Physician Questionnaire: Cardiovascular Death

Details of Death

1. Are you familiar with the events surrounding the decedent's death?
   - Yes
   - No

2. Did you witness the death?
   - Yes
   - No

   If you answered "Yes" to both or either of Questions 1 and 2, please skip to Question 4.

3. If you answered "No" to both Questions, are you aware of another physician who could provide information regarding the death?
   - Yes
   - No

   If "No," please sign and date the form at the bottom of page 2.

   If "Yes," please provide the physician's name and address, then sign and date the form at the bottom of page 2.

   Name of physician: ________________________________

   Address: ________________________________________

   ________________________________________________

   ________________________________________________

   __________________________________________________________________________

Circumstances Surrounding Death

4. What do you believe to be the underlying cause of death?
   - Acute Myocardial Infarction
   - Other Ischemic Heart Disease
   - Cerebrovascular Disease
   - Other Cardiovascular Disease
   - Non-Cardio/Cerebrovascular
     (Please specify)

5. Please specify the time between the onset of the acute episode of symptoms and death. (We are defining death as the point where spontaneous breathing ceased and the patient never recovered.) Please check the appropriate time period.
   - Less than 5 minutes
   - 5 minutes to 1 hour
   - 1 hour to 24 hours
   - More than 24 hours
   - Unknown

6. Was there an acute episode of pain in the chest, left arm or jaw during the last 72 hours prior to death?
   - Yes
   - No
   - Unknown

7. Was there an acute episode of shortness of breath during the 72 hours prior to death?
   - Yes
   - No
   - Unknown

8. Did the decedent take or was s/he given nitrates or nitroglycerin at the time of the acute episode?
   - Yes
   - No
   - Unknown
Medical History

9. Are you familiar with the decedent's medical history?
   - Yes
   - No

   If you answered "No," please skip to the bottom of the page

10. Did the decedent have a medical history of any of the following conditions or medications prior to the acute event which led to death?

   Myocardial Infarction (MI)
   - Yes
   - No
   - Unknown

   If "Yes," date of most recent MI:
   / / 

   Angina Pectoris, Coronary Insufficiency or Other Chronic Ischemic Heart Disease
   - Yes
   - No
   - Unknown

   If "Yes," date of first diagnosis:
   / / 

   Congestive Heart Failure (CHF) or Congestive Cardiomyopathy
   - Yes
   - No
   - Unknown

   Stroke (CVA)
   - Yes
   - No
   - Unknown

   If "Yes," date of most recent CVA:
   / / 

   Continued next column

Transient Ischemic Attack (TIA)
   - Yes
   - No
   - Unknown

   If "Yes," date of first diagnosis:

   Intermittent Claudication or Other Peripheral Vascular Disease (PVD)
   - Yes
   - No
   - Unknown

   Lower Extremity Bypass, Angioplasty or Amputation Secondary to PVD
   - Yes
   - No
   - Unknown

   Coronary Bypass Surgery
   - Yes
   - No
   - Unknown

   Coronary Angioplasty
   - Yes
   - No
   - Unknown

11. If you saw the participant within one month of death, please fill out the following for the most recent visit:

   Date of Visit:
   / / 

   Chief Complaint: ____________________________

   Primary Diagnosis: ____________________________

   Changes in Medical Management: ____________________________

   Form completed by: ____________________________ Date: ____________________________

   For MESA Field Center Use Only:
   Reviewer ID: ____________________________ Data Entry ID: ____________________________

   7459295180