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OMB#: 0925-0584
Exp. 2/28/2011

HCHS/SOL Medical/Family History Questionnaire

ID NUMBER:

FORM CODE: MHE
VERSION: A 12/21/07

Contact Occasion

SEQ #

Acrostic: _____

ADMINISTRATIVE INFORMATION

0a. Completion Date: / /

0b. Staff ID:

Instructions: Enter the answer given by the participant for each response. The special value, "Q", is allowed for cases where the response 'Don't know/refused' is not listed as an option. If age of onset is unknown enter the special missing value, "=", in the item.

Did you or any of your blood relatives have any of the following conditions? Do not include half-brothers or half-sisters.

1. Has a doctor ever said that you have high blood pressure or hypertension?

No 0
Yes 1

→ **FOR WOMEN: GO TO QUESTION 1a**

1a. Was this during pregnancy only?

No 0
Yes 1

Has a doctor ever said that these relatives had high blood pressure or hypertension?

1b. Mother No or Don't know 0 Yes 1
1c. Father No or Don't know 0 Yes 1
1d. Brother(s) or sister(s) No or Don't know 0 Yes 1

2. Has a doctor ever said that you have high blood cholesterol?

No 0
Yes 1

Has a doctor ever said that these relatives had high blood cholesterol?

2a. Mother No or Don't know 0 Yes 1
2b. Father No or Don't know 0 Yes 1
2c. Brother(s) or sister(s) No or Don't know 0 Yes 1

3. Has a doctor ever said that you have angina?

No 0 → **GO TO QUESTION 3b**
Yes 1

3a. At what age were you first told this?

Age in years

Has a doctor ever said that these relatives had angina?

3b. Mother No or Don't know 0 Yes 1
3c. Father No or Don't know 0 Yes 1
3d. Brother(s) or sister(s) No or Don't know 0 Yes 1

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4. Has a doctor ever said that you had a heart attack?

No 0 → **GO TO QUESTION 4b**
Yes 1

4a. At what age were you first told this?

Age in years

Has a doctor ever said that these relatives had a heart attack?

4b. Mother No or Don't know 0 Yes 1 Age

4c. Father No or Don't know 0 Yes 1 Age

4d. Brother(s) or sister(s) No or Don't know 0 Yes 1 Age

5. Has a doctor ever said that you had heart failure?

No 0
Yes 1

Has a doctor ever said that these relatives had heart failure?

5a. Mother No or Don't know 0 Yes 1

5b. Father No or Don't know 0 Yes 1

5c. Brother(s) or sister(s) No or Don't know 0 Yes 1

6. Has a doctor ever said that you had rheumatic heart disease?

No 0
Yes 1

Has a doctor ever said that these relatives had rheumatic heart disease?

6a. Mother No or Don't know 0 Yes 1

6b. Father No or Don't know 0 Yes 1

6c. Brother(s) or sister(s) No or Don't know 0 Yes 1

7. Has a doctor ever told you that you had atrial fibrillation?

No 0
Yes 1

8. Has a doctor ever said that you had some other kind of heart problem?

No 0
Yes 1

If yes, please specify: _____

9. Have you had a balloon angioplasty, a stent, or bypass surgery to the arteries in your heart to improve the blood flow to your heart?

No 0
Yes 1

16. Has a doctor ever said that you have diabetes (high sugar in blood or urine)?

No 0 → **GO TO QUESTION 16e**
Yes 1

16a. At what age were you first told this?

Age in years

16b. FOR WOMEN: Was this during pregnancy only?

No 0
Yes 1

16c. Are you being treated with insulin?

No 0 → **GO TO QUESTION 16e**
Yes 1

16d. Was insulin the first medicine used for diabetes?

No 0
Yes 1

Has a doctor ever said that these relatives had diabetes?

16e. Mother	No or Don't know	0 <input type="checkbox"/>	Yes	1 <input type="checkbox"/>
16f. Father	No or Don't know	0 <input type="checkbox"/>	Yes	1 <input type="checkbox"/>
16g. Brother(s) or sister(s)	No or Don't know	0 <input type="checkbox"/>	Yes	1 <input type="checkbox"/>

17. Has a doctor ever said that you have kidney problems?

No 0
Yes 1

18. Has a doctor ever said that you have liver disease?

No 0 → **GO TO QUESTION 19**
Yes 1

What type of liver disease?

18a. Hepatitis No 0 → **GO TO QUESTION 18C**
Yes 1

18b. What type? Type A 1
Type B 2
Type C 3
Don't know 4

18c. Cirrhosis No 0
Yes 1

18d. Other No 0
Yes 1

24. Have you ever been told by a doctor that you have a sleep disorder?

- No 0 → **GO TO QUESTION 26**
 Yes 1
 Don't know 9 → **GO TO QUESTION 26**

25. Which sleep disorder(s)?

- | | No | Yes |
|------------------|----------------------------|----------------------------|
| a. Insomnia | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| b. Restless legs | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| c. Narcolepsy | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| d. Apnea | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| e. Other | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |

→ **IF RESPONSE TO Q25d IS "YES", ASK Q25d.1.**

If other, please specify: _____

↳ **25d.1. Have you been prescribed a CPAP or BIPAP machine, or a device to wear in your mouth to treat your sleep apnea?**

No 0
 Yes 1

26. Has a doctor ever said that you have cancer or a malignant tumor?

- No 0 → **GO TO QUESTION 26b**
 Yes 1

26a. What type?

- | | No | Yes |
|-------------------------|----------------------------|----------------------------|
| a1. Lung | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| a2. Breast | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| a3. Cervical | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| a4. Blood/lymph glands | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| a5. Testes/scrotum | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| a6. Bone | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| a7. Melanoma | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| a8. Skin (not melanoma) | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| a9. Brain | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| a10. Stomach | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| a11. Colon | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| a12. Uterine | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| a13. Prostate | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| a14. Liver | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| a15. Other | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |

Has a doctor ever said that these relatives had cancer or a malignant tumor?

- 26b. Mother No or Don't know 0 Yes 1
 26c. Father No or Don't know 0 Yes 1
 26d. Brother(s) or sister(s) No or Don'tknow 0 Yes 1

MEN > STOP, END QUESTIONNAIRE

WOMEN > GO TO QUESTION 27

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FOR WOMEN ONLY

27. At what age did your menses begin?

Age in years

28. Do you currently have menstrual periods?

No 0
Yes 1 → **GO TO QUESTION 34**
Don't know 9

29. Have you had a hysterectomy?

No 0 → **GO TO QUESTION 31**
Yes, with removal of both ovaries 1
Yes, without removal of both ovaries 2
Yes, uncertain if ovaries removed 3

30. Age at surgery? Age in years → **GO TO QUESTION 31**

31. Have you reached menopause (change of life)?

No 0 → **GO TO QUESTION 33**
Yes 1
Don't know 9 → **GO TO QUESTION 33**

32. At what age? Age in years → **GO TO QUESTION 34**

33. Are you currently pregnant?

No 0
Yes 1
Don't know 9

34. Have you ever been pregnant?

No 0 → **GO TO QUESTION 37**
Yes 1
Don't know 9 → **GO TO QUESTION 37**

35. How many times have you been pregnant? Number of pregnancies

36. How many live births have you had? Number of live births

37. Have you ever taken birth control pills or other birth control medication?

No 0
Yes 1

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38. Are you currently taking female hormones other than birth control pills?

- No 0 → **END QUESTIONNAIRE**
Yes 1
Don't know 9 → **END QUESTIONNAIRE**

39. Do you take these female hormones to supplement your natural hormones?

- No 0
Yes 1