutes

ADMINISTRATIVE INFORMATION:

9. Interviewer/reviewer code: |___|___|___|

10. Interview/review date: |___|___|/|___|___|/|___|___|___|___|
Month day year

THE STRONG HEART STUDY VII
CARDIOVASCULAR DISEASE IN AMERICAN INDIANS

QUALITY OF LIFE

SHS I.D.: |___|___|___|___|___|___|___| SHS Family I.D.: |___|___|___|___|___|___|___|___|

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

The SF-12 health-related quality of life scale measures quality of life in physical and mental health.

***Instructions**: For the following questions, please check the closest answer according to the following scales.*
Mark only one answer for each question

These next questions ask how you feel about your own health.

1. In general, would you say your health is? **(Please check only one.)**

   Excellent ..... |___|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.) Yes, Limited a Lot	Yes, Limited a Little	No, Not Limited at All
2.	**Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling or playing golf.....	|___|1	|___|2	|___|3
3.	Climbing **several** flights of stairs (or climbing a hill) ...	|___|1	|___|2	|___|3

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.)

		Yes	No
4.	**Accomplished less** than you would like.....	|___|1	|___|2
5.	Were limited in the kind of work or other activities.....	|___|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.)

		Yes	No
6.	**Accomplished less** than you would like.....	|___|1	|___|2
7.	Didn't do work or other activities as carefully as usual.....	|___|1	|___|2

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
A Little Bit.....	|___|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.)

		All of the Time	Most of the Time	a Good Bit of the Time	Some of the Time	a Little of the Time	None of the Time
9.	Have you felt calm and peaceful? .	|___|1	|___|2	|___|3	|___|4	|___|5	|___|6
10.	Did you have a lot of energy?.....	|___|1	|___|2	|___|3	|___|4	|___|5	|___|6
11.	Did you feel downhearted and blue?.....	|___|1	|___|2	|___|3	|___|4	|___|5	|___|6

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 check one number.)

All the time ..... |___|1

Most of the time..... |___|2

Some of the time ..... |___|3

A Little of the time..... |___|4

None of the time..... |___|5

ADMINISTRATIVE INFORMATION:

13. Interviewer/reviewer code: |___|___|___|

14. Interview/review date: |___|___|/|___|___|/|___|___|___|___|
Month day year

THE STRONG HEART STUDY VII
CARDIOVASCULAR DISEASE IN AMERICAN INDIANS

CES-D SCALE

SHS I.D.: |___|___|___|___|___|___|___| SHS Family I.D.: |___|___|___|___|___|___|___|

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

The CES-D scale is a general screening measure of symptoms of depression. Measuring depression can be useful to assess mood, as well as health and cardiovascular risk.

Here are some questions (Q1-Q20) about your feelings during the past week. For each of the following statements, please respond as to whether you felt that way: ***Mark only one answer for each question****.*

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.	|___|1	|___|2	|___|3	|___|4	|___|9
2. I did not feel like eating; my appetite was poor.	|___|1	|___|2	|___|3	|___|4	|___|9
3. I felt that I could not shake the blues even with help from my family or friends.	|___|1	|___|2	|___|3	|___|4	|___|9
4. I felt that I was just as good as other people.	|___|1	|___|2	|___|3	|___|4	|___|9
5. I had trouble keeping my mind on what I was doing.	|___|1	|___|2	|___|3	|___|4	|___|9
6. I felt depressed	|___|1	|___|2	|___|3	|___|4	|___|9
7. I felt that everything I did was an effort.	|___|1	|___|2	|___|3	|___|4	|___|9
8. I felt hopeful about the future.	|___|1	|___|2	|___|3	|___|4	|___|9
9. I thought my life had been a failure.	|___|1	|___|2	|___|3	|___|4	|___|9
10. I felt fearful.	|___|1	|___|2	|___|3	|___|4	|___|9
11. My sleep was restless.	|___|1	|___|2	|___|3	|___|4	|___|9
12. I was happy.	|___|1	|___|2	|___|3	|___|4	|___|9

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
13. I talked less than usual.	|___|1	|___|2	|___|3	|___|4	|___|9
14. I felt lonely.	|___|1	|___|2	|___|3	|___|4	|___|9
15. People were unfriendly.	|___|1	|___|2	|___|3	|___|4	|___|9
16. I enjoyed life.	|___|1	|___|2	|___|3	|___|4	|___|9
17. I had crying spells.	|___|1	|___|2	|___|3	|___|4	|___|9
18. I felt sad.	|___|1	|___|2	|___|3	|___|4	|___|9
19. I felt that people disliked me.	|___|1	|___|2	|___|3	|___|4	|___|9
20. I felt like I couldn't do what I needed to do.	|___|1	|___|2	|___|3	|___|4	|___|9

During the **past year** . . .	Rarely or Not at ALL 1	Some 2	Often 3	Most of the Time 4	Not Applicable 9
21. I have felt depressed or sad.	|___|1	|___|2	|___|3	|___|4	|___|9

ADMINISTRATIVE INFORMATION:

22. Interviewer/reviewer code: |___|___|___|

23. Interview/review date: |___|___|/|___|___|/|___|___|___|___|
Month day year

THE STRONG HEART STUDY VII
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 |___| 3=Refused

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 circle 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.	|___| 0	|___| 1	|___| 2	|___| 3
2.Often I feel that no matter what I do, if I am going to get sick, I will get sick.	|___| 0	|___| 1	|___| 2	|___| 3
3. If I see an excellent doctor regularly, I am less likely to have health problems.	|___| 0	|___| 1	|___| 2	|___| 3
4. Most things that affect my health happen by accidental happenings.	|___| 0	|___| 1	|___| 2	|___| 3
5. I can only maintain my health by consulting health professionals.	|___| 0	|___| 1	|___| 2	|___| 3
6. I am directly responsible for my health.	|___| 0	|___| 1	|___| 2	|___| 3
7. Other people play a big part in whether I stay healthy or become sick.	|___| 0	|___| 1	|___| 2	|___| 3
8. Whatever goes wrong with my health is my own fault	|___| 0	|___| 1	|___| 2	|___| 3
9. When I am sick, I just have to let nature run its course.	|___| 0	|___| 1	|___| 2	|___| 3

	Strongly Disagree 0	Disagree 1	Agree 2	Strongly Agree 3
10 Health professionals keep me healthy.	|___| 0	|___| 1	|___| 2	|___| 3
11. When I stay healthy, I'm just plain lucky.	|___| 0	|___| 1	|___| 2	|___| 3
12. My physical well-being depends on how well I take care of myself.	|___| 0	|___| 1	|___| 2	|___| 3
13.When I feel ill, I know it is because I have not been taking care of myself properly.	|___| 0	|___| 1	|___| 2	|___| 3
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
15.Even when I take care of myself, it's easy to get sick.	|___| 0	|___| 1	|___| 2	|___| 3
16.When I become ill, it's a matter of fate.	|___| 0	|___| 1	|___| 2	|___| 3
17.I can pretty much stay healthy by taking good care of myself.	|___| 0	|___| 1	|___| 2	|___| 3
18. Following doctor's orders to the letter is the best way for me to stay healthy.	|___| 0	|___| 1	|___| 2	|___| 3

ADMINISTRATIVE INFORMATION:

19. Interviewer code: |___|___|___|

20. Interview date: |___|___|/|___|___|/|___|___|___|___|
Month day year

THE STRONG HEART STUDY VII
CARDIOVASCULAR DISEASE IN AMERICAN INDIANS

OTHER QUESTIONS ABOUT YOUR LIFE

SHS I.D.: |___|___|___|___|___|___|___| SHS Family I.D.: |___|___|___|___|___|___|___|

Posttraumatic Stress Disorder (PTSD)

Many people experience very frightening events sometime during their lives. Sometimes these experiences can upset them so much that their health suffers. The following six questions ask whether you have experienced such an event, and, if so, whether it has led to lasting problems. If you prefer not to answer a question, you can skip it.

1. Have you ever had an extremely frightening, traumatic or horrible experience like being a victim of a violent crime, seriously injured in an accident, being assaulted, seeing someone seriously injured or killed, or being a victim of a natural disaster?

   Yes |___|1 No |___|2
   (If you answered "NO," go to question 7)

   During the past month:

2. Did you relive the traumatic experience through recurrent dreams, preoccupation or flashbacks?

   Yes |___|1 No |___|2

3. Did you seem less interested than usual in important things, feel "out of it," or did you have a hard time with your feelings or emotions?

   Yes |___|1 No |___|2

4. Did you have problems sleeping, concentrating, or having a short temper?

   Yes |___|1 No |___|2

5. Did you avoid any place or anything that reminded you of the original horrible event?

   Yes |___|1 No |___|2

6. Did you have some of the above problems for more than one month?

   Yes |___|1 No |___|2

Inclusion of Community in the Self (ICS) Scale

7. Please circle the picture that best describes your relationship with the community at large. (Y=You; C=Community at Large)

1 2 3 4 5 6

ADMINISTRATIVE INFORMATION:

8. Interviewer code: |___|___|___|

9. Interview date: |___|___|/|___|___|/|___|___|___|___|
Month day year

STRONG HEART STUDY PHASE 7

RESILIENCE STUDY QUESTIONNAIRE

SHS I.D.: |___|___|___|___|___|___|

Date:|___|___| / |___|___| / |___|___|

Interviewer Code: |___|___|___|

14-Item Resilience Scale (RS-14)

Resilience may be defined as the ability to regulate emotions, maintain positive attitude, or see failure as helpful feedback despite conditions of extreme stress. The RS-14 measures traits of individual resilience, including self-reliance, perseverance, self-regard, engagement, humor, resourcefulness, meaningfulness, and composure.

***Instructions**: For the following questions, please circle the number corresponding to the best answer. **Mark only one answer for each question**. To change an answer, fully black out the incorrect mark and then circle the correct number. If you are unsure, please give the best answer you can.*

	Strongly disagree	disagree	More or less disagree	Neutral	More or less agree	Agree	Strongly agree
1. I usually manage one way or the other	|___| 1	|___| 2	|___| 3	|___| 4	|___| 5	|___| 6	|___| 7
2. I feel that I can handle many things at a time	|___| 1	|___| 2	|___| 3	|___| 4	|___| 5	|___| 6	|___| 7
3. I can get through difficult times because I have experienced difficulty before	|___| 1	|___| 2	|___| 3	|___| 4	|___| 5	|___| 6	|___| 7
4. In an emergency, I am someone people can generally rely on	|___| 1	|___| 2	|___| 3	|___| 4	|___| 5	|___| 6	|___| 7
5. When I am in a difficult situation, I can usually find my way out of it	|___| 1	|___| 2	|___| 3	|___| 4	|___| 5	|___| 6	|___| 7
6. I feel proud that I have accomplished things in life	|___| 1	|___| 2	|___| 3	|___| 4	|___| 5	|___| 6	|___| 7
7. I keep interested in things	|___| 1	|___| 2	|___| 3	|___| 4	|___| 5	|___| 6	|___| 7
8. My life has meaning	|___| 1	|___| 2	|___| 3	|___| 4	|___| 5	|___| 6	|___| 7
9. I usually take things in stride	|___| 1	|___| 2	|___| 3	|___| 4	|___| 5	|___| 6	|___| 7
10. I can usually find something to laugh about	|___| 1	|___| 2	|___| 3	|___| 4	|___| 5	|___| 6	|___| 7
11. I am determined	|___| 1	|___| 2	|___| 3	|___| 4	|___| 5	|___| 6	|___| 7
12. I have self-discipline	|___| 1	|___| 2	|___| 3	|___| 4	|___| 5	|___| 6	|___| 7
13. I am friends with myself	|___| 1	|___| 2	|___| 3	|___| 4	|___| 5	|___| 6	|___| 7
14. My belief in myself gets me through hard times	|___| 1	|___| 2	|___| 3	|___| 4	|___| 5	|___| 6	|___| 7

Multidimensional and Interpersonal Resilience Measure (MIRM)

There are many aspects of resilience. Some scientists believe that resilience is also feature of community, both defined by and improved by social support. The MIRM scale covers more complex concepts of resilience, including access to a support network, optimism, access to economic and social resources, spirituality and religiosity, relational accord, emotional regulation, emotional expression, and communication.

***Instructions**: For the following questions, please circle the number corresponding to the best answer. **Mark only one answer for each question**. To change an answer, fully black out the incorrect mark and then circle the correct number. If you are unsure, please give the best answer you can.*

	Not true at all	Rarely True	Sometimes True	Often True	True nearly all the time
1. I can deal with whatever comes my way	|___| 1	|___| 2	|___| 3	|___| 4	|___| 5
2. I am able to adapt to change	|___| 1	|___| 2	|___| 3	|___| 4	|___| 5
3. I tend to bounce back after illness or hardship	|___| 1	|___| 2	|___| 3	|___| 4	|___| 5
4. When I am confused by a problem, one of the first things I do is survey the situation and consider all the relevant pieces of information	|___| 1	|___| 2	|___| 3	|___| 4	|___| 5
5. Before criticizing somebody, I try to imagine how they would feel if I were in their place	|___| 1	|___| 2	|___| 3	|___| 4	|___| 5
6. I sometimes find it difficult to see things from another person's point of view	|___| 1	|___| 2	|___| 3	|___| 4	|___| 5
7. I often have not comforted another when he or she needed it	|___| 1	|___| 2	|___| 3	|___| 4	|___| 5
8. Sometimes when people are talking to me, I find myself wishing that they would leave	|___| 1	|___| 2	|___| 3	|___| 4	|___| 5

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
9. Overall, I expect more good things to happen to me than bad	|___| 1	|___| 2	|___| 3	|___| 4	|___| 5
10. I'm always hopeful about my future	|___| 1	|___| 2	|___| 3	|___| 4	|___| 5
11. In unclear times, I usually expect the best	|___| 1	|___| 2	|___| 3	|___| 4	|___| 5

	Lowest ……									Highest
12. Where do you think you stand at this time in your life, relative to other people in the United States? (10 = People with most money, education, or most respected jobs)	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
13. In general, how satisfied are you with your finances? (10=Very Satisfied)	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*

MIRM Continued: *Please select the closest answer according to the following scales, by circling the number.*

	Never	A Little of the Time	Sometimes	Frequently
14. How often do you feel lonely?	|___| 1	|___| 2	|___| 3	|___| 4
15. How often do your spouse, children, close friends, and relatives give you advice or information about medical, financial, or family problems?	|___| 1	|___| 2	|___| 3	|___| 4
16. How often do your spouse, children, close friends, and relatives help with daily tasks like shopping, giving you a ride, or household chores?	|___| 1	|___| 2	|___| 3	|___| 4
17. How often are your spouse, children, close friends, or relatives willing to listen when you need to talk about your worries or problems?	|___| 1	|___| 2	|___| 3	|___| 4
18. How often do your spouse, children, close friends, and relatives make you feel loved and cared for?	|___| 1	|___| 2	|___| 3	|___| 4
19. How often do your spouse, children, close friends, and relatives make too many demands on you?	|___| 1	|___| 2	|___| 3	|___| 4
20. How often are your spouse, children, close friends, and relatives critical of what you do?	|___| 1	|___| 2	|___| 3	|___| 4

	Not at all	Slightly	Moderately	Very
21. To what extent do you consider yourself a religious person?	|___| 1	|___| 2	|___| 3	|___| 4
22. To what extent do you consider yourself a spiritual person?	|___| 1	|___| 2	|___| 3	|___| 4

Revised Multigroup Ethnic Identity Scale (MEIM-R)

Identity is complex, and has been associated with resilience, social support, and health. Cultural, social, and ethnic identities may not be restricted to a single group, but can be fluid, variable, overlapping, or mixed. The MEIM-R includes self-categorization on ethnic identity as well as exploration and commitment to that identity.

Instructions: *Please fill in the blank. If you are unsure, please give the best answer you can.*

1. I consider myself as belonging to _____ race/ethnic group.

Instructions*: Please circle the best number,* ***marking only one answer for each question****. To change an answer, fully black out the incorrect answer. If you are unsure, give the best answer you can.*

	Strongly disagree	Somewhat disagree	Neutral	Somewhat agree	Strongly agree
2. I have spent time trying to find out more about my ethnic group, such as its history, traditions, and customs	|___| 1	|___| 2	|___| 3	|___| 4	|___| 5
3. I have a strong sense of belonging to my own ethnic group	|___| 1	|___| 2	|___| 3	|___| 4	|___| 5
4. I understand pretty well what my ethnic group membership means to me	|___| 1	|___| 2	|___| 3	|___| 4	|___| 5
5. I have often done things that will help me understand my ethnic group background better	|___| 1	|___| 2	|___| 3	|___| 4	|___| 5
6. I have often talked to other people in order to learn more about my ethnic group	|___| 1	|___| 2	|___| 3	|___| 4	|___| 5
7. I feel a strong attachment towards my own ethnic group	|___| 1	|___| 2	|___| 3	|___| 4	|___| 5

Instructions*: Please select all that apply. To remove an answer, fully black out the incorrect answer.*

8. I consider myself and/or my parents as belonging to:

	Yes	No
American Indian	|___|1	|___|0
Alaska Native, First Canadian	|___|1	|___|0
Pacific Islander, Native Hawaiian	|___|1	|___|0
Asian, Asian-American	|___|1	|___|0
Black, African-American	|___|1	|___|0
Hispanic, Latino	|___|1	|___|0
White, Caucasian, European	|___|1	|___|0
Other	|___|1	|___|0

- Other (Specify)

_____

Orthogonal Cultural Identity Scale (OCIS)

The degree of alignment and participation in one's own culture can have potential consequences for resilience and positive healthy aging. In youth, enculturation and social support account for 34% of resilience. The OCIS measures annual family activities, personal and family involvement in traditional culture, and personal and family success in traditional culture.

***Instructions**: For the following questions, please circle the number corresponding to the best answer. **Mark only one answer for each question**. To change an answer, fully black out the incorrect mark and then circle the correct number. If you are unsure, please give the best answer you can.*

	None	A Few	Some	A Lot
1. Some families have special activities or traditions that take place every year at particular times (holiday parties, special meals, religious activities, trips). How many of these special activities did your family have when you were growing up that were based on *Native American* or *American Indian* culture?	|___| 1	|___| 2	|___| 3	|___| 4
2. In the future, with your own family, will you do special things together or have special traditions that are based on *Native American* or *American Indian* culture?	|___| 1	|___| 2	|___| 3	|___| 4

	Not at All	Not Much	Some	A Lot
3. Does your family live by or follow the *Native American* or *American Indian* way of life?	|___| 1	|___| 2	|___| 3	|___| 4
4. Do you live by or follow the *Native American* or *American Indian* way of life?	|___| 1	|___| 2	|___| 3	|___| 4
5. Is your family a success in the *Native American* or *American Indian* way of life?	|___| 1	|___| 2	|___| 3	|___| 4
6. Are you a success in the *Native American* or *American Indian* way of life?	|___| 1	|___| 2	|___| 3	|___| 4

Reservation

7. Ever lived on the reservation	Yes |___|1	No |___|0
8. Live on the reservation now	Yes |___|1	No |___|0
9. Parents ever lived on reservation	Yes |___|1	No |___|0
10. Parents living on reservation now	Yes |___|1	No |___|0

Please fill in the blanks: (Enter N/A to Q 9-10 if participant never lived on a reservation)

9. Number of years lived on the reservation	
10. Age moved off of the reservation	
11. Recency of last visit to reservation (# of years)	
12. Days spent on reservation in the past year	

OCIS continued: *Please select the best answer by circling the correct answer, as relevant.*

Social

13. Contact with *Native American* or *American Indian* relatives living on the reservation in past year	Yes |___|1	No |___|0
14. Contact with *Native American* or *American Indian* relatives living outside of the reservation in past year	Yes |___|1	No |___|0
15. Presence of *Native American* or *American Indian* neighbors	Yes |___|1	No |___|0

Activities

16. Engage in traditional behaviors in past year (beading, singing, dancing)			Yes |___|1	No |___|0
17. Frequency of engaging these behaviors in past year (beading, singing, dancing)	*Daily* |___| 1	*Weekly* |___| 2	*Monthly* |___| 3	*Less Often* |___| 4
18. Attend traditional activities/events in past year (pow wows, fiestas)			Yes |___|1	No |___|0
19. Number of these activities/events attended in past year (pow wows, fiestas)	*Daily* |___| 1	*Weekly* |___| 2	*Monthly* |___| 3	*Less Often* |___| 4
20. Practiced *Native American* or *American Indian* religion attended in past year (sweat lodge, wake ceremony)			Yes |___|1	No |___|0
21. Number of *Native American* or *American Indian* religious ceremonies attended in past year (sweat lodge, wake ceremony)	*Daily* |___| 1	*Weekly* |___| 2	*Monthly* |___| 3	*Less Often* |___| 4
22. Currently belong to a *Native American* or *American Indian* organization			Yes |___|1	No |___|0
23. Ever belong to a *Native American* or *American Indian* organization			Yes |___|1	No |___|0

Rosenberg Self-Esteem Scale (R-SES)

Self-esteem is commonly thought to have significant associations with life, social, and health success***;*** however, these effects can vary widely and may be dependent on degree of social support. The RSES self-worth by measuring both positive and negative feelings about the self, and is believed to be objective and independent.

Instructions*: For the following questions, please circle the number corresponding to the best answer.* ***Mark only one answer for each question****. To change an answer, fully black out the incorrect mark and then circle the correct number. If you are unsure, please give the best answer you can.*

	Strongly agree	Agree	Disagree	Strongly disagree
1. On the whole, I am satisfied with myself	|___| 4	|___| 3	|___| 2	|___| 1
2. At times I think I am no good at all	|___| 1	|___| 2	|___| 3	|___| 4
3. I feel that I have a number of good qualities	|___| 4	|___| 3	|___| 2	|___| 1
4. I am able to do things as well as most other people	|___| 4	|___| 3	|___| 2	|___| 1
5. I feel I do not have much to be proud of	|___| 1	|___| 2	|___| 3	|___| 4
6. I certainly feel useless at times	|___| 1	|___| 2	|___| 3	|___| 4
7. I feel that I'm a person of worth	|___| 4	|___| 3	|___| 2	|___| 1
8. I wish I could have more respect for myself	|___| 1	|___| 2	|___| 3	|___| 4
9. All in all, I am inclined to feel that I am a failure	|___| 1	|___| 2	|___| 3	|___| 4
10. I take a positive attitude toward myself	|___| 4	|___| 3	|___| 2	|___| 1

Social Support and Social Undermining Items(SS/U)

Social support and its reverse—social undermining—are known to be significant factors in health and resilience. Just as with resilience, social support and undermining are complex and may be defined multiple ways. The SS/U scale evaluates emotional (perceived) and instrumental (received) support; critical appraisal; and isolation.

***Instructions**: For the following questions, please circle the number corresponding to the best answer. **Mark only one answer for each question**. To change an answer, fully black out the incorrect mark and then circle the correct number. If you are unsure, please give the best answer you can.*

Emotional Support

	Often	Sometimes	Never
1. How much do your friends or relatives really care about you?	|___| 3	|___| 2	|___| 1
2. How much do they understand the way you feel about things?	|___| 3	|___| 2	|___| 1
3. How much do they appreciate you?	|___| 3	|___| 2	|___| 1
4. How much can you rely on them for help if you have a serious problem?	|___| 3	|___| 2	|___| 1
5. How much can you talk to them about your worries?	|___| 3	|___| 2	|___| 1
6. How much can you relax and be yourself around them?	|___| 3	|___| 2	|___| 1

Instrumental Social Support

Among the people you know, is there someone:	Yes	No
1. You can go with to play cards, bingo, a powwow, or a community meeting?	Yes |___|1	No |___|0
2. Who would lend you money if you needed it in an emergency?	Yes |___|1	No |___|0
3. Who would lend you a car or drive you somewhere else if you really needed it?	Yes |___|1	No |___|0
4. You could call who would bail you out if you were arrested and put in jail?	Yes |___|1	No |___|0
5. You could count on to check in on you regularly?	Yes |___|1	No |___|0

Critical Appraisal

	Often	Sometimes	Never
1. How often do your friends or relatives make too many demands on you?	|___| 3	|___| 2	|___| 1
2. How often do they argue with you?	|___| 3	|___| 2	|___| 1
3. How often do they criticize you?	|___| 3	|___| 2	|___| 1
4. How often do they let you down when you are counting on them?	|___| 3	|___| 2	|___| 1
5. How often do they get on your nerves?	|___| 3	|___| 2	|___| 1
6. How often do they drink or use drugs too much?	|___| 3	|___| 2	|___| 1

Isolation

	Very Isolated	Somewhat Isolated	Not very isolated at all
1. How isolated do you feel?	|___| 3	|___| 2	|___| 1

	A lot	Sometimes	Not very much at all
2. How often do you purposely avoid family gatherings?	|___| 3	|___| 2	|___| 1

	Very	Somewhat	Not at all
3. Of those family gatherings you go to, how likely are you to leave early?	|___| 3	|___| 2	|___| 1

Social Network Index (SNI)

Another feature of social support is the size and complexity of a social network. This is important because social effects for people with a large, surface network (lots of casual acquaintances) may be different than those who have a small, deep network (few close friends). The SNI assesses 12 types of social relationships.

***Instructions**: For the following questions, please circle or enter the best answer. To change an answer, fully black out the incorrect answer. If you are unsure, please give the best answer you can.*

1. *[Marital status from main questionnaire]*

2. How many children do you have? _____

2b. How many of your children do you see or talk to on the phone at least once every 2 weeks? _____

3. Are either of your parents living? |___|1 Mother |___|2 Father |___|3 Both |___|0 Neither

3b. Do you see or talk to either or both of your parents at least once every 2 weeks? Yes |___|1 No |___|0

4. Are either of your in-laws (or partner's parents) living? |___|1 Mother |___|2 Father |___|3 Both |___|0 Neither

4b. Do you see or talk to either or both of your partner's parents at least once every 2 weeks? Yes |___|1 No |___|0

5. How many other relatives (other than your spouse, parents & children) do you feel close to? _____

5b. How many of these relatives do you see or talk to on the phone at least once every 2 weeks? _____

6. How many close friends do you have? _____

6b. How many of these friends do you see or talk to at least once every 2 weeks? _____

7. Do you belong to a church, temple, or other religious group? Yes |___|1 No |___|0

7b. How many members of your church or religious group do you talk to at least once every 2 weeks? _____

8. Do you attend any classes (school, university, adult education) on a regular basis? Yes |___|1 No |___|0

8b. How many fellow students or teachers do you talk to at least once every 2 weeks? _____

9. Are you currently employed either full or part-time? Yes |___|1 No |___|0

9b. How many people do you supervise? _____

9c. How many people at work (other than those you supervise) do you talk to more than once every 2 weeks? _____

10. How many of your neighbors do you see or talk to at least once every 2 weeks? _____

11. Are you currently involved in regular volunteer work? Yes |___|1 No |___|0

11b. How many people involved in this volunteer work do you talk to about volunteering-related issues at least once every 2 weeks? _____

12. Do you belong to any groups where you talk to members about group-related issues at least once every 2 weeks? (Examples: social clubs, recreational groups, trade unions, commercial groups, professional organizations, groups with children like PTA or Boy Scouts, community service groups) Yes |___|1 No |___|0

13. Consider those groups where you talk to a fellow member at least once every 2 weeks. Please provide the following for each: the name or type of group, the number of members that you talk to > once every 2 weeks.

Group _____ # Members you talk to at least every 2 weeks _____
Group _____ # Members you talk to at least every 2 weeks _____
Group _____ # Members you talk to at least every 2 weeks _____
Group _____ # Members you talk to at least every 2 weeks _____
Group _____ # Members you talk to at least every 2 weeks _____
Group _____ # Members you talk to at least every 2 weeks _____
Group _____ # Members you talk to at least every 2 weeks _____

Functional Activities Questionnaire (FAQ)

Dementia is a clinical syndrome wherein the patient is unable to perform the usual activities of their daily lives, such as preparing balanced meals or managing personal finances. Dementia can be caused by caused by cardiovascular, cerebrovascular, neurodegenerative, or other disease. The Functional Activities Questionnaire (FAQ) measures the ability to perform these instrumental activities of daily living (IADLs).

Instructions*: Please rate your ability to complete the following daily tasks, according to the following scale, by circling the best answer. If you* ***never did*** *the task or activity, rate* ***how well you think you would do, if you were to do it now****. For each task or activity, also indicate whether your ability has changed* ***over the past year****. Mark only one answer for each question. To change an answer, fully black out the incorrect mark and then circle the correct number. If you are unsure, please give the best answer you can.*

	Normal or Never Did (1)	*Have Difficulty But Can Do By Myself (2)*	*Can Do But Need Assistance (3)*	*Dependent on Others (4)*
1. Write checks, pay bills, balance checkbook	|___|1	|___| 2	|___| 3	|___| 4
2. Assemble business affairs, papers, tax records	|___|1	|___| 2	|___| 3	|___| 4
3. Shop alone for clothes, household necessities, or groceries	|___|1	|___| 2	|___| 3	|___| 4
4. Play a game of skill, work on a hobby	|___|1	|___| 2	|___| 3	|___| 4
5. Heat water, make a cup of coffee, turn off stove after use	|___|1	|___| 2	|___| 3	|___| 4
6. Prepare a balanced meal	|___|1	|___| 2	|___| 3	|___| 4
7. Keep track of current events	|___|1	|___| 2	|___| 3	|___| 4
8. Pay attention to & understand TV, books, magazines	|___|1	|___| 2	|___| 3	|___| 4
9. Remember appointments, family occasions, holidays, medications	|___|1	|___| 2	|___| 3	|___| 4
10. Travel out of neighborhood, drive, arrange to take the bus	|___|1	|___| 2	|___| 3	|___| 4

11. Have any of these abilities declined due to a cognitive or memory problem?	Yes |___|1	No |___|0
12. Are any of these limitations due to a physical limitation such as use of a cane, walker, or wheelchair?	Yes |___|1	No |___|0

THE STRONG HEART STUDY VII
CARDIOVASCULAR DISEASE IN AMERICAN INDIANS

FOOD ASSISTANCE AND FOOD SECURITY

SHS I.D.: |___|___|___|___|___|___|___| SHS Family I.D.: |___|___|___|___|___|___|___|___|

1. In the past 12 months, have you or other members of your household participated in any of the following services? (*please check all you have used*)
   i. □ WIC – Women Infants & Children Program
   ii. □ SNAP/EBT – Supplemental Nutrition Assistant Program
   iii. □ Tribal Food Distribution Program (commodities)
   iv. □ Elderly Nutrition Program
   v. □ Food Pantry, Soup Kitchen
   vi. □ Free/Reduced School Breakfast or Lunch, or Summer Meals Program
   vii. □ Do Not Participate in any of these programs
   viii. □ I choose not to answer

2. In the past 12 months, the food that your household bought just didn't last, and your household didn't have money to get more.
   i. □ Often true
   ii. □ Sometimes true
   iii. □ Never true
   iv. □ I choose not to answer

3. In the past 12 months, your household couldn't afford to eat balanced meals.
   i. □ Often true
   ii. □ Sometimes true
   iii. □ Never true
   iv. □ I choose not to answer

4. In the last 12 months, did your household ever cut the size of your meals or skip meals because there wasn't enough money for food?
   i. □ Yes
   ii. □ No
   iii. □ I choose not to answer

   iv. IF YES How often did this happen—almost every month, some months but not every month, or in only 1 or 2 months?
      a. □ Almost every month
      b. □ Some months but not every month
      c. □ Only 1 or 2 months
      d. □ I choose not to answer

5. In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?
   a. □ Yes
   □ No
   □ I choose not to answer

6. In the last 12 months, were you every hungry but didn't eat because there wasn't enough money for food?
   - □ Yes
   - □ No
   - □ I choose not to answer

ADMINISTRATIVE INFORMATION

7. Examiner code: |___|___|___|

8. Examination date: |___|___|/|___|___|/|___|___|___|___|
   Month day year

THE STRONG HEART STUDY VII
CARDIOVASCULAR DISEASE IN AMERICAN INDIANS

PHYSICAL EXAMINATION

SHS I.D.: |___|___|___|___|___|___|___| SHS Family I.D.: |___|___|___|___|___|___|___|

EXAMINATION OF EXTREMITIES FOR AMPUTATIONS

1. Are any extremities missing? Yes |___|1 No |___|2 ***(go to Q2)***

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

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

	Extremities	Check if Missing		Cause	If Other, please specify
a)	Right arm	|___|		|___|	_____
b)	Right hand	|___|		|___|	_____
c)	Right finger(s)	|___|	_____ # missing	|___|	_____
d)	Left arm	|___|		|___|	_____
e)	Left hand	|___|		|___|	_____
f)	Left finger(s)	|___|	_____ # missing	|___|	_____
g)	Right leg above knee	|___|		|___|	_____
h)	Right leg below knee	|___|		|___|	_____
i)	Right foot	|___|		|___|	_____
j)	Right toe(s)	|___|	_____ # missing	|___|	_____
k)	Left leg above knee	|___|		|___|	_____
l)	Left leg below knee	|___|		|___|	_____
m)	Left foot	|___|		|___|	_____
n)	Left toe(s)	|___|	_____ # missing	|___|	_____

BLOOD PRESSURE

2. Right arm circumference, measured in centimeters (cm) |___|___|___|
Midway between acromion and olecranon.

3. Cuff size (arm circumference in brackets)

Pediatric (under 24cm) |___|1
Regular arm (24 – 32cm) |___|2
Large arm (33 – 41cm) |___|3
Thigh (>41cm) |___|4

4. Pulse obliteration pressure |___|___|___|

5. Seated Blood Pressure:

	Systolic BP	***Diastolic BP***
a) **First** Blood Pressure Measurement	|___|___|___|	|___|___|___|
b) **Second** Blood Pressure Measurement	|___|___|___|	|___|___|___|
c) **Third** Blood Pressure Measurement	|___|___|___|	|___|___|___|

6. Were the above blood pressures taken from RIGHT arm? Yes |___|1

No |___|2

Specify: _____

7. Recorder ID (For the SHS staff who took BP): |___|___|___|

ANTHROPOMETRIC MEASUREMENTS:

(Take off shoes and remove heavy objects from pockets.)

		METRIC SYSTEM (centimeters/kilograms)	***ENGLISH SYSTEM*** (inches/pounds)
8.	Height (Standing)	**|___|___|___|** centimeters	|___|___|___| inches
9.	Weight (Standing)	**|___|___|___|** kilograms	|___|___|___| pounds
10.	Hip circumference (Standing)	**|___|___|___|** centimeters	|___|___|___| inches
11.	Waist measurement at umbilicus (Supine) ...	**|___|___|___|** centimeters	|___|___|___| inches

PEDAL PULSES AND EDEMA

		PRESENT	ABSENT	MISSING LIMBS	UNABLE TO ASSESS
12.	Right posterior tibial pulse	|___|1	|___|2	|___|3	|___|9
13.	Right dorsalis pedis pulse	|___|1	|___|2	|___|3	|___|9
14.	Left posterior tibial pulse	|___|1	|___|2	|___|3	|___|9
15.	Left dorsalis pedis pulse	|___|1	|___|2	|___|3	|___|9

16. Pedal edema Absent |___|1 Mild |___|2 Marked |___|3

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
17.	a)	First systolic B.P.	|___|___|___|	|___|___|___|	|___|___|___|
	b)	Second systolic B.P.	|___|___|___|	|___|___|___|	|___|___|___|
	c)	Location	Posterior tibial |___|1	Posterior tibial |___|1	
			Dorsalis pedis |___|2	Dorsalis pedis |___|2	

ADMINISTRATIVE INFORMATION

18. Examiner code: |___|___|___|

19. Examination date: |___|___|/|___|___|/|___|___|___|___|
Month day year

THE STRONG HEART STUDY VII
CARDIOVASCULAR DISEASE IN AMERICAN INDIANS

PHYSICAL EXAMINATION – QC DUPLICATE MEASUREMENT

SHS I.D.: |___|___|___|___|___|___|___| SHS Family I.D.: |___|___|___|___|___|___|___|

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 Large arm (33-41cm) |___|3

   Regular arm (24-32cm) |___|2 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 RIGHT arm? Yes |___|1 No |___|2

   a) If no, why? Amputation |___|1 Wound/dressing |___|2 Cast |___|3 Refusal |___|8

6. Recorder ID: |___|___|___|

ANTHROPOMETRIC MEASUREMENTS:

		ENGLISH SYSTEM (inches/pounds)	***METRIC SYSTEM*** (centimeters/kilograms)
7.	Weight (Standing)	|___|___|___| pounds	|___|___|___| kilograms
8.	Height (Standing).....	|___|___|___| inches	|___|___|___| centimeters
9.	Waist (Supine)	|___|___|___| inches	|___|___|___| centimeters
10.	Hip circumference (Standing).....	|___|___|___| inches	|___|___|___| centimeters

ADMINSTRATIVE INFORMATION:

11.	Interviewer code:	|___|___|___|
12.	Interviewer date:	|___|___|/|___|___|/|___|___|___|___| Month day year

THE STRONG HEART STUDY VII
CARDIOVASCULAR DISEASE IN AMERICAN INDIANS

SAMPLE COLLECTION CHECKLIST

SHS I.D.: |___|___|___|___|___|___|___| SHS Family I.D.: |___|___|___|___|___|___|___|___|

1. Is ***FASTING*** blood sample taken?

   Yes, and participant has been fasting ..... |___|1

   Yes, but participant has NOT been fasting ..... |___|2

   No, participant has not been fasting ..... |___|3

   Other, specify: _____ |___|4

   No, participant refused ..... |___|8

2. When was the last time you ate? *(use military time)* |___|___|:|___|___|

3. Time of collection of fasting samples. *(use military time)* |___|___|:|___|___|

4. Is urine sample taken? Yes |___| 1 ***(go to Q7)*** No |___| 2

5. If no, why?

   On dialysis ..... |___|1

   Cannot urinate ..... |___|2

   Other, specify: _____ |___|3

6. Time of collection of urine sample *(use military time)* |___|___|:|___|___|

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

Item	Purpose	Type	Check
a) Three 10 ml SST	Chem Profile Lipids, Insulin, CRP, FFA	Serum	|___|
b) One 4.5 ml Lt Blue	Fibrinogen	Plasma	|___|
c) One 4 ml Gray	Fasting glucose	Plasma	|___|
d) Three 10 ml Purple	HbA1c, Leptin, DNA	Whole blood/Plasma/ Buffy coat	|___|
e) One Purple (size site specific)	CBC	Whole blood	|___|
f) Two PAXgene	RNA	Whole blood	|___|
g) Urine (One cup)	Albumin/Creatinine	Urine	|___|

8. Is this participant also a volunteer for blood/urine QC? Yes |___|1 No |___|2 (***go to Q12)***

9. **QC ID (second digit is "3"):** |___|___|___|___|___|___|

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

Item	Purpose	Type	Check
a) One 10 ml SST	Chem Profile Lipids, Insulin, CRP, FFA	Serum	|___|
b) One 4 ml Gray	Fasting glucose	Plasma	|___|
c) One 10 ml Purple	HbA1c/Leptin	Whole blood/Plasma	|___|
d) Urine (One cup)	Albumin/Creatinine	Urine	|___|

11. 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."
If you did, when and what: _____

ADMINISTRATIVE INFORMATION:

12. SHS Code of person completing this form: |___|___|___|

13. Today's Date: |___|___|/|___|___|/|___|___|___|___|
Month day year

THE STRONG HEART STUDY VII
CARDIOVASCULAR DISEASE IN AMERICAN INDIANS

CBC RESULTS

SHS I.D.: |___|___|___|___|___|___| SHS Family I.D.:|___|___|___|___|___|___|___|

Each center's results may appear in different order. Please be careful when entering the results.

1. WBC (10^9/L or K/cmm or K/uL) .....|___|___|. |___|___|
2. RBC (10^{12}/L or M/cmm or M/uL).....|___|___|. |___|___|
3. HGB (g/dL).....|___|___|. |___|___|
4. HCT (%).....|___|___|___|. |___|___|
5. MCV (fL) .....|___|___|___|. |___|___|
6. MCH (pg) .....|___|___|. |___|___|
7. MCHC (g/dL).....|___|___|. |___|___|
8. RDW (%).....|___|___|. |___|___|
9. Platelet count (PLT. 109/L or K/cmm or K/uL) ..... |___|___|___|___|. |___|___|
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 (%) .....|___|___|. |___|___|

ADMINISTRATIVE INFORMATION:

16. Did the participant have a CBC? Yes |___|1 No |___|2
17. Completer code: |___|___|___|
18. Completion date: |___|___|/|___|___|/|___|___|___|___|
    Month day year

The Bristol Stool Chart - A Tool to Track Your Bowel Movement

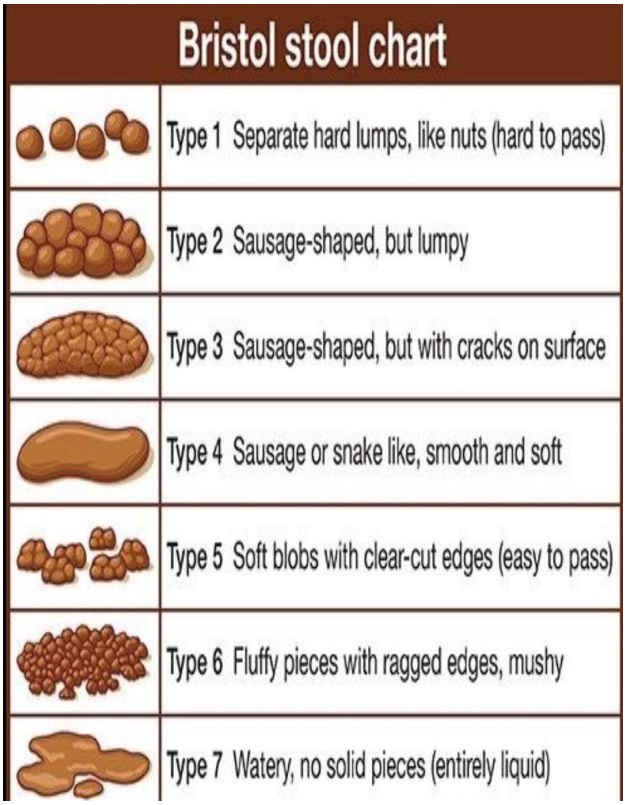
What is the Bristol Stool Chart

The bowel is a part of the digestive system that allows people to absorb nutrients from food and expel the waste that the body cannot use. If feces pass too quickly or too slowly, it may indicate a problem with the bowels.

The Bristol Stool Chart is a quick, inexpensive, and reliable way to assess how long a stool has spent in the bowels. The tool breaks down stools into seven types based on their appearance, ranging from type 1 (hard) to type 7 (loose). The scale was created in 1997 by a team of healthcare providers at the British Royal Infirmary in Bristol, England. Doctors can use the tool as a practical guide to identify problems with bowel movements and know if your bowel movement is healthy. Researchers have also used the chart to identify problematic foods, supplements, digestive health and other lifestyle stressors, and assess how well various treatments work for people with certain GI problems.

Why Stool Type Matters

Why does your type of stool matter? It can help you to identify what is normal and if you are experiencing constipation or diarrhea. It can also help you to describe to your doctor what you are experiencing when you are using the restroom.



Types of Stool and What They Mean

The Bristol Stool Chart classifies stools into seven groups. Types 1-2 indicate constipation. Types 3-5 are considered normal, and types 6-7 indicate diarrhea.

Regular Bowel Movements

So, what is normal? When it comes to your bowel movements everyone seems to have their own normal. We are all unique. But, in general your bowel movements should pass easily and be well formed. You should be using the restroom on a regular basis, and using the restroom should not be a struggle.

When to Speak with a Doctor

If a person is persistently passing stools at either end of the Chart or switching from one end of the scale to the other, it is advisable that they consult with a doctor.

A healthcare professional can help identify the potential cause of the abnormal bowel movements and recommend suitable treatments to allow an individual to pass regular and healthy stools.

Maintaining Good Bowel Health

Maintaining good bowel health typically includes three steps:

- Eating plenty of fiber. Fiber provides bulk to help stool pass
- Drinking enough fluid. Fluids help keep things lubricated and moving
- Being physically active. Physical activity helps to keep the body and bowels healthy.

Bristol Stool Chart

SHS I.D.: |___|___|___|___|___|___|___|

Please indicate the type of stool passed by putting a check mark in the appropriate box for each of the 3 days listed below

Date	**Type 1** Separate hard lumps like nuts (hard to pass)	**Type 2** Sausage shaped but lumpy	**Type 3** Like a sausage but with cracks on surface	**Type 4** Like a sausage or snake, smooth and soft	**Type 5** Soft blobs with clear-cut edges (passed easily)	**Type 6** Fluffy pieces with ragged edges, a mushy stool	**Type 7** Watery, no solid pieces (entirely liquid)
							
Day 1 (2 days BEFORE stool sample was collected) __ __/__ __/__ __ __ __ Month Day Year							
Day 2 (1 day BEFORE stool sample was collected) __ __/__ __/__ __ __ __ Month Day Year							
The day ON which stool sample was collected __ __/__ __/__ __ __ __ Month Day Year							

Adapted from the Bristol Stool Scale developed by KW Heaton and SJ Lewis at the University of Bristol, 1997