Final ASA 88

HARVARD MEDICAL SCHOOL **PHYSICIANS' HEALTH STUDY**

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* Please note the time period for ALL questions is January 1, 1987 to January 25, 1988.
* Please check YES or NO to EVERY item even if you have previously reported it.
* If you respond YES to ANY item in questions 1 or 2, please provide exact month and year of diagnosis or procedure.
* If you checked YES to ANY item(s) in 1 and 2, please sign and date the consent form on the back.

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1. From January 1, 1987 through January 25, 1988, were you NEWLY DIAGNOSED as having any of the following conditions? (Please check YES or NO for ALL items, and provide date for each diagnosis.)

	NO	YES	Date of DX Month/Year		NO	YES	Date of DX Month/Year
Myocardial infarction	☐	☐	________	Arthritis	☐	☐	________
Pulmonary embolism	☐	☐	________	Gout	☐	☐	________
Skin cancer, type ______	☐	☐	________	Gallstones	☐	☐	________
Deep vein thrombosis	☐	☐	________	Gallbladder removal	☐	☐	________
Stroke	☐	☐	________	Bronchitis	☐	☐	________
Cancer (non-skin): Site _____	☐	☐	________	Diabetes mellitus	☐	☐	________
Coronary angioplasty (PTCA)	☐	☐	________	Varicose veins	☐	☐	________
Angina pectoris	☐	☐	________	Appendix removal	☐	☐	________
Coronary bypass (CABG)	☐	☐	________	Renal disease	☐	☐	________
Bleeding hemorrhoids	☐	☐	________	Subconjunctival hemorrhage	☐	☐	________
Non-bleeding hemorrhoids	☐	☐	________	Carotid artery surgery	☐	☐	________
Melena	☐	☐	________	Intermittent claudication	☐	☐	________
Hematemesis	☐	☐	________	Other peripheral artery surgery	☐	☐	________
Other GI bleeding: Site ______	☐	☐	________	Site ____________			
Transient cerebral ischemia (TIA)	☐	☐	________	Glaucoma	☐	☐	________
Peptic ulcer	☐	☐	________	Periodontal disease	☐	☐	________
Liver disease	☐	☐	________	Teeth lost in past year	☐	☐	________
Osteoporosis	☐	☐	________	Number of teeth lost		#	________

Other conditions requiring medical treatment ________________________

2. From January 1, 1987 through January 25, 1988, were you diagnosed as having a cataract

	NO	YES		Month/Year
In your RIGHT eye?	☐	☐	Date of RIGHT eye diagnosis	________
In your LEFT eye?	☐	☐	Date of LEFT eye diagnosis	________

From January 1, 1987 through January 25, 1988, did you have a cataract extraction

	NO	YES		Month/Year
In your RIGHT eye?	☐	☐	Date of extraction in RIGHT eye	________
In your LEFT eye?	☐	☐	Date of extraction in LEFT eye	________

3. From January 1, 1987 through January 25, 1988, did you experience any of the following? (Please check YES or NO for ALL items.)

	NO	YES		NO	YES
Symptoms suggestive of gastritis	☐	☐	Hematuria	☐	☐
Symptoms suggestive of peptic ulcer	☐	☐	Easy bruising	☐	☐
Nausea	☐	☐	Epistaxis	☐	☐
Constipation	☐	☐	Other bleeding	☐	☐
Diarrhea	☐	☐	Headache	☐	☐
Skin discoloration	☐	☐	Migraine	☐	☐

Other symptoms ________________________

PLEASE TURN OVER →

4. Date of birth: ____ / ____ / 19 ____ (Necessary for verification)
Month Day Year

If you have any of the conditions in questions 1 and 2, please complete and sign the following consent form. This information will be used solely for medical statistical purposes and maintained in the strictest professional confidence.

I hereby grant permission to Charles H. Hennekens, MD, Associate Professor of Medicine, Harvard Medical School, 55 Pond Avenue, Brookline, MA 02146, to review a copy of the records of my hospitalization or treatment for:

Diagnosis: ____________________

Name of hospital/physician ____________________

Address ____________________

City ____________________ State ____________________ Zip ____________________

Dates of hospitalization/treatment ____________________

Signed ____________________ Date ____________________