3-yr follow-up

HEART AND SOUL STUDY 3-YEAR FOLLOW-UP INTERVIEW FORM

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Start Time:	•LL	

Ston	Time:	

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Form/Procedure	Please mark with an X when completed	Comments/Notes
Address/phone # update (#1-4) (have patient's current address available)	□Yes □No	
Outcome events, hospitalizations (#5) (have date of last appointment or interview available)	□Yes □No	
Hospital and doctor contact information (#6)	□Yes □No	
PHQ (#7)	□Yes □No	
Depression, including depression module of CDIS (#8-9)	□Yes □No	
Overall Health (#10-12)	□ Yes □ No	
Angina (#13-19)	□Yes □No	
Cognitive function (#20-21) (have patient's DOB available)	□Yes □No	
Activities of daily living (#22-24)	□ Yes □ No	
Medication Inventory Form, part 1-4	□Yes □No	
Future interview/test (#25-26)	□Yes □No	
Personal contact info (#27)	□Yes □No	







RTICIPANT II

Please use ALL CAPITAL LETTERS when writing words.

Question 1 and 2 to be completed by interviewer (do not need to ask patient)			
1. First Name MI Last Name			
2. Date of last appointment/interview / / /			
Patient is able to complete interview — Go to question 3			
Patient is unable to complete interview Complete below and continue with interview as appropriate			
Patient deceased ———— Please complete death form with person listed below.			
If patient is unable to complete the interview themselves, obtain the name and phone number of a friend or relative who can answer questions for them:			
LAST NAME: FIRST NAME:			
PHONE NUMBER: RELATIONSHIP TO PATIENT: - -			
3. What is your current phone number? – –			
4. Has your address changed from <i><insert address=""></insert></i> ? Yes No			
If yes, please indicate new address below:			
Street Number Street Name Apt Number			
City State Zip Code Image: State Image: State Image: State			

PARTICIPANT ID HEART AND SOUL STUDY Heart Attack or myocardial infarction Coronary angioplasty (inflating a balloon in heart vessel or placing a stent in heart vessel) Angina (cardiac chest pain) requiring admission to a hospital Congestive heart failure requiring admission to a hospital Stroke (blockage or rupture of a blood vessel in the brain) Other hospitalization _____ Explain in box below: None of the above

HOSPITAL AND DOCTOR INFORMATION

If you have been admitted to a hospital (or if he/she was admitted to a hospital), could you provide the name, address, city, and phone number of each hospital?

Do you remember the approximate date of the hospitalization?

Do you remember the name of the doctor(s) who took care of you (or Mr./Mrs.____) during this hospitalization (including address, city and phone number)?

Interviewer: Please list hospitals, including name, address, city, phone number, approximate dates of hospitalization, and the doctor who took care of patient (Please complete hospital/ doctor form for up to 4 hospitalizations).

6. Do you have a doctor at the VA Medical Center?		
Yes	No	
	\mathbf{T}	
—	name, address and telephone number of the doctor or place that you usually	
go to for your health care:	ML Leet News	
First Name	MI Last Name	
Street Number S	Street Name Suite/Room	
City	State Zip Code Phone	

PARTICIPANT ID

PHQ

7. Over the LAST 2 WEEKS, how often have you been bothered by any of the following problems?				
	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things.				
b. Feeling down, depressed, or hopeless.				
c. Trouble falling or staying asleep, or sleeping too much.				
d. Feeling tired or having little energy.				
e. Poor appetite or overeating.				
f. Feeling bad about yourself, or that you are a failure or have let yourself or your family down.				
g. Trouble concentrating on things, such as reading the newspaper or watching television.				
h. Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual.				
i. Thoughts that you would be better off dead or hurting yourself in some way.				



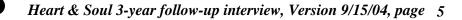


HEART AND SOUL STUDY

8. Complete the depression module of the CDIS now.

At the end of the depression module:		
9. Have you (insert stated symptoms of depression, been feeling sad, lost interest, etc) lately?		
Yes No Ves No IF YES, for how long?	O days (up to one month)O monthsO years	

10. Compared to other people your own age, how would you rate your <u>overall health</u> ?	11. Compared to other people your own age, how would you rate your <u>overall quality of life</u> ?
Excellent	Excellent
Very Good	Very Good
Good	Good
Fair	Fair
Poor	Poor



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.)?		
All of the time	A little of the time	
Most of the time	None of the time	
Some of the time		

13. Overall, which <u>one</u> of the following statements best describes the symptoms associated with heart condition:	n your
I have no limitation of physical activity. Ordinary physical activity does not cause fatigue, shortness of breath or chest pain.	
I have slight limitation of physical activity. Ordinary physical activity results in fatigue, shortness of breath or chest pain.	
I have marked limitation of physical activity. Less than ordinary activity causes fatigue, shortness of breath or chest pain.	
I am unable to engage in any physical activity without discomfort. Fatigue, shortness of breath or chest pain may be present even at rest.	

ANGINA				
14. Over the <u>past four weeks</u> , on average, how many times have you had chest pain , chest tightness, or angina?	15. Over the <u>past four weeks</u> , how many times have you had to take nitroglycerin (nitroglycerin tablets or spray) for your chest pain, chest tightness, or angina?			
None over the past 4 weeks	None over the past 4 weeks			
Less than once a week	Less than once a week			
1-2 times per week	1-2 times per week			
3 or more times per week but not every day	3 or more times per week but not every day			
1-3 times per day	1-3 times per day			
4 or more times per day	4 or more times per day			

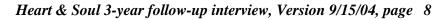
PARTICIPANT I	D
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HEART AND SOUL STUDY .

16. Over the <u>past four weeks</u> , how many times has your chest pain, chest tightness, or angina limited your enjoyment of life?
I don't have angina or it has not limited my enjoyment of life
It has barely limited my enjoyment of life
It has slightly limited my enjoyment of life
It has moderately limited my enjoyment of life
It has severely limited my enjoyment of life
17. If you had to spend the rest of your life with the same level of chest pain, chest tightness, or angina that you have right now, how would you feel about this?
Completely satisfied or no chest pain in the last 4 weeks
Mostly satisfied
Somewhat satisfied
Mostly dissatisfied
Not satisfied at all
18. How often do you think or worry that you may have a heart attack or die suddenly?
I never think or worry about it
I rarely think or worry about it
I occasionally think or worry about it
I often think or worry about it
I can't stop thinking or worrying about it

19. Please go over the activities listed below and indicate how much limitation you have had **due** to chest pain, chest tightness, or angina <u>over the past 4 weeks</u>. Please mark with an X only one box for each statement. "How much limitation do you experience when you: a, b, c,d,e,f,g or h?"

	Not at all limited	A little limited	Moderately limited	Quite a bit limited	Severely limited	Limited for other reasons or did not do the activity
a. Dressing yourself						
b. Walking indoors on level ground						
c. Showering						
d. Climbing a hill or a flight of stairs without stopping						
e. Gardening, vacuuming, or carrying groceries						
f. Walking more than a block at a brisk pace						
g. Running or jogging						
h. Lifting or moving heavy objects (e.g., furniture, children)						
i. Participating in strenuous sports						







COGNITIVE FUNCTION

20. Now, I'm going to ask you a few basic memory questions.

Note to interviewer (Do not read to patient): No aids to memory, such as looking at a calendar or newspaper, or asking for hints, are permitted. Refusal to answer any question usually means that the patient does not know the answer, and the item should be scored as incorrect.

	Correct	Incorrect
1. What is the date today? (Exact month, day, year required)		
2. What day of the week is it?		
3. Where are you right now? (Any correct description acceptable)		
4. What is your date of birth? (Exact month day, day, year required)		
5. How old are you? (Correct if corresponds to DOB)		
6. Who is the president of the United States now? (Correct if knows last name only)		
7. Who was the president just before him? (Correct if knows last name only)		
8. What was your mother's maiden name? (Correct if last name other than subject's last name is given)		
9. Please subtract 3 from 20, and keep subtracting 3 from each new number, all the way down. (Any error is scored as incorrect. Entire series must be performed correctly: 17, 14, 11, 8, 5, 2.)		
21. To be completed by the interviewer (do not need to ask the patient)	Yes	No
1. Did the patient know his or her telephone number?		
2. Did the patient know his or her address?		

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HEART AND SOUL STUDY

ACTIVITIES OF DAILY LIVING

22. Now, I am going to ask you some questions about how you take care of yourself AT THIS TIME. Each question is about some activity of daily living, things we all need to do as part of our daily lives.

AT THIS TIME, do you receive assistance with:	Receive no assistance	Receive some assistance	Unable to do alone
Washing or bathing yourself?			
Dressing and undressing (other than tying shoes)?			
Going to the toilet or cleaning yourself?			
Getting in and out of bed or a chair?			
Eating (other than precutting meat or buttering bread)?			
Walking (other than using a single, straight cane)?			
Using the telephone, including looking up and dialing numbers, and answering the phone?			
Getting to places out of walking distance by using public transportation or driving your car?			
Shopping for groceries or clothes?			
Preparing, serving, and providing meals for yourself?			
Doing light housework, such as dusting or washing dishes?			
Doing laundry?			
Taking pills or medicines in the correct amounts and at the correct times?			
Handling your own money, including writing checks and paying bills?			





23. AT THIS TIME:	Never	Sometimes	Often
How often do you have accidents with your bowels during the day or night?			
How often do you wet yourself during the day or night?			
24.	\geq 3 days	1 or 2 days	0 days
In the past 2 weeks , how many times have you been outside of your house (or residence)?			

FUTURE INTERVIEW/TEST

At the conclusion of the interview, state:

"I'd like to thank you very much for participating in our study. You were patient #xxx out of a total of 1030 participants. The Heart and Soul Study has already been recognized as contributing to the improvement of the health of cardiac patients. Our results have been published in several prestigious medical journals. Your contribution has been significant to the study's success. As a token of our appreciation for completing our study interviews during the past 3 years, we will be sending you a check for \$50 within 1 -2 weeks. Additionally, you may have the opportunity to return to the VA Hospital for free heart testing within the next couple of years."

25. If we are able to continue t	he study into the future, may we call to interview you again?
· ·	e willing to come back for some free heart tests sometime in the can see how your heart is doing?



PARTICIPANT ID



CONTACT INFORMATION UPDATE

27. Please write down the following information for two persons who do not live with you and who would know how to reach you in case you move and we need to get in touch with you. These people do not have to live near you.

Contact person number one:

New Contact	Decline to State	No Change Since Last Asked
First Name	MI Last Nan	e
Street Number	_ Street Name	Apt Number
City	State Zip Co	de Home Phone
How is the contact pe	rean above related to you?	(area code)
	erson above related to you?	
My son or daught	ter My niece or ne	phew Friend/ neighbor
My brother or sis	ter My grandchild	Someone else
Contact person number t	wo:	
New Contact	Decline to State	No Change Since Last Asked
First Name	MI Last Nam	e
Street Number	Street Name	Apt Number
City	State Zip Co	de Home Phone
How is the contact pe	rson above related to you?	(area code)
	·	
My son or daught	er My niece or ne	bhew Friend/ neighbor
My brother or sist	ter My grandchild	Someone else
Ok - Do you have any o	ther questions at this point?	
Great. Thank you again	for your valuable participat	ion in our study.

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