

**TELEPHONE FOLLOW-UP PACKET** NACC UNIFORM DATA SET (UDS)

## Form D2: Clinician-assessed Medical Conditions

ADC name: \_\_\_\_\_ Subject ID: \_\_\_\_\_ Form date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Visit #: \_\_\_\_\_ Examiner's initials: \_\_\_\_\_

*INSTRUCTIONS: This form is to be completed by a physician, physician's assistant, nurse practitioner, or other qualified practitioner. For additional clarifications and examples, see UDS Coding Guidebook for Telephone Follow-up Packet, Form D2.*

**Medical conditions and procedures**

The following questions should be answered based on review of all available information, including new diagnoses made during the current visit, previous medical records, procedures, laboratory tests, and the clinical exam.

1. Cancer (excluding non-melanoma skin cancer), primary or metastatic

- 0 No **(SKIP TO QUESTION 2)**  
 1 Yes, primary/non-metastatic  
 2 Yes, metastatic  
 8 Not assessed **(SKIP TO QUESTION 2)**

1a. If yes, specify primary site: \_\_\_\_\_

***If any of the conditions below are present (even if successfully treated), please check Yes.***

2. Diabetes  0 No  
 1 Yes, Type I  
 2 Yes, Type II  
 3 Yes, other type (diabetes insipidus, latent autoimmune diabetes/type 1.5, gestational diabetes)  
 9 Not assessed or unknown

	No	Yes	Not assessed
3. Myocardial infarct	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 8
4. Congestive heart failure	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 8
5. Atrial fibrillation	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 8
6. Hypertension	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 8
7. Angina	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 8
8. Hypercholesterolemia	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 8
9. B12 deficiency	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 8
10. Thyroid disease	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 8

**If any of the conditions below are present (even if successfully treated), please check Yes.**

	No	Yes	Not assessed
11. Arthritis <i>If No or Not assessed, SKIP TO QUESTION 12</i>	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 8
11a. If yes, what type?			
<input type="checkbox"/> 1 Rheumatoid			
<input type="checkbox"/> 2 Osteoarthritis			
<input type="checkbox"/> 3 Other (SPECIFY): _____			
<input type="checkbox"/> 9 Unknown			
11b. If yes, regions affected (check at least one):			
11b1. <input type="checkbox"/> 1 Upper extremity			
11b2. <input type="checkbox"/> 1 Lower extremity			
11b3. <input type="checkbox"/> 1 Spine			
11b4. <input type="checkbox"/> 1 Unknown			
12. Incontinence — urinary	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 8
13. Incontinence — bowel	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 8
14. Sleep apnea	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 8
15. REM sleep behavior disorder (RBD)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 8
16. Hyposomnia/insomnia	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 8
17. Other sleep disorder (SPECIFY): _____	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 8
18. Carotid procedure: angioplasty, endarterectomy, or stent	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 8
19. Percutaneous coronary intervention: angioplasty and/or stent	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 8
20. Procedure: pacemaker and/or defibrillator	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 8
21. Procedure: heart valve replacement or repair	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 8
22. Antibody-mediated encephalopathy	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 8
22a. Specify antibody: _____			
23. Other medical conditions or procedures not listed above (IF YES, SPECIFY): _____	<input type="checkbox"/> 0	<input type="checkbox"/> 1	