



Clinic Interview

EPSTAFF

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- 1 On most nights, how many hours do you sleep each night? *SLSLPHRS* hours
- 2 How many hours of sleep do you need each night to feel rested? (Please answer to the nearest hour.) *SLRESTED* hours

- 3 Do you take naps regularly? Yes No Don't know
- ↓ *SLNAP*

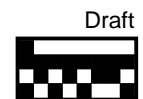
a. How many days per week do you usually nap? *SLNAPDY* days *SLNAPDLY* *SLNAPHWK*

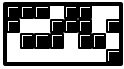
b. On average, how many hours do you nap each time? *SLNAPHR*

1 Less than 1 hour 2 At least 1 hour but no more than 2 hours 3 More than 2 hours

- 4 How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to think about out how they would have affected you. Give the most appropriate response for each situation.

	<i>EPEPWORT</i> <i>EPEDS</i>	Would <u>Never</u> Doze	<u>Slight</u> Chance of Dozing	<u>Moderate</u> Chance of Dozing	<u>High</u> Chance of Dozing
a. Sitting and reading	<i>EPREAD</i>	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
b. Watching TV	<i>EPTV</i>	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
c. Sitting inactive in a public place (e.g. a theater or a meeting)	<i>EPPUB</i>	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
d. As a passenger in a car for an hour without a break	<i>EPCAR</i>	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
e. Lying down to rest in the afternoon when circumstances permit	<i>EPREST</i>	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
f. Sitting and talking to someone	<i>EPTALK</i>	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
g. Sitting quietly after a lunch without alcohol	<i>EPEAT</i>	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
h. In a car, while stopped for a few minutes in traffic	<i>EPTRAF</i>	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3





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The following questions are about how well you are able to do certain activities, by yourself and without using any special aids.

5 Do you have ANY difficulty walking 2 or 3 blocks outside on level ground? **QLBLK1**
QLBLK2
QLRBLK1

Yes No I don't do it **QLBLK**

QLBLKLVL **GO TO QUESTION #6**

How much difficulty do you have doing this?
 Some difficulty Much difficulty Unable to do it

Is this because of a health or physical problem? **QLBLKPRB**
 Yes No I don't know

6 Do you have ANY difficulty climbing up 10 steps without resting? **QLSTP1**
QLSTP2
QLRSTP1

Yes No I don't do it **QLSTP**

QLSTPLVL **GO TO QUESTION #7**

How much difficulty do you have doing this?
 Some difficulty Much difficulty Unable to do it

Is this because of a health or physical problem? **QLSTPPRB**
 Yes No I don't know

7 Do you have ANY difficulty preparing your own meals? **QLMEL1**
QLMEL2
QLRMEL1

Yes No I don't do it **QLMEL**

QLMELLVL **GO TO QUESTION #8**

How much difficulty do you have doing this?
 Some difficulty Much difficulty Unable to do it

Is this because of a health or physical problem? **QLMELPRB**
 Yes No I don't know

8 Do you have ANY difficulty doing heavy housework, like scrubbing floors or washing windows? **QLHHW1**
QLHHW2
QLRHHW1

Yes No I don't do it **QLHHW**

QLHHWLVL **GO TO QUESTION #9**

How much difficulty do you have doing this?
 Some difficulty Much difficulty Unable to do it

Is this because of a health or physical problem? **QLHHWPRB**
 Yes No I don't know

9 Do you have ANY difficulty doing your own shopping for groceries or clothes? **QLSHP1**
QLSHP2
QLRSHP1

Yes No I don't do it **QLSHP**

QLSHPLVL **GO TO NEXT SECTION**

How much difficulty do you have doing this?
 Some difficulty Much difficulty Unable to do it

Is this because of a health or physical problem? **QLSHPPRB**
 Yes No I don't know



QLFXST51
QLFXST52

PAGE 2

Version 1.0 08.22.03
MrOSYYFunctionalStatus



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Introduction: 'Are you comfortable? I would like to ask you a few questions that require concentration and memory. Some are a little bit more difficult than others. Some questions will be asked more than once.'



What time was the Mini-Mental test administered (start time)?

		:		
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- A.M.
- P.M.

1 A. When were you born?

		/			/				
Month			Day			Year			

B. Where were you born? Place of Birth?

	Answer given*	Can't do/ Refused	Not attempted
_____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
City or town			
_____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
State/Country			

* If answer is given, you will ask again in questions #18

2 I am going to say three words for you to remember. Repeat them after I have said all three words:

Ball, Tree, Flag

Do not repeat the words for the participant until after the first trial. The participant may give the words in any order. If there are errors on the first trial, repeat the items up to six times until they are learned.

	Correct	Error/ Refused	Not attempted
A. Ball	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Tree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Flag	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

D. Number of presentations necessary for the participant to repeat the sequence presentations

3 A. I would like you to count from 1 to 5.

- Able to count forward
- Unable to count forward
↓
Say "1,2,3,4,5"

B. Now I would like you to count backwards from 5 to 1.

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Record the response in the order given. Enter 99999 if no response.

4 A. Spell 'world'.

- Able to spell
- Unable to spell
↓
Say "Its spelled W-O-R-L-D"

B. Now spell world backwards

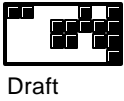
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Record the response in the order given. Enter XXXXX if no response.

SEE PAGE 7 FOR SCORING VARIABLES

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5 What three words did I ask you to remember?

A. Ball

- Spontaneous recall
- Correct word, incorrect form
- After 'A toy.'
- After 'ball, doll, block.'
- Unable to recall/refused
- Not attempted

B. Tree

- Spontaneous recall
- Correct word, incorrect form
- After 'A plant.'
- After 'tree, flower, bush'
- Unable to recall/refused
- Not attempted

C. Flag

- Spontaneous recall
- Correct word, incorrect form
- After 'Hangs on a pole.'
- After 'flag, banner, sign.'
- Unable to recall/refused
- Not attempted

6 A. What is today's date?

		/			/				
Month			Day			Year			

B. What is the day of the week?

- Correct
- Error/Refused _____ day of the week
- Not attempted

C. What season of the year is it?

- Correct
- Error/Refused _____ season
- Not attempted

7 A. What state are we in?

- Correct
- Error/Refused _____ state
- Not attempted

B. What county are we in?

- Correct
- Error/Refused _____ county
- Not attempted

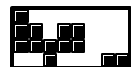
C. What city/town are we in?

- Correct
- Error/Refused _____ city/town
- Not attempted

D. Are we in a clinic, store, or home?

- Correct
- Error/Refused _____
- Not attempted

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8 Point to the object or part of your own body and ask the participant to name it. Score 'Error/Refused' if the participant cannot name it within 2 seconds or gives an incorrect name.

	Correct	Error/ Refused	Not attempted
A. Pencil: 'What is this?'	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Watch: 'What is this?'	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Forehead: 'What do you call this part of the face?'	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. Chin: 'And this part?'	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E. Shoulder: 'And this part of the body?'	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F. Elbow: 'And this part?'	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
G. Knuckle: 'And this part?'	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

9 What animals have four legs? Tell me as many as you can.

Discontinue after 30 seconds. If the participant gives no response in 10 secs and there are at least 10 secs remaining, gently remind them (once only): 'What (other) animals have four legs?'. The first time an incorrect answer is provided, say 'I want four-legged animals.' Do not correct for subsequent errors.

Score (total correct responses)

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Record correct responses:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Record additional correct answers on a separate sheet

10

A. In what way are an arm and a leg alike?

- Limbs, extremities, appendages
- Lesser correct answer (e.g., body parts, both bend, have joints)
- Error/Refused
- Not attempted

B. In what way are laughing and crying alike?

- Expressions of feelings, emotions
- Lesser correct answer (e.g., sounds, expressions, or other similar responses)
- Error/Refused
- Not attempted

C. In what way are eating and sleeping alike?

- Necessary bodily functions, essential for life
- Lesser correct answer (e.g., bodily functions, relaxing, 'good for you' or other similar responses)
- Error/Refused
- Not attempted

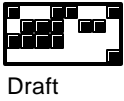
11

Repeat what I say: 'I would like to go out.'

- Correct
- 1 or 2 words missed
- 3 or more words missed
- Not attempted

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12 Now repeat: 'No ifs, ands or buts.'

	Correct	Error/ Refused	Not attempted
A. no ifs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. ands	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. or buts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

13 Hold up Card #1 and say: 'Please do this.'

If participant does not close their eyes within 5 secs, prompt by pointing to the card and saying 'Read and do what this says.'

- Closes eyes without prompting
- Closes eyes after prompting
- Reads aloud, but does not close eyes
- Does not read aloud or close eyes/Refused
- Not attempted

14 Please write the following sentence: I would like to go out.

	Correct	Error/ Refused	Not attempted
A. would	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. like	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. to	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. go	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E. out	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Which hand does the participant use to write? If task not done, ask if they are right or left handed.

- 1 Right 2 Left 3 Unknown

15 Here is a drawing. Please copy the drawing onto this piece of paper.

A. Pentagon 1

- 5 approximately equal sized sides
- 5 sides, but longest:shortest side is >2:1
- Nonpentagon enclosed figure
- 2 or more lines, but it is not an enclosed figure
- Less than 2 lines, Refused
- Not attempted

B. Pentagon 2

- 5 approximately equal sized sides
- 5 sides, but longest:shortest side is >2:1
- Nonpentagon enclosed figure
- 2 or more lines, but it is not an enclosed figure
- Less than 2 lines, Refused
- Not attempted

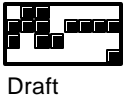
C. Intersection

- 4-cornered enclosure
- Not a 4-cornered enclosure
- No enclosure, Refused
- Not attempted, Disabled

TMHAND

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ACROST



16 Refer to Question 14 to check whether the participant is right or left-handed.
Take this paper with your left hand (right for left-handed person), fold it in half using both hands, and hand it back to me.

	Correct	Error/ Refused	Not attempted
A. Takes paper in correct hand	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Folds paper in half	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Hands paper back	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

18 Would you please tell me again where you were born?

	Matches	Does not match/ Refused	Not attempted
_____ City or town	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
_____ State/Country	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

17 What three words did I ask you to remember earlier?

A. Ball

- Spontaneous recall
- Correct word, incorrect form
- After 'A toy.'
- After 'ball, doll, block'
- Unable to recall/refused
- Not attempted

B. Tree

- Spontaneous recall
- Correct word, incorrect form
- After 'A plant.'
- After 'tree, flower, bush.'
- Unable to recall/refused
- Not attempted

C. Flag

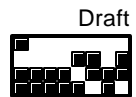
- Spontaneous recall
- Correct word, incorrect form
- After 'Hangs on a pole.'
- After 'flag, banner, sign'
- Unable to recall/refused
- Not attempted

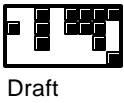
19 Please indicate if the participant has any physical/functional disabilities or other problems which made it difficult or impossible to complete any of the tasks above. Check all that apply.

- Vision *TMDIFFVI*
- Hearing *TMDIFFHE* *TMDIFFWR*
- Writing problems due to injury or illness
- Illiteracy/Lack of education *TMDIFFIL*
- Language *TMDIFFLA*
- Other: _____ *TMDIFFOT*

TMMFLAG
TMBDAY
TMREGIS
TMREVERS
TMRECALL
TMTEMPOR
TMSPACE
TMNAMING
TM4LEG
TMMSCORE

TMM1SSCR





Trail Making Task B & DVT

TBSTAFF

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Trails B Staff ID#

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① Was the participant able to complete the Sample Response Sheet? Yes No **TBSAMP**

TBWHYN

- Why not?
- 1 Unable due to physical problems (hand tremor, cast, etc.)
 - 2 Participant did not understand directions
 - 3 Other
 - 4 Participant Refused

② What time was the Trails B test administered (start time)?

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 A.M. P.M. **TBTIMEM**

③ Number of circles connected (maximum=25):

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 circles **TBCIRCLE** Total time (max=300 seconds):

--	--	--

 secs **TBSECON** # of errors made by participant:

--	--

 errors **TBERROR**

④ Is the hand being used to complete Trails B the participant's usual or dominant hand for writing? Yes No **TBDOMH**

⑤ Are there any peripheral injuries (e.g., crushed or missing fingers, broken bones in the hand) or other things that have occurred in the participant's life history that would adversely affect their ability to do the test? Yes No **TBAFFECT**

⑥ Did the participant have a hand tremor (dominant hand)? No Mild Marked **TBTREM**

Digit Vigilance Test

DVT Staff ID# **DVSTAFF**

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① Did participant complete the sample vigilance test? Yes No **DVVIGIL**

② Did participant complete page 1 in <400 seconds (6 minutes 40 seconds)? Yes No **DVVIGPG1**

- Why not? **DVVIGNO**
- 1 Unable
 - 2 Did not understand directions
 - 3 Other
 - 4 Refused

DVTMSCOR

If NO, Do NOT have participant complete page 2. Record time and errors for page 1 ONLY below.

③ Total Time:

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 seconds **DVTIME**

NOTE: If both pages completed record TOTAL time and errors.

④ Omission Errors:

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 errors **DVOMERR** Commission Errors:

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 errors **DVCOMERR** **DVTOTERR**





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Height & Weight

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HWHEIGHT

① Was STANDING HEIGHT measured? Yes No → Explain: _____

a. Is the participant standing sideways due to kyphosis? Yes No *HWKYPH*

Measurement 1 *HWMEAS1* mm Measurement 2 *HWMEAS2* mm

b. Do Measurement 1 and Measurement 2 differ by 4 or more mm? Yes No *HWGT4*

HWHGT
HW1SHT
HWDSHT

Complete Measurements 3 & 4

Measurement 3 *HWMEAS3* mm Measurement 4 *HWMEAS4* mm

HWWEIGHT

② Was WEIGHT measured? Yes No → Explain: _____

HWBMI
HW1SBMI
HWDSBMI

HWWT . kg

HW1SWT
HWDSWT
HWWTLS25

HW1SWTPC
HWDSWTPC

HWCIRCUM

③ Were the circumference measurements taken? Yes No → Explain: _____

Round up to the nearest 0.1cm.

	1st Reading	2nd Reading	3rd Reading
<i>HWNECK</i>			
a. Neck	<i>HWNECK1</i> cm	<i>HWNECK2</i> cm	<i>HWNECK3</i> cm
<i>HWWAIS</i>			
b. Waist	<i>HWWAIS1</i> cm	<i>HWWAIS2</i> cm	<i>HWWAIS3</i> cm
<i>HWHIP</i>			
c. Hip	<i>HWHIP1</i> cm	<i>HWHIP2</i> cm	<i>HWHIP3</i> cm

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Grip Strength

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Exclusion Criteria:

1 Has any pain or arthritis in your hands gotten worse recently?

Yes No Refused Don't Know **GSWEAK**

Which side? Left Right Both **GSSDWEAK**

DO NOT TEST LEFT	DO NOT TEST RIGHT	DO NOT TEST EITHER SIDE
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2 Have you had any surgery on your hands or wrists in the past 3 months (12 weeks)?

Yes No **GSSURG**

Which side? Left Right Both **GSSDSURG**

DO NOT TEST LEFT	DO NOT TEST RIGHT	DO NOT TEST EITHER SIDE
-------------------------	--------------------------	--------------------------------

GSFLAGEX

3

Right side

GSRT1

Trial 1 kg

Refused
 Unable, did not attempt

GSRT2

Trial 2 kg

Refused
 Unable, did not attempt

GSGRPRAV

GSGRPAVG
GSGRPMAX

GS1SAVGS
GSDSAVGS
GS1SGSPC
GSDSGSPC

4

Left side

GSLF1

Trial 1 kg

Refused
 Unable, did not attempt

GSLF2

Trial 2 kg

Refused
 Unable, did not attempt

GSGRPLAV

GSUNABLE



Chair Stands

NFCSTAFF

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INTRODUCTION/SCREENING QUESTIONS

- 1 Ask the participant: **Do you use any walking aids, such as a cane?** *NFAIDS*
 1 No aids 2 Cane or quad cane 3 Walker, wheelchair, leg brace, crutches
- 2 Does the participant have any of the following? If you are uncertain about one of following conditions, ask the participant. (Mark all that apply)
NFORTH *NFLIMB* *NFPROTHE* *NFPARALY*
 1 Orthosis 1 Missing limbs 1 Prosthesis 1 Paralysis of extremity or side of body
- 3 Ask the participant: **Do you have any problems from recent surgery, injury or other health conditions that might prevent you from standing straight up from a chair or walking quickly?**

NFPROB

- Yes →
 No

Tell the participant: "Before we do each test, I'll describe it to you. Please tell me if you think that you shouldn't attempt the test because of the problems you described."

SINGLE CHAIR STAND

- 4 Could the participant stand up one time unassisted? *NFSTAND1*
 1 Yes 0 No, unable to stand 3 No, rises using arms 7 Did not attempt/Refused

Do **NOT** perform Repeat Chair Stands. Go on to Six Meter Usual Pace

REPEATED CHAIR STANDS

- 5 Did the participant complete all 5 stands?

Yes

No

NF5STAND

Time to complete stands? *NFTIME5* seconds

- Record arm use: 1 Did not use arms
 2 Used arms part of the time 3 Used arms all of the time

NFARMU5A

NFTIME5A

How many chair stands were completed? *NF5MANY* stands

Why weren't 5 chair stands completed?

- 4 Attempted, but unable to stand once without help
 5 Completed at least 1 stand, but unable to complete 5 without help
 7 Did not attempt/refused *NFARMU5B*

NFSTDARM

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Walking Tests

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SIX METER USUAL PACE

1 Did the participant complete Trial 1? **NFWLKNA1**

Yes No, participant attempted but unable No, unable to assess

Record time and number of steps: **NFWLKTM1** seconds **NFWLKST1** steps

Aid used: No aid Straight cane Quad cane Walker Crutch **NFWLKAD1**

2 Did the participant complete Trial 2?

Yes No, participant attempted but unable No, unable to assess **NFWLKNA2**

Record time and number of steps: **NFWLKTM2** seconds **NFWLKST2** steps

Aid used: No aid Straight cane Quad cane Walker Crutch **NFWLKAD2**

NFSTPLGT
NFWLKSPD
NFWLKSPA
NF6MWTM
NF6MPACE
NF6MPACA
NF6MABLE
NF1SS7PL
NFDSSTPL
NF1SWLKS
NFDSWLKS
NF1S6MWT
NFDS6MWT
NF1S6MPA
NFDS6MPA

20 cm NARROW WALK

3 Did the participant successfully stay within the lines on Trial 1 (have 2 or less deviations)?

Yes No, 3 or more deviations/Unable to complete No, trial not attempted **NFNWKNA1**

Record time: **NFNWKT M1** seconds

Aid used: No aid
 Straight cane Crutch
 Quad cane Walker

4 Did the participant successfully stay within the lines on Trial 2 (have 2 or less deviations)?

Yes No, 3 or more deviations/Unable to complete No, trial not attempted **NFNWKNA2**

Record time: **NFNWKT M2** seconds

Aid used: No aid
 Straight cane Crutch
 Quad cane Walker

NFNWTIME
NFNWPACE
NFPCTDIF
NF1SNWTI
NFDSNWTI
NF1SNWPA
NFDSNWPA
NF1SPTDF
NFDSPTDF
NFNWNUM
NFNWABLE
NFNWNUMA
NFNWABLA

Perform trial 3 only if trial 1 or trial 2 were marked 'No, 3 or more deviations/Unable to complete'

5 Did the participant successfully stay within the lines on Trial 3 (have 2 or less deviations)?

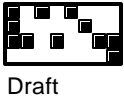
Yes No, 3 or more deviations/Unable to complete No, trial not attempted **NFNWKNA3**

Record time: **NFNWKT M3** seconds

Aid used: No aid
 Straight cane Crutch
 Quad cane Walker

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Blood Pressure & ECG

BPSTAFF

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BP Staff ID#

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BLOOD PRESSURE

① Was first sitting blood pressure obtained? Yes No **BPBP**



SITTING MEASUREMENT 1	
Systolic <i>BPBPSYS</i> [][] mmHg	Diastolic <i>BPBPDIA</i> [][] mmHg

② Was second sitting blood pressure obtained? Yes No **BPBP2**

**BPBPSYSM
BPBPDIAM**



SITTING MEASUREMENT 2	
Systolic <i>BPBPSYS2</i> [][] mmHg	Diastolic <i>BPBPDIA2</i> [][] mmHg

③ Cuff Size: Small Regular Large Thigh **BPCUFF**

④ Arm Used: Right Left **BPARM** → Why wasn't right arm used: _____

⑤ Was an alert noted? Yes No



Complete the Blood Pressure section on the Medical Alert Form

ECG

ECG Staff ID#

--	--	--	--

① Was an ECG obtained? Yes No **ECNOECG**



<p>Why not?</p> <p><input type="radio"/> Equipment failure</p> <p><input type="radio"/> Participant unable to understand instructions</p> <p><input type="radio"/> Participant unable to physically cooperate</p> <p><input type="radio"/> Participant refused</p> <p><input type="radio"/> Other _____</p>
--

② Was an alert noted? Yes No



Complete the ECG section on the Medical Alert Form

Draft





DXA
Bone Density Form

Office Use Only--									
MrOS ID#					Acrostic			Staff ID#	



① Was a bone density measurement obtained for the whole body?
 1 Yes 0 No, unable 7 No, refused *DXWB*

↓

Last 2 characters of scan ID #:

② Which hip was scanned at the baseline visit?
 Right Left

③ Which hip was scanned at this visit?
 Right Left Hip not scanned

④ Was the same hip scanned at this visit as the baseline visit?

Yes

No, other hip scanned

Scan not completed

Record reason:

- Fracture
- Hip replacement
- Other _____

Record reason:

- 1 Refused radiation
- 2 Unable to lie on table
- 3 Bilateral hip replacement
- 5 Other _____

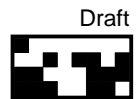
DXNOSCAN

↓

Last 2 characters of scan ID #:

⑤ Date of scan(s): / /

⑥ Temperature of room during scan: degrees Celsius
DXQDTEMP





Blood Collection & Processing

Office Use Only--														
MrOS ID#					Acrostic					Staff ID#				

① Was any blood drawn? Yes No



② Was a fasting sample collected? Yes No **SCFAST**

③ Time of blood draw:

--	--

 :

--	--

 am pm
Hours Minutes

④ Date of Lab Processing:

--	--

 /

--	--

 /

--	--	--	--

Month Day Year

⑤ Was a blood blotter collected? Yes No

⑥ Was a second blood blotter collected? Yes No

Vial #1:(Clear/1.0 mL serum) Complete Hemolyzed Partial Hemolyzed/partial Not filled

Vial #2:(Clear/1.0 mL serum) Complete Hemolyzed Partial Hemolyzed/partial Not filled

Vial #3:(Clear/1.0 mL serum) Complete Hemolyzed Partial Hemolyzed/partial Not filled

Vial #4:(Clear/1.0 mL serum) Complete Hemolyzed Partial Hemolyzed/partial Not filled

Vial #5:(Brown/4.0 mL serum) Complete Hemolyzed Partial Hemolyzed/partial Not filled

⑦ Ending time of laboratory processing:

--	--

 :

--	--

 am pm
Hours Minutes

⑧ Enter ID from bar code label:

--	--	--	--	--	--

Affix bar code label:



Urine Collection & Processing

Office Use Only--
 MrOS ID#
 Acrostic
 Staff ID#

1 Was urine collected? Yes No **SCUPSG**

A. Date of specimen collection: / /
 Month Day Year

B. Time participant collected specimen: : am pm

C. What void was this? 1st 2nd >2nd

Date of Lab Processing: / /
 Month Day Year

Start time of lab processing: : am pm
 Hours Minutes

Vial #6:(Yellow/4.0mL urine) Complete Partial Not filled

Vial #7:(Yellow/4.0mL urine) Complete Partial Not filled

Enter ID from bar code label:

Portland Only: Did participant complete 24hr urine collection? Yes No
SC24UACT **SC24URIN**

A. Date of specimen collection: / /
 Month Day Year

B. Time participant started collection: : am pm
 Hours Minutes

C. Did collection last 24 hours? Yes No **SC24U24H**

D. Were all voids collected? Yes No **SC24UALL**

Date of Lab Processing: / /
 Month Day Year

Start time of lab processing: : am pm
 Hours Minutes

Vial #8:(Green/4.0mL urine, central storage) Complete Partial Not filled

Vial #9: (Green/4.0mL urine, central storage) Complete Partial Not filled

Vial #10: (4.0mL urine) Complete Partial Not filled

Vial #11: (4.0mL urine) Complete Partial Not filled

Vial #12: (4.0mL urine) Complete Partial Not filled

Vial #13: (4.0mL urine) Complete Partial Not filled

SC24UVOL **SC24UACT**

Draft





PSG Morning Survey

Office Use Only--														
MrOS ID#					Acrostic					Staff ID#				
[][][][][]					[][][][][][]					[][][][][][][]				

Date of PSG: [][] / [][] / [][][][][]

- ① What time did you go to bed (lay down and turn off the lights) last night? **POXBEDTM** [][] : [][] A.M. P.M.
- ② What time did you wake up today? **POXWKTM** [][] : [][] A.M. P.M.
- ③ How much time do you think you actually slept last night? [][] hours [][] minutes **POXSLPMN**
- ④ What time did you collect your urine? [][] : [][] A.M. P.M. **POXURITM**
- ⑤ Rate the quality of your sleep last night. Do not compare to usual sleep quality. My sleep last night was (mark a number for each)...

POXQUAL1	a. LIGHT	<input checked="" type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	DEEP
POXQUAL2	b. SHORT	<input checked="" type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	LONG
POXQUAL3	c. RESTLESS	<input checked="" type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	RESTFUL

- ⑥ Compared to your usual night's sleep, how well did you sleep last night? **POXUSUAL**
- 1 Much worse than usual 4 A little better than usual
- 2 Somewhat worse than usual 5 Much better than usual
- 3 As well as usual

- ⑦ How long did it take you to fall asleep at bedtime last night? **POXFALL** [][] hours [][] minutes

- ⑧ What was your sleeping arrangement LAST NIGHT? **POXSLARR**
- 1 Another person in same bed 2 Another person in same room, but different bed 3 Alone in room

- ⑨ What is your USUAL sleeping arrangement? **POXSLUS**
- 1 Another person in same bed 2 Another person in same room, but different bed 3 Alone in room

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PSG Morning Survey

Office Use Only--
MrOS ID#

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POXCAF
POXDRNK

For questions 9-11, please think back to the 4 hour period before you went to sleep **LAST NIGHT**.

10 How many of the following drinks did you have during the 4 hours before you went to sleep last night? Please write '0' if you did not drink any of that beverage.

a. **POXWINE**

--	--

 glasses of wine (4 oz.)

d. **POXCOFF**

--	--

 cups of regular coffee (with caffeine)

b. **POXLIQ**

--	--

 drinks with hard liquor (1 shot)

e. **POXTEA**

--	--

 cups of tea (with caffeine)

c. **POXBEER**

--	--

 bottles or cans of beer (12 oz.)

f. **POXSODA**

--	--

 glasses or cans of cola or other soda (with caffeine)

11 How much did you smoke during the 4 hours before you went to sleep last night? Please write '0' for each that you did not smoke last night.

a. **POXCIG**

--	--

 number of cigarettes

c. **POXCIGAR**

--	--

 number of cigars

b. **POXPIPE**

--	--

 number of pipe bowls

POXNASAL

12 Did you have nasal stuffiness, obstruction, or discharge last night? Yes No

Did this interfere with your sleep last night? Yes No

POXINTER

13 During the PAST MONTH, how often have you had trouble sleeping because of...

		0	1	2	3	Not During the Past Month	Less than Once a Week	Once or Twice a Week	Three or More Times a Week
a. Coughing	POXCOUGH	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Snorting or gasping	POXSNORT	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Chest pain or discomfort	POXCPAIN	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Shortness of breath	POXSBRE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Nasal stuffiness	POXSTUFF	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Heart burn or reflux	POXHBURN	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Leg jerks or kicks	POXLEGK	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Page 1 contains confidential information that is not collected by the Coordinating Center.



Sleep Habits

Office Use Only-- MrOS ID#						Acrostic			Staff ID#		

Questions 1 - 9 relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month.

- ① During the past month, what time have you usually gone to bed at night? **PQPTMBED** : A.M. P.M.
- ② During the past month, how long (in minutes) has it usually taken you to fall asleep each night? **PQPSLPM4** A.M. P.M. **PQPSLDUR** **PQPINBED** minutes
- ③ During the past month, when have you usually gotten up in the morning? **PQPTMWAK** : A.M. P.M.
- ④ During the past month, how many hours of actual sleep did you get each night? (This may be different than the number of hours you spent in bed.) **PQPACTSL** A.M. P.M. **PQPEFFCY** **PQPEFFIC** hours

For questions 5-9, mark the one best response. Please answer all questions.

⑤ During the past month, how often have you had trouble sleeping because you... **PQPLATEN** **PQDISTUR** **PQDAYDYS** **PQPSQI** **PQBADSLP**

		Not During the Past Month	Less than Once a Week	Once or Twice a Week	Three or More Times a Week
a. Cannot get to sleep within 30 minutes	PQP30M	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
b. Wake up in middle of the night or early morning	PQPWAKE	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
c. Have to get up to use the bathroom	PQP BATH	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
d. Cannot breathe comfortably	PQPBREA	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
e. Cough or snore loudly	PQPSNOR	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
f. Feel too cold	PQPCOLD	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
g. Feel too hot	PQPHOT	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
h. Have bad dreams	PQP BAD	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
i. Have pain	PQPPAIN	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
j. Have leg jerks or leg cramps	SLJERK	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
k. Have heartburn	SLHBURN	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
l. Other reasons Describe: _____	PQPOTH	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3





Sleep Habits

Office Use Only-- MrOS ID#	<input type="radio"/> MISSING Acrostic
<input type="text"/>	<input type="text"/>

For questions 6 - 9, mark the one best response. Please answer all questions.

- | | Not During
the Past
Month | Less than
Once a
Week | Once or
Twice a
Week | Three or
More Times
a Week | |
|--|--|-----------------------------|----------------------------|----------------------------------|-----------------|
| 6 During the past month, how often have you taken medicine (prescribed or "over the counter") to help you sleep? | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <i>PQPSLMED</i> |
| 7 During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity? | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <i>PQPTRBSA</i> |
| 8 During the past month, how would you rate your sleep quality overall? | <input type="radio"/> Very good <input type="radio"/> Fairly good <input type="radio"/> Fairly bad <input type="radio"/> Very bad | | | | <i>PQPSQUAL</i> |
| 9 During the past month, how much of a problem has it been for you to keep up enough enthusiasm to get things done? | <input type="radio"/> No problem at all <input type="radio"/> Only a slight problem <input type="radio"/> Somewhat of a problem <input type="radio"/> A very big problem | | | | <i>PQPENTH</i> |
| 10 Do you have a bed partner or roommate? | <input type="radio"/> Yes | <input type="radio"/> No | <i>PQBEDPAR</i> | | |

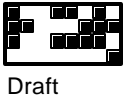
Please describe your bed partner or roommate: *PQBPTYPE*

1 Partner or Roommate in SAME bed
 2 Partner in SAME room but NOT SAME bed
 3 Partner or Roommate in OTHER room

Please ask your bed partner or roommate how often in the past month you have had...	Not During the Past Month	Less than Once a Week	Once or Twice a Week	Three or More Times a Week	
a. Loud snoring	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<i>PQBPLOUD</i>
b. Long pauses between breaths while asleep	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<i>PQBPPAUS</i>
c. Legs twitching or jerking while you sleep	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<i>PQBPLEGS</i>
d. Episodes of disorientation or confusion during sleep	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<i>PQBPCONF</i>
e. Other restlessness while you sleep: Please describe: _____	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<i>PQBPOTH</i>

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Functional Outcomes of Sleep

Office Use Only--
MrOS ID#

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Some people have difficulty performing everyday activities when they feel tired or sleepy. The purpose of the next set of questions is to find out if you generally have difficulty carrying out certain activities because you are too sleepy or tired. In questions 1 - 25, when the words 'sleepy' or 'tired' are used, it means the feeling that you can't keep your eyes open, your head is droopy, that you want to 'nod off', or that you feel the urge to take a nap. These words do not refer to the tired or fatigued feeling you may have after you exercise.

Please fill in the circle for your answer to questions 1 - 26. Select only one answer for each question. Please try to be as accurate as possible.

FOPRODUC FOSOCIAL
FOACTIV FOVIGIL
FOFOSQ

I don't do
this activity
for other
reasons

No
difficulty

Yes,
a little
difficulty

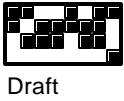
Yes,
moderate
difficulty

Yes,
extreme
difficulty

① Do you have difficulty concentrating on the things you do because you are sleepy or tired?	<input type="radio"/> 0	<input type="radio"/> 4	FOSOCOTH <input type="radio"/> 3 <input type="radio"/> 2 <input type="radio"/> 1
② Do you generally have difficulty remembering things because you are sleepy or tired?	<input type="radio"/> 0	<input type="radio"/> 4	FOSOREM <input type="radio"/> 3 <input type="radio"/> 2 <input type="radio"/> 1
③ Do you have difficulty finishing a meal because you become sleepy or tired?	<input type="radio"/> 0	<input type="radio"/> 4	FOSOMEAL <input type="radio"/> 3 <input type="radio"/> 2 <input type="radio"/> 1
④ Do you have difficulty working on a hobby (for example, sewing, collecting, gardening) because you are sleepy or tired?	<input type="radio"/> 0	<input type="radio"/> 4	FOSOHOBB <input type="radio"/> 3 <input type="radio"/> 2 <input type="radio"/> 1
⑤ Do you have difficulty doing work around the house (for example, cleaning house, doing laundry, taking out the trash, repair work) because you are sleepy or tired?	<input type="radio"/> 0	<input type="radio"/> 4	FOSOHOUS <input type="radio"/> 3 <input type="radio"/> 2 <input type="radio"/> 1
⑥ Do you have difficulty operating a motor vehicle for short distances (less than 100 miles) because you are sleepy or tired?	<input type="radio"/> 0	<input type="radio"/> 4	FOSOMOT1 <input type="radio"/> 3 <input type="radio"/> 2 <input type="radio"/> 1
⑦ Do you have difficulty operating a motor vehicle for long distances (greater than 100 miles) because you are sleepy or tired?	<input type="radio"/> 0	<input type="radio"/> 4	FOSOMOT2 <input type="radio"/> 3 <input type="radio"/> 2 <input type="radio"/> 1

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Functional Outcomes of Sleep

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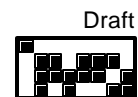
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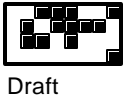
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	I don't do this activity for other reasons	No difficulty	Yes, a little difficulty	Yes, moderate difficulty	Yes, extreme difficulty
8 Do you have difficulty getting things done because you are too sleepy to drive or take public transportation?	<i>FOSODRIV</i> <input type="radio"/> 0	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1
9 Do you have difficulty taking care of financial affairs and doing paperwork (for example, writing checks, paying bills, keeping financial records, filling out tax forms, etc.) because you are sleepy or tired?	<i>FOSOFIN</i> <input type="radio"/> 0	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1
10 Do you have difficulty performing employed or volunteer work because you are sleepy or tired?	<i>FOSOWORK</i> <input type="radio"/> 0	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1
11 Do you have difficulty maintaining a telephone conversation because you become sleepy or tired?	<i>FOSOPHON</i> <input type="radio"/> 0	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1
12 Do you have difficulty visiting with your family or friends in <u>your</u> home because you become sleepy or tired?	<i>FOSOVIS1</i> <input type="radio"/> 0	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1
13 Do you have difficulty visiting with your family or friends in <u>their</u> home because you become sleepy or tired?	<i>FOSOVIS2</i> <input type="radio"/> 0	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1
14 Do you have difficulty doing things for your family or friends because you are too sleepy or tired?	<i>FOSOFAM</i> <input type="radio"/> 0	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1
15 Do you have difficulty exercising or participating in sporting activity because you are too sleepy or tired?	<i>FOSOSPOR</i> <input type="radio"/> 0	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1
16 Do you have difficulty watching a movie or videotape because you become sleepy or tired?	<i>FOSOMOV</i> <input type="radio"/> 0	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1





Medical History

Office Use Only--
MrOS ID#

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Acrostic

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① Have you ever snored (now or at anytime in the past)? Yes No Don't know

SLSNORE ↓

How often do you snore now?

SLOFTSNO

0 Do not snore anymore

3 Frequently (3 to 5 nights a week)

1 Rarely (less than 1 night a week)

4 Always or almost always (6 or 7 nights a week)

2 Sometimes (1 or 2 nights a week)

Don't know

② Are there times when you stop breathing during your sleep?

Yes

No

Don't know

SLSTOPBR

How often do you have times when you stop breathing during your sleep?

1 Rarely (less than one night a week)

4 Always or almost always (6 or 7 nights a week)

2 Sometimes (1 or 2 nights a week)

8 Don't know

3 Frequently (3 to 5 nights a week)

SLSBTIMS

③ Has a doctor or health care provider ever told you that you have sleep apnea (a condition in which breathing stops briefly during sleep)?

Yes

No

Don't know

SLSA

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

Yes

No

SLSCAP

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

Yes

No

SLSSURG

④ Has a doctor or health care provider ever told you that you have a sleep disorder other than sleep apnea?

Yes

No

Don't know

SLSLPDIS

What other sleep disorder? Check all that apply.

1 Insomnia

1 Restless legs

1 Periodic leg movements

1 Narcolepsy

SLINSOMN

SLRESTLG

SLPERLEG

SLNARC

1 Other → Please describe: _____

SLSDOTH

⑤ Do you usually use oxygen therapy (oxygen delivered by a mask or nasal cannula) during your sleep?

Yes

No

Don't Know

SLOXOTHER

⑥ Do you ever drink alcohol to help you sleep?

Yes

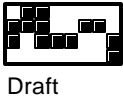
No

Don't know

SLSLALC

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Medical History

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MrOS ID#

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Acrostic

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7) During the past 12 months, have you fallen and landed on the floor or ground, or fallen and hit an object like a table or chair? Yes No **MHFALL**

a. How many times have you fallen in the past 12 months? 1 2-3 4-5 6 or more

b. Which of the following injuries did you have? (Mark all that apply)

MHFRACT I broke or fractured a bone

MHBRUISE I had a bruise or bleeding

MHHEAD I hit or injured my head

MHOTHER I had some other kind of injury

MHSPRAIN I had a sprain or a strain

MHNOINJR I did not have any injuries from a fall in the past 12 months

8) Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?

0 None 1 1 time 2 2 times 3 3 times 4 4 times 5 5 times or more

9) Has a doctor or other health care provider ever told you that you had:

a. Diabetes?

Yes No **MHDIAB**



Are you currently being treated for this by a doctor? Yes No

MHDIABT

b. High thyroid, Graves disease or an overactive thyroid gland?

Yes No **MHHTHY**



Are you currently being treated for this by a doctor? Yes No

MHHTHYT

f. Rheumatoid arthritis?

Yes No **MHRHEU1**



Are you currently being treated for this by a doctor? Yes No

MHRHEUT

c. Low thyroid or an under active thyroid gland?

Yes No **MHLTHY**



Are you currently being treated for this by a doctor? Yes No

MHLTHYT

d. Osteoporosis, sometimes called thin or brittle bones?

Yes No **MHOSTEO**



Are you currently being treated for this by a doctor? Yes No

MHOSTEOT

e. Osteoarthritis or degenerative arthritis?

Yes No **MHOA**



Are you currently being treated for this by a doctor? Yes No

MHOAT

Draft





Medical History

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9 Has a doctor or other health care provider ever told you that you had (continued):

g. Prostatitis (inflammation or infection of the prostate)?

Yes No

MHPROST

Are you currently being treated for this by a doctor? Yes No

h. Parkinson's disease?

Yes No

MHPARK

Are you currently being treated for this by a doctor? Yes No

i. Liver disease?

Yes No

MHLIVER

Are you currently being treated for this by a doctor? Yes No

j. Chronic kidney (renal) disease or kidney (renal) failure?

Yes No

MHRENAL

Do you currently undergo dialysis? Yes No

k. COPD, chronic obstructive lung disease, or emphysema?

Yes No

MHCOBPD

Are you currently being treated for this by a doctor? Yes No

MHCOBPDT

l. Chronic bronchitis?

Yes No

MHBRONC

Are you currently being treated for this by a doctor? Yes No

MHBRONCT

m. Asthma?

Yes No

MHASTHM

Are you currently being treated for this by a doctor? Yes No

MHASTHMT

n. Hayfever or seasonal allergies?

Yes No

MHALLER

Are you currently being treated for this by a doctor? Yes No

MHALLERT

o. Glaucoma?

Yes No

MHGLAU

Are you currently being treated for this by a doctor? Yes No

MHGLAUT

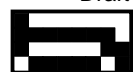
p. Cataracts?

Yes No

MHCAT

*MHAFIB MHAFIBS
MHHR MHHR*

Draft





Cardiovascular History

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- ① **Has a doctor or other health care provider ever told you that you had:**
- a. Heart attack, coronary or myocardial infarction? Yes No *MHMI*
- e. TIA, transient ischemic attack, or mini-stroke? Yes No *CVTIA*

Are you currently being treated for this by a doctor? Yes No *MHMIT*

Are you currently being treated for this by a doctor? Yes No *CVTIAT*

- b. Angina (chest pain)? Yes No *MHANGIN*

- f. A stroke, blood clot in the brain or bleeding in the brain? Yes No *MHSTRK*

Are you currently being treated for this by a doctor? Yes No *MHANGINT*

Are you currently being treated for this by a doctor? Yes No *MHSTRKT*

- c. Congestive heart failure or enlarged heart? Yes No *MHCHF*

- g. Rheumatic heart disease or valvular heart disease? Yes No *CVRHD*

Are you currently being treated for this by a doctor? Yes No *MHCHFT*

Are you currently being treated for this by a doctor? Yes No *CVRHDT*

- d. Intermittent claudication or pain in your legs from a blockage of the arteries? Yes No *CVBLKA*

- h. Hypertension or high blood pressure? Yes No *MHBP*

Are you currently being treated for this by a doctor? Yes No *CVBLKAT*

Are you currently being treated for this by a doctor? Yes No *MHBPT*

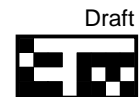
- ② **Have you ever had any medical or surgical procedure in your heart, neck or blood vessels, such as angioplasty or bypass surgery?**

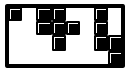
Yes No Don't Know *CVSURG*

- a. Coronary bypass surgery, heart bypass or CABG? *CVCABG*
 Yes No Don't Know
- b. Angioplasty of coronary arteries, which is a dilation of arteries of the heart with a balloon? *CVAPCORA*
 Yes No Don't Know
- c. Repair of aortic aneurysm? *CVAORANE*
 Yes No Don't Know
- d. Bypass procedure on the arteries of your legs? *CVBPLEGS*
 Yes No Don't Know

- e. Angioplasty of lower extremity arteries, which is dilation of arteries of the leg with a balloon? *CVAPLOW*
 Yes No Don't Know
- f. Carotid endarterectomy, which is surgery on the blood vessels in your neck? *CVSURGBV*
 Yes No Don't Know
- g. Pacemaker implant? *CVPACE*
 Yes No Don't Know
- h. Replacement of a heart valve? *CVVALVE*
 Yes No Don't Know

CVCHD
CVCER
CVCPPA





Draft

Cardiovascular History

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3 Have you ever had any pain or discomfort in your chest?

Yes No Don't Know *CVCHPAIN*

↓ **GO TO NEXT PAGE** ↓

CVROSE
CVROSEGR

a. Do you get it when you walk up a hill or hurry?

Yes No Don't Know *CVCPHILL*



1. Do you get it when you walk at an ordinary pace on a level surface?

Yes No Don't Know *CVCPWALK*

2. What do you do if you get it while you are walking? *CVCPDO*

Stop or slow down Continue at same pace Don't Know

3. If you stand still, is the pain relieved or not relieved?

Relieved Not relieved Don't Know *CVCPREL*



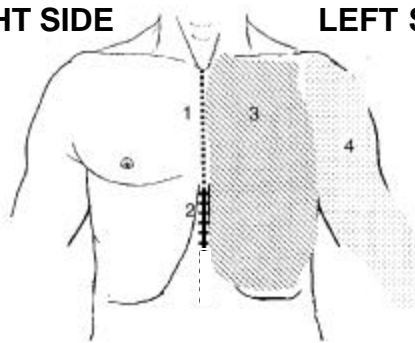
How soon is it relieved? *CVCPRELT*

10 minutes or less More than 10 minutes Don't Know

4. Where do you get this pain or discomfort? Mark any areas that apply with an X.

RIGHT SIDE

LEFT SIDE



Clinic Use
Only

SUM *CVLOCSUM*
 SL *CVLOCSL*
 LC *CVLOCLC*
 LA *CVLOCLA*
 OT *CVLOCOT*
 DK *CVLOCDK*

b. Have you ever had a severe pain across the front of your chest lasting for half an hour or more? Yes No Don't Know *CVCP30M*



1. Did you see a doctor because of this pain?

Yes No Don't Know *CVCPDOC*

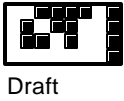


What did your doctor say this was? *CVCPDSAY*

Angina Heart attack Other Don't Know

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Cardiovascular History

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5 Do you get a pain or discomfort in your legs when you walk?

Yes No Don't Know *CVLGPAIN*



a. Does this pain ever begin when you are standing still or sitting?

Yes No Don't Know *CVLPSTIL*

b. Do you get it if you walk uphill or hurry?

Yes No Don't Know *CVLPHILL*

c. Do you get it when you walk at an ordinary pace on a level surface?

Yes No Don't Know *CVLPWALK*

d. What happens if you stand still? *CVLPSTST*

Usually continues for more than 10 minutes

Usually disappears in 10 minutes or less

Don't Know

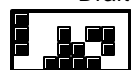
e. Do you get this pain in your calf (or calves)?

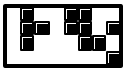
Yes No Don't Know *CVLPCALF*

f. Were you hospitalized for this problem in your legs?

Yes No Don't Know *CVLPHOSP*

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Lifestyle

QLCOMP
QL1SCOMP
QLISCOMP

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- ① Compared to other people your own age, how would you rate your overall health?
 Excellent for my age Good for my age Fair for my age Poor for my age Very poor for my age

QLHEALTH

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

- | | | | | |
|---|----------|-----------------------|----------------------------------|---------------------------|
| | | 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? | QLMODLIM | <input type="radio"/> | <input checked="" type="radio"/> | <input type="radio"/> |
| ③ Climbing several flights of stairs? | QLSEVLIM | <input type="radio"/> | <input checked="" type="radio"/> | <input type="radio"/> |

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities because of your physical health?

- ④ Accomplished less than you would like Yes No QLACCOM
- ⑤ Were limited in the kind of work or other activities Yes No QLKIND

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities because of any emotional problems (such as feeling depressed or anxious)?

- ⑥ Accomplished less than you would like Yes No QLACCLV
- ⑦ Didn't do work or other activities as carefully as usual Yes No QLCARE

- ⑧ During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

Not at all A little bit Moderately Quite a bit Extremely QLPAIN

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 . . .

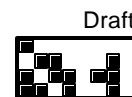
- | | | | | | | | |
|---------------------------------------|----------|----------------------------------|-----------------------|---------------------------|-----------------------|-------------------------|-----------------------|
| | | All of the
time | Most of
the time | A good bit
of the time | Some of
the time | A little of
the time | None of
the time |
| ⑨ Have you felt calm and peaceful? | QLCALM | <input checked="" type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| ⑩ Did you have a lot of energy? | QLENERGY | <input checked="" type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| ⑪ Have you felt downhearted and blue? | QLBLUE | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

- 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 friends, relatives, etc.)?

All of the time Most of the time Some of the time A little of the time None of the time

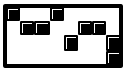
QLSOCIAL

QLPCS12
QLMCS12



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Physical Activity

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The next few questions ask about your physical activity during the **last 7 days**. If the last 7 days have not been typical because of illness or bad weather, please estimate based on two or three weeks ago.

① Over the **past 7 days**, how often did you participate in sitting activities such as reading, watching TV or doing handcrafts?

- Never
 Seldom (1-2 days)
 Sometimes (3-4 days)
 Often (5-7 days)
PASIT



Go to Question 2

What were these activities? _____

PASITT

On average, how many hours per day did you engage in these sitting activities?

- Less than 1 hour
 Between 1 and 2 hours
 2-4 hours
 More than 4 hours

② Over the **past 7 days**, how often did you take a walk outside your home or yard for any reason? For example, for fun or exercise, walking to work, walking the dog, etc.?

- Never
 Seldom (1-2 days)
 Sometimes (3-4 days)
 Often (5-7 days)
PAWALK **PAWALKW**



Go to Question 3

What were these activities? _____

On average, how many hours per day did you spend walking? **PAWALKT**

- Less than 1 hour
 Between 1 and 2 hours
 2-4 hours
 More than 4 hours

③ Over the **past 7 days**, how often did you engage in light sport or recreational activities such as bowling, golf with a cart, shuffleboard, fishing from a boat or pier, or other similar activities?

- Never
 Seldom (1-2 days)
 Sometimes (3-4 days)
 Often (5-7 days)
PALTE **PALTEW**



Go to Question 4

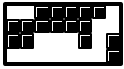
What were these activities? _____

On average, how many hours per day did you engage in these light sport or recreational activities? **PALTE**

- Less than 1 hour
 Between 1 and 2 hours
 2-4 hours
 More than 4 hours

Draft





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Physical Activity

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4 Over the past 7 days, how often did you engage in moderate sport and recreational activities such as doubles tennis, ballroom dancing, hunting, ice skating, golf without a cart, softball or other similar activities?

- Never
 Seldom (1-2 days)
 Sometimes (3-4 days)
 Often (5-7 days)

PAMOD

PAMODW



Go to Question 5

What were these activities? _____

On average, how many hours per day did you engage in these moderate sport or recreational activities?

PAMODT

- Less than 1 hour
 Between 1 and 2 hours
 2-4 hours
 More than 4 hours

5 Over the past 7 days, how often did you engage in strenuous sport and recreational activities such as jogging, swimming, cycling, singles tennis, aerobic exercise, skiing (downhill or cross country) or other similar activities?

- Never
 Seldom (1-2 days)
 Sometimes (3-4 days)
 Often (5-7 days)

PASTR

PASTRW



Go to Question 6

What were these activities? _____

On average, how many hours per day did you engage in these strenuous sport or recreational activities?

PASTRT

- Less than 1 hour
 Between 1 and 2 hours
 2-4 hours
 More than 4 hours

6 Over the past 7 days, how often did you do any exercise specifically to increase muscle strength and endurance, such as lifting weights or pushups, etc.?

- Never
 Seldom (1-2 days)
 Sometimes (3-4 days)
 Often (5-7 days)

PAWGT

PAWGTTW



Go to Question 7

What were these activities? _____

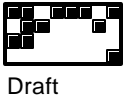
On average, how many hours per day did you engage in exercises to increase muscle strength and endurance?

PAWGTT

- Less than 1 hour
 Between 1 and 2 hours
 2-4 hours
 More than 4 hours

Draft





Physical Activity

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- 7 During the past 7 days, have you done any light housework, such as dusting or washing dishes?
 Yes No *PALHW* *PALHWW*
- 8 During the past 7 days, have you done any heavy housework or chores, such as vacuuming, scrubbing floors, washing windows or carrying wood?
 Yes No *PAHHW* *PAHHWW*
- 9 During the past 7 days, did you engage in any of the following activities? (Please answer yes or no for each item.) *PAHOME* *PAHOMEW*
- Home repairs, like painting, wallpapering, electrical work, etc.? Yes No
- Lawn work or yard care, including snow or leaf removal, wood chopping, etc.? *PALAWN* *PALAWNW*
 Yes No
- Outdoor gardening? *PAGARDEN* *PAGARDNW*
 Yes No
- Caring for another person, such as children, dependent spouse, or another adult? *PACARE* *PACAREW*
 Yes No
- 10 During the past 7 days did you work either for pay or as a volunteer?
 Yes No *PAWK* *PAWKW*



a. How many hours in the past week did you work for pay and/or as a volunteer? hours *PAWKHR*

b. Which of the following categories best describes the amount of physical activity required on your job and/or volunteer work? *PAWKPA*

1○ Mainly sitting with slight arm movements
Examples: office worker, watchmaker, seated assembly line worker, bus driver, etc.

2○ Sitting or standing with some walking
Examples: cashier, general office worker, light tool and machinery worker

3○ Walking, with some handling of materials generally weighing less than 50 pounds
Examples: mailman, waiter/waitress, construction worker, heavy tool and machinery worker

4○ Walking and heavy manual work often requiring handling material weighing more than 50 pounds
Examples: lumberjack, stone mason, farm or general laborer.

PASCORE

PASEOCC



Draft



PASELEIS

PASEHOUS





Caffeine, Tobacco & Alcohol

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<input type="text"/>	<input type="text"/>

① Do you currently drink regular coffee? (Not decaffeinated) Yes No

CFCAFF

CFCCOF



CFCCUP

How many cups of REGULAR coffee do you drink per day? cups

② Do you currently drink regular tea? (Not herbal or decaffeinated) Yes No

CFCTEA



CFTCUP

How many cups of REGULAR tea do you drink per day? cups

③ Do you currently drink sodas that contain caffeine, such as Pepsi, Coca-Cola, Dr. Pepper, and Mountain Dew? (Do NOT include Sprite or 7-up or other sodas without caffeine) Yes No

CFCCOK



CFCCAN

How many cans of CAFFEINATED soda do you drink per day? cans

④ Do you smoke cigarettes now? Yes No *TUSMKNOW*

TURSMOKE



TUSMKCGN

About how many cigarettes do you smoke per day? cigarettes

⑤ Do you currently smoke a pipe or cigars regularly? *TUPIPEC* Yes No



TUCPIAMT

About how much do you smoke per week? pipes or cigars per week

⑥ In the past 12 months, have you had at least 12 drinks of any kind of alcoholic beverage? Yes No I don't know

TU12DRIN



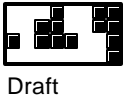
On average, how many alcoholic drinks do you consume per week?

TUDRAMT

- 1 Less than one drink per week
- 2 1-2 drinks per week
- 3 3-5 drinks per week
- 4 6-13 drinks per week
- 5 14 or more drinks per week

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Moods in the Last Week

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Choose the best answer for how you felt over the LAST WEEK.

①	Are you basically satisfied with your life?	<i>DPSAT</i>	<input type="radio"/> Yes	<input type="radio"/> No
②	Have you dropped many of your activities and interests?	<i>DPDROP</i>	<input type="radio"/> Yes	<input type="radio"/> No
③	Do you feel that your life is empty?	<i>DPEMPT</i>	<input type="radio"/> Yes	<input type="radio"/> No
④	Do you often get bored?	<i>DPBORE</i>	<input type="radio"/> Yes	<input type="radio"/> No
⑤	Are you in good spirits most of the time?	<i>DPGOOD</i>	<input type="radio"/> Yes	<input type="radio"/> No
⑥	Are you afraid something bad is going to happen to you?	<i>DPSBAD</i>	<input type="radio"/> Yes	<input type="radio"/> No
⑦	Do you feel happy most of the time?	<i>DPHAPY</i>	<input type="radio"/> Yes	<input type="radio"/> No
⑧	Do you often feel helpless?	<i>DPHPLS</i>	<input type="radio"/> Yes	<input type="radio"/> No
⑨	Do you prefer to stay at home, rather than going out and doing new things?	<i>DPHOME</i>	<input type="radio"/> Yes	<input type="radio"/> No
⑩	Do you feel you have more problems with memory than most?	<i>DPMEM</i>	<input type="radio"/> Yes	<input type="radio"/> No
⑪	Do you think it is wonderful to be alive now?	<i>DPWOND</i>	<input type="radio"/> Yes	<input type="radio"/> No
⑫	Do you feel pretty worthless the way you are now?	<i>DPWRTH</i>	<input type="radio"/> Yes	<input type="radio"/> No
⑬	Do you feel full of energy?	<i>DPENER</i>	<input type="radio"/> Yes	<input type="radio"/> No
⑭	Do you feel that your situation is hopeless?	<i>DPSIT</i>	<input type="radio"/> Yes	<input type="radio"/> No
⑮	Do you think that most people are better off than you are?	<i>DPMOST</i>	<input type="radio"/> Yes	<input type="radio"/> No

DPGDSSC
DPGDS15
DPGDSYN

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Draft

Feelings

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Choose the best answer for how you have been feeling over the LAST MONTH.

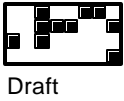
①	Have you felt keyed up or on edge?	<i>AXKEYED</i>	<input type="radio"/> Yes	<input type="radio"/> No
②	Have you been worrying a lot?	<i>AXWORRY</i>	<input type="radio"/> Yes	<input type="radio"/> No
③	Have you been irritable?	<i>AXIRTBL</i>	<input type="radio"/> Yes	<input type="radio"/> No
④	Have you had difficulty relaxing?	<i>AXRELAX</i>	<input type="radio"/> Yes	<input type="radio"/> No
⑤	Have you been sleeping poorly?	<i>AXPOORSP</i>	<input type="radio"/> Yes	<input type="radio"/> No
⑥	Have you had headaches or neckaches?	<i>AXNKACHE</i>	<input type="radio"/> Yes	<input type="radio"/> No
⑦	Have you had any of the following: trembling, tingling, dizzy spells, sweating, diarrhea or needing to pass water more often than usual?	<i>AXTREMB</i>	<input type="radio"/> Yes	<input type="radio"/> No
⑧	Have you been worried about your health?	<i>AXWORHTL</i>	<input type="radio"/> Yes	<input type="radio"/> No
⑨	Have you had difficulty falling asleep?	<i>AXDIFSLP</i>	<input type="radio"/> Yes	<input type="radio"/> No
⑩	Have you been lacking energy?	<i>AXENRGY</i>	<input type="radio"/> Yes	<input type="radio"/> No
⑪	Have you lost interest in things?	<i>AXLOST</i>	<input type="radio"/> Yes	<input type="radio"/> No
⑫	Have you lost confidence in yourself?	<i>AXCONFID</i>	<input type="radio"/> Yes	<input type="radio"/> No
⑬	Have you felt hopeless?	<i>AXHOPELS</i>	<input type="radio"/> Yes	<input type="radio"/> No
⑭	Have you had difficulty concentrating?	<i>AXCONCNT</i>	<input type="radio"/> Yes	<input type="radio"/> No
⑮	Have you lost weight (due to poor appetite)?	<i>AXLOSTWT</i>	<input type="radio"/> Yes	<input type="radio"/> No
⑯	Have you been waking early?	<i>AXEARLY</i>	<input type="radio"/> Yes	<input type="radio"/> No
⑰	Have you felt slowed up?	<i>AXSLOWED</i>	<input type="radio"/> Yes	<input type="radio"/> No
⑱	Have you tended to feel worse in the morning?	<i>AXWORSE</i>	<input type="radio"/> Yes	<input type="radio"/> No

AXANXSC
 AXANX50
 AXDEPSC
 AXDEP50



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Actigraphy Checklist

Office Use Only--									
MrOS ID#					Acrostic			Staff ID#	



① Did the participant receive an actigraph? Yes No

VSACTIG
VSACTRSN

ACSERNUM

Watch Serial Number

ACACTARM

What arm was watch worn on?
(should be non-dominant when possible)

1 Left, non-dominant
2 Left, dominant
3 Right, non-dominant
4 Right, dominant

Why not?

7 Refused
1 Cognitive Impairment
2 Physical/Medical Problem
3 No watch available/Schedule problem
4 Other _____

② Date watch given to participant / /

Month Day Year

③ Date watch returned to clinic / /

Month Day Year

④ How many nights were watch data collected? nights →

If less than 3 nights, will participant rewear the watch? Yes No

⑤ Was the sleep diary completed? Yes No →

Why not? Refused Unable

ACDIARY

ACDIARYN

Was the diary completed accurately for all days and all sections? Yes No

ACDIARYA

Please indicate which sections were not accurately completed for ALL days (mark all that apply):

1 Napping Information 1 Removal times information
1 Still times information 1 Bed time and wake time information

ACSTILAC

ACBEDAC

Draft

