For office use only
Participant ID: _____

MURDOCK Study Registry Follow-up Form

To be reviewed and completed by the Study participant or his/her legal representative

First name: _____ Middle initial: ____ Last name: _____

Year of birth: _____

Note: *If this person is deceased and you are the legal representative, you do not need to complete the rest of this form. Please enter the date of death and return this page.*

Date of death: _____

General Demographics

Please update any of the following information that has changed in the past year.

❑ All of my contact information is the same. Skip to question 5.

1. Mailing address:

Street_____

City:_____ State:_____ Zip Code:_____

County:_____

2. Physical address (if different):

Street: _____

City:_____ State:_____ Zip Code:_____

County:_____

3. Home phone: (____) ____-_____

Cell/mobile phone: (____) ____-_____

Work phone: (____) ____-_____

Is it okay to send you text messages? ❑Yes ❑No

4. Email address: _____

Alternate Contact Information

Note: *An alternate contact is someone we have your permission to communicate with if your contact information changes and we are not able to get in touch with you. We will contact your alternate contact in order to obtain updated contact information for you.*

5. Alternate Contact First name:_____ Last name: _____

6. Alternate Contact mailing address Street:_____

7. City: _____ State:_____ Zip Code:_____

8. Alternate Contact phone (____) ____-_____:

9. Alternate Contact Email:_____

10. Height (in feet and inches): _____feet _____ inches
(Example: 5 feet, 7 inches – please use only whole numbers with no ranges)

11. Weight (in pounds): _____ lbs. *(Example: 125 lbs)*

12. Who is your **primary care or main doctor**? _____

- ❑ Don't have a primary care doctor or provider
- ❑ Don't know

13. What is the **name of the primary care practice** where you are usually seen?_____

- ❑ Don't have a primary care practice
- ❑ Don't know

14. Health Problems and Procedures

Please indicate if you have received a **new** diagnosis of any of the following medical conditions **in the past year**.

Heart			
Coronary artery disease	❑ Yes	❑ No	❑ Don't know
Atrial fibrillation	❑ Yes	❑ No	❑ Don't know
Heart attack or angina	❑ Yes	❑ No	❑ Don't know
Congestive heart failure	❑ Yes	❑ No	❑ Don't know
Implantable cardiac defibrillator (ICD) or pacemaker placement	❑ Yes	❑ No	❑ Don't know
Cancer			
Breast cancer	❑ Yes	❑ No	❑ Don't know
Colon cancer	❑ Yes	❑ No	❑ Don't know
Lung cancer	❑ Yes	❑ No	❑ Don't know
Prostate cancer	❑ Yes	❑ No	❑ Don't know
Cervical cancer	❑ Yes	❑ No	❑ Don't know
Melanoma *(a specific type of skin cancer)*	❑ Yes	❑ No	❑ Don't know
Skin cancer, not melanoma	❑ Yes	❑ No	❑ Don't know
Oral cancer	❑ Yes	❑ No	❑ Don't know
Other type of cancer	❑ Yes	❑ No	❑ Don't know

Health Problems (*continued*)

Metabolic			
Diabetes	❑ Yes	❑ No	❑ Don't know
High Cholesterol	❑ Yes	❑ No	❑ Don't know
Thyroid Disease	❑ Yes	❑ No	❑ Don't know
High blood pressure	❑ Yes	❑ No	❑ Don't know
Obesity	❑ Yes	❑ No	❑ Don't know
Lung/Respiratory			
Asthma	❑ Yes	❑ No	❑ Don't know
Emphysema or "COPD"	❑ Yes	❑ No	❑ Don't know
Bone/Joint			
Osteoarthritis	❑ Yes	❑ No	❑ Don't know
Rheumatoid arthritis	❑ Yes	❑ No	❑ Don't know
Other autoimmune disease (Other than Multiple Sclerosis)	❑ Yes	❑ No	❑ Don't know
Osteoporosis/Osteopenia	❑ Yes	❑ No	❑ Don't know
Gout	❑ Yes	❑ No	❑ Don't know
Neurological			
Alzheimer's disease	❑ Yes	❑ No	❑ Don't know
Depression	❑ Yes	❑ No	❑ Don't know
Other mental illness	❑ Yes	❑ No	❑ Don't know
Stroke	❑ Yes	❑ No	❑ Don't know
Multiple sclerosis	❑ Yes	❑ No	❑ Don't know
Gastrointestinal/Renal			
Crohn's disease/ulcerative colitis	❑ Yes	❑ No	❑ Don't know
Liver disease	❑ Yes	❑ No	❑ Don't know
Kidney disease	❑ Yes	❑ No	❑ Don't know

Procedures

Please indicate if you have had of any of the following medical procedures <u>in the past year</u>.

15. Heart/cardiac catheterization

- ❑ Yes
- ❑ No

16. Heart/cardiac angioplasty or stent

- ❑ Yes
- ❑ No

17. Coronary artery bypass surgery

- ❑ Yes
- ❑ No

18. Heart/cardiac stress test

- ❑ Yes
- ❑ No

19. Joint replacement

- ❑ Yes → Which joint? _____
- ❑ No

20. Chest x-ray

- ❑ Yes
- ❑ No

21. Joint x-ray

- ❑ Yes → Which joint? _____
- ❑ No

22. CT or MRI scan

- ❑ Yes → Which part of the body was scanned? _____
- ❑ No

Lifestyle Habits

Please provide the best answer for the following questions.

23. Do you **currently smoke cigarettes?**

- ❑ Yes, only some days
- ❑ Yes, everyday
- ❑ No→ **skip to question 25**

24. If you currently smoke cigarettes, about **how many cigarettes a day** do you smoke, on the average?

_____ Cigarettes/day

25. During the **past month**, have you had at least **one drink of any alcoholic beverage**, such as beer, wine, wine coolers, or liquor?

- ❑ Yes
- ❑ No ➞ **skip to question 27**
- ❑ Don't Know

26. During the past month, on **how many days per week did you drink any alcoholic beverages**, on the average?

- ❑ Less than 1 day/don't drink alcoholic beverages
- ❑ 1–2 days per week
- ❑ 3–4 days per week
- ❑ 5–7 days per week

27. On an average day that you drink an alcoholic beverage (a can or bottle of beer, a 4-ounce glass of wine, or one cocktail containing one ounce of liquor), how many drinks do you have?

Please specify a number: _____ Drinks (on an average day)

- ❑ Don't drink alcoholic beverages

Medication List

Please list any pharmaceutical and/or natural medications (including vitamins) that you are currently taking.

❑ Not currently taking any pharmaceutical or natural medications and/or vitamins.

Medication Name	Reason for Use

Hospitalizations

If you **have not been hospitalized within the last year**, please check the box below and continue to the next page.

❑ I have not been hospitalized within the last year.

If you **have been hospitalized within the last year**, please list the reason(s) you were hospitalized, the date(s) you were admitted, and the name(s) of the hospital(s).

Reason for Hospitalization	Admission Date (Month/Year)	Hospital Name

Views About Your Health

Please indicate how you feel about each of the following questions.

28. In general, would you say your health is:

Excellent	Very good	Good	Fair	Poor
❑	❑	❑	❑	❑

29. Does your health now limit you in climbing one flight of stairs?

Not at all	Very little	Somewhat	Quite a lot	Cannot do
❑	❑	❑	❑	❑

30. Does your health now limit you in walking more than a mile?

Not at all	Very little	Somewhat	Quite a lot	Cannot do
❑	❑	❑	❑	❑

31. Does your health now limit you in lifting or carrying groceries?

Not at all	Very little	Somewhat	Quite a lot	Cannot do
❑	❑	❑	❑	❑

32. Does your health now limit you in bending, kneeling, or stooping?

Not at all	Very little	Somewhat	Quite a lot	Cannot do
❑	❑	❑	❑	❑

33. Does your health now limit you in doing vigorous activities, such as running, lifting heavy objects, participating in strenuous sports?

Not at all	Very little	Somewhat	Quite a lot	Cannot do
❑	❑	❑	❑	❑

34. Are you able to do chores such as vacuuming or yard work?

Without any difficulty	With a little difficulty	With some difficulty	With much difficulty	Unable to do
❑	❑	❑	❑	❑

35. Are you able to dress yourself, including tying shoelaces and doing buttons?

Without any difficulty	With a little difficulty	With some difficulty	With much difficulty	Unable to do
❑	❑	❑	❑	❑

36. Are you able to wash and dry your body?

Without any difficulty	With a little difficulty	With some difficulty	With much difficulty	Unable to do
❑	❑	❑	❑	❑

37. Are you able to get on and off the toilet?

Without any difficulty	With a little difficulty	With some difficulty	With much difficulty	Unable to do
❑	❑	❑	❑	❑

38. Are you able to run five miles?

Without any difficulty	With a little difficulty	With some difficulty	With much difficulty	Unable to do
❑	❑	❑	❑	❑

In the past 7 days…

39. I felt fearful.

Never	Rarely	Sometimes	Often	Always
❑	❑	❑	❑	❑

40. I found it hard to focus on anything other than my anxiety.

Never	Rarely	Sometimes	Often	Always
❑	❑	❑	❑	❑

41. My worries overwhelmed me.

Never	Rarely	Sometimes	Often	Always
❑	❑	❑	❑	❑

42. I felt uneasy.

Never	Rarely	Sometimes	Often	Always
❑	❑	❑	❑	❑

In the past 7 days…

43. I felt worthless.

Never	Rarely	Sometimes	Often	Always
❑	❑	❑	❑	❑

44. I felt unhappy.

Never	Rarely	Sometimes	Often	Always
❑	❑	❑	❑	❑

45. I felt depressed.

Never	Rarely	Sometimes	Often	Always
❑	❑	❑	❑	❑

46. I felt hopeless.

Never	Rarely	Sometimes	Often	Always
❑	❑	❑	❑	❑

In the past 7 days…

47. How fatigued were you on average?

Not at all	A little bit	Somewhat	Quite a bit	Very much
❑	❑	❑	❑	❑

48. How run-down did you feel on average?

Not at all	A little bit	Somewhat	Quite a bit	Very much
❑	❑	❑	❑	❑

49. How tired did you feel on average?

Not at all	A little bit	Somewhat	Quite a bit	Very much
❑	❑	❑	❑	❑

In the past 7 days…

50. How would you rate your pain on average?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

No pain — **Worst imaginable pain**

51. How much did pain interfere with your day to day activities?

Not at all	A little bit	Somewhat	Quite a bit	Very much
❑	❑	❑	❑	❑

52. How much did pain interfere with your ability to participate in social activities?

Not at all	A little bit	Somewhat	Quite a bit	Very much
❑	❑	❑	❑	❑

53. How much did pain interfere with your enjoyment of life?

Not at all	A little bit	Somewhat	Quite a bit	Very much
❑	❑	❑	❑	❑

In the past 7 days…

54. I was satisfied with my sleep.

Not at all	A little bit	Somewhat	Quite a bit	Very much
❑	❑	❑	❑	❑

55. I felt angry.

Never	Rarely	Sometimes	Often	Always
❑	❑	❑	❑	❑

56. I am satisfied with my ability to perform my daily routines.

Not at all	A little bit	Somewhat	Quite a bit	Very much
❑	❑	❑	❑	❑

57. I am satisfied with my ability to do leisure activities.

Not at all	A little bit	Somewhat	Quite a bit	Very much
❑	❑	❑	❑	❑