

TELEPHONE INITIAL VISIT PACKET NACC UNIFORM DATA SET (UDS)

Form A5: Subject Health History

ADC name: _____ Subject ID: _____ Form date: ____/____/____

Visit #: ____ Examiner's initials: ____

INSTRUCTIONS: This form is to be completed by the clinician or ADC staff. For additional clarification and examples, see UDS Coding Guidebook for Telephone Initial Visit Packet, Form A5. Check only one box per question.

1. History of cigarette smoking and alcohol use	
CIGARETTE SMOKING	
1a. Has subject smoked within the last 30 days?	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 9 Unknown
1b. Has subject smoked more than 100 cigarettes in her/his life? (If No or Unknown, SKIP TO QUESTION 1F)	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 9 Unknown
1c. Total years smoked (<i>99=unknown</i>):	____
1d. Average number of packs smoked per day:	<input type="checkbox"/> 1 1 cigarette to less than ½ pack <input type="checkbox"/> 2 ½ pack to less than 1 pack <input type="checkbox"/> 3 1 pack to less than 1½ packs <input type="checkbox"/> 4 1½ packs to less than 2 packs <input type="checkbox"/> 5 2 packs or more <input type="checkbox"/> 9 Unknown
1e. If the subject quit smoking, specify the age at which he/she last smoked (i.e., quit) (<i>888=N/A, 999=unknown</i>):	____
ALCOHOL USE	
1f. In the past three months, has the subject consumed any alcohol?	<input type="checkbox"/> 0 No (SKIP TO QUESTION 2a) <input type="checkbox"/> 1 Yes <input type="checkbox"/> 9 Unknown (SKIP TO QUESTION 2a)
1g. During the past three months, how often did the subject have at least one drink of any alcoholic beverage such as wine, beer, malt liquor, or spirits?	<input type="checkbox"/> 0 Less than once a month <input type="checkbox"/> 1 About once a month <input type="checkbox"/> 2 About once a week <input type="checkbox"/> 3 A few times a week <input type="checkbox"/> 4 Daily or almost daily <input type="checkbox"/> 9 Unknown

FOR SECTIONS 2–7, BELOW, record the presence or absence of a **history** of these conditions **at this visit**, as determined by the clinician’s best judgment following the medical history interview with the subject and co-participant.

A CONDITION SHOULD BE CONSIDERED ...

- **Absent** IF ... it is not indicated by information obtained from the subject and co-participant interview.
- **Recent/Active** IF ... it happened within the last year or still requires active management and is consistent with information obtained from the subject and co-participant interview.
- **Remote/Inactive** IF ... it existed or occurred in the past (more than one year ago) but was resolved or there is no treatment currently under way.
- **Unknown** IF ... there is insufficient information available from the subject and co-participant interview.

2. Cardiovascular disease	Absent	Recent/ active	Remote/ inactive	Unknown
2a. Heart attack / cardiac arrest (If absent or unknown, SKIP TO QUESTION 2b)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
2a1. More than one heart attack? <input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 9 Unknown				
2a2. Year of most recent heart attack (9999 = unknown): _____				
2b. Atrial fibrillation	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
2c. Angioplasty / endarterectomy / stent	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
2d. Cardiac bypass procedure	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
2e. Pacemaker and/or defibrillator	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
2f. Congestive heart failure	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
2g. Angina	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
2h. Heart valve replacement or repair	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
2i. Other cardiovascular disease (SPECIFY): _____	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
3. Cerebrovascular disease	Absent	Recent/ active	Remote/ inactive	Unknown
3a. Stroke — by history, not exam (imaging is not required) <i>(If absent or unknown, SKIP TO QUESTION 3b)</i>	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
3a1. More than one stroke? <input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 9 Unknown				
3a2. Year of most recent stroke (9999 = unknown): _____				
3b. Transient ischemic attack (TIA) (If absent or unknown, SKIP TO QUESTION 4a)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
3b1. More than one TIA? <input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 9 Unknown				
3b2. Year of most recent TIA (9999 = unknown): _____				

4. Neurologic conditions	Absent	Recent/ active	Remote/ inactive	Unknown
4a. Parkinson's disease (PD) (If Absent or Unknown, SKIP TO QUESTION 4b) 4a1. Year of PD diagnosis (9999 = unknown): _____	<input type="checkbox"/> 0	<input type="checkbox"/> 1		<input type="checkbox"/> 9
4b. Other parkinsonism disorder (e.g., PSP, CBD) (If absent or unknown, SKIP TO QUESTION 4c) 4b1. Year of parkinsonism disorder diagnosis (9999 = unknown): _____	<input type="checkbox"/> 0	<input type="checkbox"/> 1		<input type="checkbox"/> 9
4c. Seizures	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
4d. Traumatic brain injury (TBI) (If Absent or Unknown, SKIP TO QUESTION 5a) 4d1. TBI with brief loss of consciousness (<5 minutes) <input type="checkbox"/> 0 No <input type="checkbox"/> 1 Single <input type="checkbox"/> 2 Repeated/multiple <input type="checkbox"/> 9 Unknown 4d2. TBI with extended loss of consciousness (≥5 minutes) <input type="checkbox"/> 0 No <input type="checkbox"/> 1 Single <input type="checkbox"/> 2 Repeated/multiple <input type="checkbox"/> 9 Unknown 4d3. TBI without loss of consciousness (as might result from military detonations or sports injuries)? <input type="checkbox"/> 0 No <input type="checkbox"/> 1 Single <input type="checkbox"/> 2 Repeated/multiple <input type="checkbox"/> 9 Unknown 4d4. Year of most recent TBI (9999 = unknown): _____	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
5. Medical conditions	Absent	Recent/ active	Remote/ inactive	Unknown
<i>If any of the conditions still require active management and/or medications, please select "Recent/active."</i>				
5a. Diabetes (If absent or unknown, SKIP TO QUESTION 5b) 5a1. If Recent/active or Remote/inactive, which type? <input type="checkbox"/> 1 Type 1 <input type="checkbox"/> 2 Type 2 <input type="checkbox"/> 3 Other type (diabetes insipidus, latent autoimmune diabetes/type 1.5, gestational diabetes) <input type="checkbox"/> 9 Unknown	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
5b. Hypertension	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
5c. Hypercholesterolemia	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
5d. B12 deficiency	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
5e. Thyroid disease	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
5f. Arthritis (If absent or unknown, SKIP TO QUESTION 5g) 5f1. Type of arthritis: <input type="checkbox"/> 1 Rheumatoid <input type="checkbox"/> 2 Osteoarthritis <input type="checkbox"/> 3 Other (SPECIFY): _____ <input type="checkbox"/> 9 Unknown 5f2. Region(s) affected (check all that apply): 5f2a. <input type="checkbox"/> 1 Upper extremity 5f2b. <input type="checkbox"/> 1 Lower extremity 5f2c. <input type="checkbox"/> 1 Spine 5f2d. <input type="checkbox"/> 1 Unknown	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9

5. Medical conditions (cont.)	Absent	Recent/ active	Remote/ inactive	Unknown
5g. Incontinence — urinary	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
5h. Incontinence — bowel	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
5i. Sleep apnea	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
5j. REM sleep behavior disorder (RBD)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
5k. Hyposomnia/insomnia	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
5l. Other sleep disorder (SPECIFY): _____	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
6. Substance abuse	Absent	Recent/ active	Remote/ inactive	Unknown
6a. Alcohol abuse: clinically significant impairment occurring over a 12-month period manifested in one of the following areas: work, driving, legal, or social.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
6b. Other abused substances: clinically significant impairment occurring over a 12-month period manifested in one of the following areas: work, driving, legal, or social. (If absent or unknown, SKIP TO QUESTION 7a)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
6b1. If recent/active or remote/inactive, specify abused substance: _____				
7. Psychiatric conditions, diagnosed or treated by a physician	Absent	Recent/ active	Remote/ inactive	Unknown
7a. Post-traumatic stress disorder (PTSD)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
7b. Bipolar disorder	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
7c. Schizophrenia	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
7d. Depression 7d1. Active depression in the last two years <input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 9 Unknown 7d2. Depression episodes more than two years ago <input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 9 Unknown				
7e. Anxiety	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
7f. Obsessive-compulsive disorder (OCD)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
7g. Developmental neuropsychiatric disorders (e.g., autism spectrum disorder [ASD], attention-deficit hyperactivity disorder [ADHD], dyslexia)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
7h. Other psychiatric disorders (If absent or unknown, END FORM HERE.) 7h1. If recent/active or remote/inactive, specify disorder: _____	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9