

Form A5/D2: Participant Health History / Clinician-assessed Medical Conditions

ADRC: _____ PTID: _____ Form date: ___/___/____ Visit #: _____ Examiner's initials: _____

Language: <input type="checkbox"/> 1 English <input type="checkbox"/> 2 Spanish	Mode: <input type="checkbox"/> 1 In-person <input type="checkbox"/> 2 Remote (reason): ___ <input type="checkbox"/> 1 Telephone <input type="checkbox"/> 2 Video	Key (remote reason): 1=Too cognitively impaired 2=Too physically impaired 3=Homebound/nursing home 4=Refused in-person visit 5=Other
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INSTRUCTIONS: This form is to be completed by the clinician or ADRC staff based on the medical history interview with the participant and co-participant, as well as review of any medical records that are available. Any conditions identified during the visit should be included on the form. For additional clarification and examples, see [UDS Coding Guidebook for Form A5/D2](#). Check only one box per question, unless otherwise stated.

Section 1 – Cigarette smoking, alcohol, and substance use

Cigarette smoking

1a.	Has the participant smoked <u>more than</u> 100 cigarettes in their life — (IF NO OR UNKNOWN, SKIP TO QUESTION 1f)	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 9 UNK
1b.	Total years smoked (99 = Unknown)	_____		
1c.	Average number of packs smoked per day:	<input type="checkbox"/> 1 1 cigarette to less than ½ pack	<input type="checkbox"/> 4 ½ packs to less than 2 packs	
		<input type="checkbox"/> 2 ½ pack to less than 1 pack	<input type="checkbox"/> 5 2 packs or more	
		<input type="checkbox"/> 3 1 pack to less than 1½ packs	<input type="checkbox"/> 9 Unknown	
1d.	Has the participant smoked within <u>the last 30 days</u> ?	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 9 UNK
1e.	If the participant quit smoking, specify the age at which they last smoked (i.e., quit) (888 = N/A, 999 = unknown)	_____		

Alcohol use

1f.	In the past 12 months, how often has the participant had a drink containing alcohol? (IF NEVER OR UNKNOWN, SKIP TO QUESTION 1i)	<input type="checkbox"/> 0 Never	<input type="checkbox"/> 3 2-3 times a week
		<input type="checkbox"/> 1 Monthly or less	<input type="checkbox"/> 4 4 or more times a week
		<input type="checkbox"/> 2 2-4 times a month	<input type="checkbox"/> 9 Unknown
1g.	On a day when the participant drinks alcoholic beverages, how many standard drinks does the participant typically consume? (Standard drink: 12oz of regular beer, 5oz of wine, 1.5oz of distilled spirits)	<input type="checkbox"/> 1 1 or 2	<input type="checkbox"/> 4 7 to 9
		<input type="checkbox"/> 2 3 to 4	<input type="checkbox"/> 5 10 or more
		<input type="checkbox"/> 3 5 to 6	<input type="checkbox"/> 9 Unknown
1h.	In the past 12 months, how often did the participant have six or more drinks containing alcohol in one day?	<input type="checkbox"/> 0 Never	<input type="checkbox"/> 3 Weekly
		<input type="checkbox"/> 1 Less than once a month	<input type="checkbox"/> 4 Daily or almost daily
		<input type="checkbox"/> 2 Monthly	<input type="checkbox"/> 9 Unknown

Substance use

1i.	Has the participant used substances including prescription or recreational drugs that caused significant impairment in one or more of the following areas: work, driving, legal, social, or others.			
1i1.	Within the past 12 months	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 9 UNK
1i2.	Prior to 12 months ago	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 9 UNK
1j.	In the past 12 months, how often has the participant consumed cannabis (edibles, smoked, or vaporized)?	<input type="checkbox"/> 0 Never	<input type="checkbox"/> 3 2-3 times a week	
		<input type="checkbox"/> 1 Monthly or less	<input type="checkbox"/> 4 4 or more times a week	
		<input type="checkbox"/> 2 2-4 times a month	<input type="checkbox"/> 9 Unknown	

In the following sections (pages 2-7) record the presence or absence of a **history of these conditions**, as determined by the clinician's best judgment following the medical history interview with the participant and co-participant, as well as review of any medical records that are available.

A CONDITION SHOULD BE CONSIDERED ...

Absent:	Recent/Active:	Remote/Inactive:	Unknown (UNK)
It has never been present.	It happened within the last year or still requires active management.	It existed or occurred in the past (<i>more than one year ago</i>) but was resolved or there is no treatment currently under way.	There is insufficient information available to assess this condition.

Section 2 – Cardiovascular disease

		ABSENT	RECENT/ACTIVE	REMOTE/INACTIVE	UNKNOWN
2a.	Heart attack (<i>heart artery blockage</i>) — (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 UNK
2a2.	Age at most recent heart attack (999 = Unknown)	_____			
2b.	Cardiac arrest (heart stopped) — (IF ABSENT OR UNKNOWN, SKIP TO QUESTION 2c)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
2b1.	Age at most recent cardiac arrest (999 = Unknown)	_____			
2c.	Atrial fibrillation	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
2d.	Coronary artery angioplasty / endarterectomy / stenting	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
2e.	Coronary artery bypass procedure — (IF ABSENT OR UNKNOWN, SKIP TO QUESTION 2f)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
2e1.	Age at most recent surgery (999 = Unknown)	_____			
2f.	Pacemaker and/or defibrillator implantation — (IF ABSENT OR UNKNOWN, SKIP TO QUESTION 2g)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
2f1.	Age at first implantation (999 = Unknown)	_____			
2g.	Congestive heart failure (including pulmonary edema)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
2h.	Heart valve replacement or repair — (IF ABSENT OR UNKNOWN, SKIP TO QUESTION 2i)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
2h1.	Age at most recent procedure (999 = Unknown)	_____			
2i.	Other cardiovascular disease (SPECIFY): _____	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9

Section 3 – Cerebrovascular disease

		ABSENT	RECENT/ACTIVE	REMOTE/INACTIVE	UNKNOWN
3a.	Stroke by history, not exam (<i>imaging is not required</i>) — (IF ABSENT OR UNKNOWN, SKIP TO QUESTION 3b)	<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 UNK
3a2.	Age at most recent stroke (999 = Unknown)	_____			
		NEVER IMPROVED	PARTIALLY IMPROVED	IMPROVED / BACK TO NORMAL	UNKNOWN
3a3.	What is the status of stroke symptoms?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9

Section 3 – Cerebrovascular disease *continued...*

3a4.	Carotid artery surgery or stenting? (IF NO OR UNKNOWN, SKIP TO QUESTION 3b)	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 9 UNK
3a5.	Age at most recent carotid artery surgery or stenting (999 = Unknown)	_ _ _		
		ABSENT	RECENT/ACTIVE	REMOTE/ INACTIVE
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
3b1.	Age at most recent TIA (999 = Unknown)	_ _ _		

Section 4 – Neurologic conditions

		ABSENT	RECENT/ACTIVE	REMOTE/ INACTIVE	UNKNOWN																		
4a.	Parkinson's disease (PD) — (IF ABSENT OR UNKNOWN, SKIP TO QUESTION 4b)	<input type="checkbox"/> 0	<input type="checkbox"/> 1		<input type="checkbox"/> 9																		
4a1.	Age at estimated PD symptom onset (999 = Unknown)	_ _ _																					
4b.	Other parkinsonism disorder (e.g., DLB) — (IF ABSENT OR UNKNOWN, SKIP TO QUESTION 4c)	<input type="checkbox"/> 0	<input type="checkbox"/> 1		<input type="checkbox"/> 9																		
4b1.	Age at parkinsonism disorder diagnosis (999 = Unknown)	_ _ _																					
4c.	Epilepsy and/or history of seizures (excluding childhood febrile seizures) — (IF REMOTE/INACTIVE, SKIP TO QUESTION 4c2, IF ABSENT OR UNKNOWN, SKIP TO QUESTION 4d)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9																		
4c1.	How many seizures has the participant had in the past 12 months? <input type="checkbox"/> 0 None <input type="checkbox"/> 1 1 or 2 <input type="checkbox"/> 2 3 or more <input type="checkbox"/> 9 Unknown																						
4c2.	Age at first seizure (excluding childhood febrile seizures) (999 = Unknown)	_ _ _																					
4d.	Chronic headaches	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9																		
4e.	Multiple sclerosis	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9																		
4f.	Normal-pressure hydrocephalus	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9																		
4g.	Repetitive head impacts (e.g. from contact sports, intimate partner violence, or military duty), regardless of whether it caused symptoms. (IF NO OR UNKNOWN, SKIP TO QUESTION 4h)	<input type="checkbox"/> 0 No		<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 9 UNK																		
4g1.	Indicate the source(s) of exposure for repeated hits to the head: <i>(Check all that apply)</i>	<table style="width: 100%; border: none;"> <tr><td>4g1a.</td><td><input type="checkbox"/> 1 American football</td></tr> <tr><td>4g1b.</td><td><input type="checkbox"/> 1 Soccer</td></tr> <tr><td>4g1c.</td><td><input type="checkbox"/> 1 Ice hockey</td></tr> <tr><td>4g1d.</td><td><input type="checkbox"/> 1 Boxing or mixed martial arts</td></tr> <tr><td>4g1e.</td><td><input type="checkbox"/> 1 Other contact sport</td></tr> <tr><td>4g1f.</td><td><input type="checkbox"/> 1 Intimate partner violence</td></tr> <tr><td>4g1g.</td><td><input type="checkbox"/> 1 Military service</td></tr> <tr><td>4g1h.</td><td><input type="checkbox"/> 1 Physical assault</td></tr> <tr><td>4g1i.</td><td><input type="checkbox"/> 1 Other (SPECIFY): _____</td></tr> </table>				4g1a.	<input type="checkbox"/> 1 American football	4g1b.	<input type="checkbox"/> 1 Soccer	4g1c.	<input type="checkbox"/> 1 Ice hockey	4g1d.	<input type="checkbox"/> 1 Boxing or mixed martial arts	4g1e.	<input type="checkbox"/> 1 Other contact sport	4g1f.	<input type="checkbox"/> 1 Intimate partner violence	4g1g.	<input type="checkbox"/> 1 Military service	4g1h.	<input type="checkbox"/> 1 Physical assault	4g1i.	<input type="checkbox"/> 1 Other (SPECIFY): _____
4g1a.	<input type="checkbox"/> 1 American football																						
4g1b.	<input type="checkbox"/> 1 Soccer																						
4g1c.	<input type="checkbox"/> 1 Ice hockey																						
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4g1f.	<input type="checkbox"/> 1 Intimate partner violence																						
4g1g.	<input type="checkbox"/> 1 Military service																						
4g1h.	<input type="checkbox"/> 1 Physical assault																						
4g1i.	<input type="checkbox"/> 1 Other (SPECIFY): _____																						
4g2.	Indicate the total length of time in years that the participant was exposed to repeated hits to the head <i>(e.g. playing American football for 7 years)</i> (999 = Unknown)	_ _ _																					

Section 4 – Neurologic conditions continued...

4h.	Head injury (e.g. in a vehicle accident, being hit by an object, in a fall, while playing sports or biking, in an assault, or during military service) that resulted in a period of feeling "dazed or confused," being unable to recall details of the injury, or loss of consciousness (if multiple head injuries, consider most severe episode). (IF NO OR UNKNOWN, SKIP TO QUESTION 5a)	<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 9 UNK
4h1.	After a head injury, what was the longest period of time that the participant was unconscious?	<input type="checkbox"/> 0 Less than 5 minutes	<input type="checkbox"/> 4 7 days or more	
		<input type="checkbox"/> 1 5 minutes to less than 30 minutes	<input type="checkbox"/> 8 Not applicable, no loss of consciousness	
		<input type="checkbox"/> 2 30 minutes to less than 24 hours	<input type="checkbox"/> 9 Unknown duration	
		<input type="checkbox"/> 3 1 day to less than 7 days		
4h2.	After a head injury, what was the longest period that the participant was "dazed or confused" or unable to recall details of the injury?	<input type="checkbox"/> 0 Less than 5 minutes	<input type="checkbox"/> 4 7 days or more	
		<input type="checkbox"/> 1 5 minutes to less than 30 minutes	<input type="checkbox"/> 8 Not applicable, never dazed and confused	
		<input type="checkbox"/> 2 30 minutes to less than 24 hours	<input type="checkbox"/> 9 Unknown duration	
		<input type="checkbox"/> 3 1 day to less than 7 days		
4h3.	Total number of head injuries in which the participant felt "dazed or confused," unable to recall details of the injury or experienced loss of consciousness?	<input type="checkbox"/> 0 None	<input type="checkbox"/> 3 6-12	
		<input type="checkbox"/> 1 1-2	<input type="checkbox"/> 4 13 or more	
		<input type="checkbox"/> 2 3-5	<input type="checkbox"/> 9 Unknown	
4h4.	Age of <u>first</u> head injury that resulted in a period of feeling "dazed or confused," being unable to recall details of the injury, or loss of consciousness: (999 = Unknown)	_____		
4h5.	Age of <u>most recent</u> head injury that resulted in a period of feeling "dazed or confused," being unable to recall details of the injury, or loss of consciousness: (999 = Unknown)	_____		

Section 5 – Medical conditions

If any of the conditions still require active management and/or medications, please select "Recent / Active."

		ABSENT	RECENT/ACTIVE	REMOTE/ INACTIVE	UNKNOWN
5a.	Diabetes — (IF ABSENT OR UNKNOWN, SKIP TO QUESTION 5b)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
5a1.	Which type?	<input type="checkbox"/> 1 Type 1 <input type="checkbox"/> 2 Type 2 <input type="checkbox"/> 3 Other (diabetes insipidus, latent autoimmune diabetes/type 1.5, gestational diabetes, prediabetes) <input type="checkbox"/> 9 Unknown			
5a2.	Treated with (Check all that apply)	5a2a. <input type="checkbox"/> 1 Insulin 5a2b. <input type="checkbox"/> 1 Oral medications 5a2c. <input type="checkbox"/> 1 GLP-1 receptor agonist 5a2d. <input type="checkbox"/> 1 Other non-insulin, non-GLP-1 receptor agonist injection medication 5a2e. <input type="checkbox"/> 1 Diet 5a2f. <input type="checkbox"/> 1 Unknown			
5a3.	Age at diabetes diagnosis (999 = Unknown)	_____			
5b.	Hypertension (or taking medication for hypertension) — (IF ABSENT OR UNKNOWN, SKIP TO QUESTION 5c)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
5b1.	Age at hypertension diagnosis (999 = Unknown)	_____			
5c.	Hypercholesterolemia (or taking medication for high cholesterol) — (IF ABSENT OR UNKNOWN, SKIP TO QUESTION 5d)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
5c1.	Age at hypercholesterolemia diagnosis (999 = Unknown)	_____			
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

Section 5 – Medical conditions *continued...*

		ABSENT	RECENT/ACTIVE	REMOTE/ INACTIVE	UNKNOWN
5f.	Arthritis — (IF ABSENT OR UNKNOWN, SKIP TO QUESTION 5g)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
5f1.	Type of arthritis (Check all that apply)	5f1a. <input type="checkbox"/> 1 Rheumatoid 5f1b. <input type="checkbox"/> 1 Osteoarthritis 5f1c. <input type="checkbox"/> 1 Other (SPECIFY): _____ 5f1d. <input type="checkbox"/> 1 Unknown			
5f2.	Regions 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			
5g.	Incontinence — urinary (occurring at least weekly)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
5h.	Incontinence — bowel (occurring at least weekly)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
5i.	Sleep apnea — (IF ABSENT, REMOTE/INACTIVE, OR UNKNOWN, SKIP TO QUESTION 5j)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
5i1.	Typical use of breathing machine (e.g. CPAP) at night over the past 12 months	<input type="checkbox"/> 0 None <input type="checkbox"/> 1 < 4 hours per night <input type="checkbox"/> 2 > 4 hours per night <input type="checkbox"/> 9 Unknown			
5i2.	Typical use of an oral device or implanted breathing pacemaker for sleep apnea at night over the past 12 months?	<input type="checkbox"/> 0 None <input type="checkbox"/> 1 < 4 hours per night <input type="checkbox"/> 2 > 4 hours per night <input type="checkbox"/> 9 Unknown			
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 (occurring at least weekly or requiring medication)	<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
5m.	Cancer, primary or metastatic — (Report all known diagnoses. Exclude non-melanoma skin cancer. IF ABSENT OR UNKNOWN, SKIP TO QUESTION 5n)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
5m1.	Type of cancer (Check all that apply)	5m1a. <input type="checkbox"/> 1 Primary/non-metastatic 5m1b. <input type="checkbox"/> 1 Metastatic (CHECK ALL THAT APPLY) 5m1b1. <input type="checkbox"/> 1 Metastatic to brain 5m1b2. <input type="checkbox"/> 1 Metastatic to sites other than brain 5m1c. <input type="checkbox"/> 1 Unknown			
5m2.	Primary site of cancer: (Check all that apply)	5m2a. <input type="checkbox"/> 1 Blood 5m2b. <input type="checkbox"/> 1 Breast 5m2c. <input type="checkbox"/> 1 Colon 5m2d. <input type="checkbox"/> 1 Lung 5m2e. <input type="checkbox"/> 1 Prostate 5m2f. <input type="checkbox"/> 1 Other (SPECIFY): _____			
5m3.	Type of cancer treatment (Check all that apply)	5m3a. <input type="checkbox"/> 1 Radiation 5m3b. <input type="checkbox"/> 1 Surgical Resection 5m3c. <input type="checkbox"/> 1 Immunotherapy 5m3d. <input type="checkbox"/> 1 Bone marrow transplant 5m3e. <input type="checkbox"/> 1 Chemotherapy 5m3f. <input type="checkbox"/> 1 Hormone therapy 5m3g. <input type="checkbox"/> 1 Other (SPECIFY): _____			
5m4.	Age at most recent cancer diagnosis (999 = Unknown)	_____			

Section 5 – Medical conditions *continued...*

		ABSENT	RECENT/ACTIVE	REMOTE/ INACTIVE	UNKNOWN
5n.	COVID-19 infection — (IF ABSENT OR UNKNOWN, SKIP TO QUESTION 5o)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
5n1.	Requiring hospitalization?		<input type="checkbox"/> 0 No	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 9 UNK
5o.	Asthma/COPD/pulmonary disease	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
5p.	Chronic kidney disease — (IF ABSENT OR UNKNOWN, SKIP TO QUESTION 5q)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
5p1.	Age at diagnosis (999 = Unknown)	— — —			
5q.	Liver disease — (IF ABSENT OR UNKNOWN, SKIP TO QUESTION 5r)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
5q1.	Age at diagnosis (999 = Unknown)	— — —			
5r.	Peripheral vascular disease — (IF ABSENT OR UNKNOWN, SKIP TO QUESTION 5s)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
5r1.	Age at diagnosis (999 = Unknown)	— — —			
5s.	Human Immunodeficiency Virus (HIV) — (IF ABSENT OR UNKNOWN, SKIP TO QUESTION 5t)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
5s1.	Age at diagnosis (999 = Unknown)	— — —			
5t.	Other medical conditions or procedures (SPECIFY): _____	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9

Section 6 – Psychiatric conditions

*In order to diagnose a disorder, **DSM-5-TR criteria require** that symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. For more guidance see the **UDS Coding Guidebook, Form A5/D2**.

		ABSENT	RECENT/ACTIVE	REMOTE/ INACTIVE	UNKNOWN
6a.	Depressive disorder				
6a1.	Major depressive disorder (DSM-5-TR criteria*)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
6a2.	Other specified depressive disorder (DSM-5-TR criteria*)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
6a3.	If Recent/Active depressive disorder (Q6a1 or Q6a2), choose if treated or untreated.	<input type="checkbox"/> 0 Untreated <input type="checkbox"/> 1 Treated with medication and/or counseling			
6b.	Bipolar disorder (DSM-5-TR criteria*)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
6c.	Schizophrenia or other psychosis disorder (DSM-5-TR criteria*)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
6d.	Anxiety disorder (DSM-5-TR criteria*) (IF ABSENT OR UNKNOWN, SKIP TO QUESTION 6e)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
6d1.	Generalized Anxiety Disorder	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
6d2.	Panic Disorder	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
6d3.	Obsessive–compulsive disorder (OCD)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
6d4.	Other (SPECIFY): _____	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
6e.	Post-traumatic stress disorder (PTSD) (DSM-5-TR criteria*)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9

Section 6 – Psychiatric conditions *continued...*

	ABSENT	RECENT/ACTIVE	REMOTE/ INACTIVE	UNKNOWN
6f. 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
6g. Other psychiatric disorders (SPECIFY): _____	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9

Section 7 – Menstrual and reproductive health

If questions about menstrual and reproductive health are relevant to this participant, continue to question 7a. Otherwise, **END FORM HERE**.

7a. How old was the participant when they had their first menstrual period? (888 = Never had a menstrual period, 999 = Unknown) (IF NEVER HAD A MENSTRUAL PERIOD, SKIP TO 7d)	_____
7b. How old was the participant when they had their last menstrual period? (888 = Still menstruating, 999 = Unknown) (IF STILL MENSTRUATING, SKIP TO QUESTION 7d)	_____
7c. If the participant has stopped having menstrual periods, please indicate the reason. (Check all that apply)	<p>7c1. <input type="checkbox"/> 1 Natural menopause</p> <p>7c2. <input type="checkbox"/> 1 Hysterectomy (surgical removal of uterus)</p> <p>7c3. <input type="checkbox"/> 1 Surgical removal of both ovaries</p> <p>7c4. <input type="checkbox"/> 1 Chemotherapy for cancer or another condition</p> <p>7c5. <input type="checkbox"/> 1 Radiation treatment or other damage/injury to reproductive organs</p> <p>7c6. <input type="checkbox"/> 1 Hormonal supplements (e.g. the Pill, injections, Mirena, HRT)</p> <p>7c7. <input type="checkbox"/> 1 Anti-estrogen medication such as Tamoxifen, anastrozole (Arimidex), exemestane (Aromasin), or letrozole (Femara)</p> <p>7c8. <input type="checkbox"/> 1 Unsure</p> <p>7c9. <input type="checkbox"/> 1 Other (SPECIFY): _____</p>
7d. Has the participant taken female hormone replacement pills or patches (e.g. estrogen)? (IF NO OR UNKNOWN, SKIP TO QUESTION 7e)	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 9 UNK
7d1. How many years in total? (999 = Unknown)	_____
7d2. Age at first use (999 = Unknown)	_____
7d3. Age at last use (888= Still presently using, 999 = Unknown)	_____
7e. Has the participant ever taken birth control pills? (IF NO OR UNKNOWN, END FORM HERE)	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 9 UNK
7e1. How many years in total? (999 = Unknown)	_____
7e2. Age at first use (999 = Unknown)	_____
7e3. Age at last use (888= Still presently using, 999 = Unknown)	_____