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Study of Osteoporotic Fractures (SOF)

Study Collection Forms

Visit 5

Medical History

General Medical Conditions

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

No

Yes →

No

Yes

b. Angina

No

Yes →

No

Yes

c. Congestive heart failure, enlarged heart

No

Yes →

No

Yes

d. Other heart disease

No

Yes →

No

Yes

e. Stroke

No

Yes →

No

Yes

f. Diabetes (not borderline)

No

Yes →

No

Yes

V5SDIAB

V5SDIABT

g. Parkinson's disease

No

Yes →

No

Yes

h. Dementia or Alzheimer's disease

No

Yes →

No

Yes

i. Other neurologic disease

No

Yes →

No

Yes

j. Depression

No

Yes →

No

Yes

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

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

k. Chronic obstructive lung disease, chronic bronchitis, asthma, emphysema, COPD	<input type="checkbox"/> No	<input type="checkbox"/> Yes →	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	V5SCOPD			V5SCOPDT
l. Arthritis of hands or arms	<input type="checkbox"/> No	<input type="checkbox"/> Yes →	<input type="checkbox"/> No	<input type="checkbox"/> Yes
m. Arthritis of shoulder	<input type="checkbox"/> No	<input type="checkbox"/> Yes →	<input type="checkbox"/> No	<input type="checkbox"/> Yes
n. Arthritis of hips	<input type="checkbox"/> No	<input type="checkbox"/> Yes →	<input type="checkbox"/> No	<input type="checkbox"/> Yes
o. Arthritis of knees	<input type="checkbox"/> No	<input type="checkbox"/> Yes →	<input type="checkbox"/> No	<input type="checkbox"/> Yes
p. Osteoarthritis or degenerative arthritis	<input type="checkbox"/> No	<input type="checkbox"/> Yes →	<input type="checkbox"/> No	<input type="checkbox"/> Yes
q. Rheumatoid arthritis	<input type="checkbox"/> No	<input type="checkbox"/> Yes →	<input type="checkbox"/> No	<input type="checkbox"/> Yes
r. Arthritis (type unknown)	<input type="checkbox"/> No	<input type="checkbox"/> Yes →	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Questions 27 - 34 ask about events that have taken place over the LAST TWO YEARS.

Fractures/Medical Conditions

27. IN THE LAST TWO YEARS, has a doctor told you that you had a broken or fractured bone?

Yes

No

Don't know

PLEASE GO TO QUESTION 28

IF YES, which bone(s)? _____

28. IN THE LAST TWO YEARS, has a doctor told you that you had a fracture of the spine or fracture of the vertebrae?

Yes

No

Don't know

29. IN THE LAST TWO YEARS, has a doctor told you that you had osteoporosis, sometimes called thin or brittle bones?

Yes

No

Don't know

30. IN THE LAST TWO YEARS, has a doctor told you that you had kidney stones?

V5SKID

Yes

No

Don't know

PLEASE GO TO QUESTION 31

IF YES, how many times have you passed a stone (or had a kidney stone attack)?

V5KIDYR

_____ times in the last two years.