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Online™

# Study of Osteoporotic Fractures (SOF)

## Study Collection Forms

### **Visit 5**

#### **Medical History**

Cardiovascular disease history

Form Type: Self-Administered Questionnaire

#### **LEGEND:**

**Raw form variable** names are located next to the question they represent and do not have a border around the variable name.

**Calculated variable** names are derived from other variables and have a border around the variable name. The calculated variables names are located in close proximity to the questions from which they were derived.

Some of the questions and measurements on these forms are not being released, and therefore no variable name is provided for them.

This next section asks you about some common health conditions and symptoms.

### Extended Medical History

**31.** Has a doctor ever told you that you have:

**IF YES,**  
are you currently  
being treated for  
this condition by a  
doctor?

- |   |                             |                                |                             |                              |
|---|-----------------------------|--------------------------------|-----------------------------|------------------------------|
| a. Heart attack, coronary, or myocardial infarction | <input type="checkbox"/> No | <input type="checkbox"/> Yes → | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| b. Angina   | <input type="checkbox"/> No | <input type="checkbox"/> Yes → | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| c. Congestive heart failure, enlarged heart         | <input type="checkbox"/> No | <input type="checkbox"/> Yes → | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| d. Other heart disease                              | <input type="checkbox"/> No | <input type="checkbox"/> Yes → | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| e. Stroke   | <input type="checkbox"/> No | <input type="checkbox"/> Yes → | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| f. Diabetes (not borderline)                        | <input type="checkbox"/> No | <input type="checkbox"/> Yes → | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| g. Parkinson's disease                              | <input type="checkbox"/> No | <input type="checkbox"/> Yes → | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| h. Dementia or Alzheimer's disease                  | <input type="checkbox"/> No | <input type="checkbox"/> Yes → | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| i. Other neurologic disease                         | <input type="checkbox"/> No | <input type="checkbox"/> Yes → | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| j. Depression                                       | <input type="checkbox"/> No | <input type="checkbox"/> Yes → | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

**V5SHEART**

**V5SHRTT**

**V5SANGIN**

**V5SANGIT**

**V5SCONG**

**V5SCONGT**

**V5SOHRT**

**V5SOHRTT**

**V5SSTRK**

**V5SSTRKT**