

HP35: Post-Trial Survey Home Interview

Purpose

The HDFP Post-Trial Survey (PTS) began in July of 1980, approximately one year after the final HDFP annual examinations were completed. The objectives of the PTS study can be found in **Section 17.1** of the *Manual of Operations*. These objectives were met by continuing the follow-up of the hypertensive and non-hypertensive participants for a period of two years. This follow-up involved both a home interview and a mailed mortality surveillance for hypertensives. Those persons who were found to be hypertensive during the HDFP screening and were randomized to either Stepped or Referred Care were contacted twice during the PTS. One contact involved a home interview (HP35) and the other contact a simple mortality surveillance through the mail or over the telephone (HP36). Fifty percent of all the former Stepped and Referred Care participants had the home interview during the first year and the mortality surveillance during the second year. The other fifty percent received them in the reverse order. Whether the home interview or the mortality surveillance was to be done during the first year for the particular participant was determined randomly.

The “non-hypertensive” group, i.e. persons screened during HDFP but not randomized into the trial, were followed for vital status alone. The same mortality surveillance procedures used for the hypertensives were employed for these non-hypertensives. The entire group was contacted twice, once during each of the two years of follow-up; contact was either by mail or telephone.

The HP35 form is described in detail in **Chapter 17** and **Sections 17.4** and **17.5** of the *Manual of Operations*.

POST-TRIAL SURVEY HOME INTERVIEW

FORM NUMBER 4.2

COMPLETE ITEMS 1, 2, 6b, 9, 31a and 32 AT CENTER PRIOR TO HOUSEHOLD VISIT

1. Program Number: 3 4 5 6 7 8 9 10 11 1 12 13 14 15 16 17
Coordinating Center
2. Name: (PRINT IN BLOCK CAPITALS) 2 BATCH NUMBER 18 19 20 21 22 23 24 25 ACROSTIC
(Mr., Miss, Mrs., Ms.) Last First Middle
3. Current address:
House No. Street Name or RR No. Apt. No.
City or Town State Zip Code
4. Telephone No. / Area Code

INTERVIEWER: Has identifying information (Items 1-4) changed since last contact?
NO YES
☐ ☐ → Complete HP11A

TO BE COMPLETED AT CENTER BY INTERVIEWER

5. a. Was the interview conducted?

4 2 ☐ NO 32 1 ☐ YES, home → Skip to 6
3 ☐ YES, phone → Skip to 6

- b. The primary reason is that participant:

- 5 33 {
1 ☐ is deceased → Complete HP07
2 ☐ has moved away from center but is known to be alive → Complete HP11A and initiate mailed survey.
3 ☐ has moved to unknown address and vital status is unknown
4 ☐ currently refuses to participate
5 ☐ is terminally ill
6 ☐ other, specify 634 P 0/1

- c. Date last known alive or date of death: 7 35 36 37 38 19 39 40 → Skip to 7

6. a. Date of Interview: 8 41 42 43 44 19 45 46

- b. Date of last scheduled interview (HP25): 9 47 48 49 50 19 51 52

- c. Time Interval Begun: 10 53 54 : 11 55 56 a.m. p.m. 57 12

- d. Time Interval Completed: 13 58 59 : 14 60 61 a.m. p.m. 62 15

7. a. Interviewer: 63 64 16

- b. Date information Obtained: 3 26 27 28 29 19 30 31

8. Are you currently a participant in another program or study related to high blood pressure?

NO 17 DK YES
2 ☐ 3 ☐ 1 ☐
65

1 ☐ Dietary Intervention Study for Hypertension (DISH)
2 ☐ Hypertension Control Program (HCP) 19 67 0/1
3 ☐ Other, specify name and location: 18

9. a. AT THE TIME OF OUR LAST SURVEY, you were _____
(marital status from last survey)

b. Has this changed?

NO YES
2 ☐ 68 1 ☐ 20

c. What is your marital status now? 21
1 ☐ Married 3 ☐ Separated 5 ☐ Remarried
69 2 ☐ Widowed 4 ☐ Divorced

10. a. What is your current work status?

1 ☐ Working full or part-time
22 2 ☐ Not working but looking for work and worked during the past year
70 3 ☐ Retired or disabled
4 ☐ Not retired or disabled but not working for more than one year → Skip to 11
5 ☐ Housewife or full-time student

b. Is your work status or job now different from what it was when we last saw you on (_____)?
(date of last survey)

NO YES
2 ☐ 71 1 ☐ 23

Was this change made for reasons of health?

NO YES
24 2 ☐ 72 1 ☐
Specify: 25 73 0/1

INTERVIEWER: Ask parts (c) and (d) only if the participant is currently employed full or part-time; otherwise, skip to Item 11.

c. What kind of work do you do? 26 74 0/1

d. What is the name and address of the workplace? 27 75 0/1

Now I'd like to ask you some questions about your blood pressure:

11. a. Do you believe you now have high blood pressure?

NO YES
 (28) 2 ☐ 76 1 ☐ → Skip to 12

- b. Do you believe that the high blood pressure our clinic staff told you about is completely cured, under control, or that you never had it?

(29) Cured Under control Never had it DK
 77 1 ☐ 2 ☐ 3 ☐ 4 ☐

12. a. About how many months has it been since you LAST had your blood pressure taken at the doctor's office or clinic?

(30) Less than 1-6 7-12 More than
 one month months months 12 months
 78 1 ☐ 2 ☐ 3 ☐ 4 ☐

Skip to 13

- b. How many times DURING THE PAST TWELVE MONTHS have you had your blood pressure measured?

(Do not count times while a patient in a hospital)

(31) 79 80 81 times

13. At the time your blood pressure was last taken at the doctor's office or clinic:

- a. Were you told that your blood pressure reading was:

(32) High Low Normal Down Not Told DK
 82 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐

Skip to 14

- b. Were you told the readings?

(33) NO YES DK
 83 2 ☐ 1 ☐ 3 ☐

Now I would like to know some of your ideas about blood pressure and health:

14. If a person has high blood pressure, how likely do you think it would be than any serious health problems would result from it?

Would you say:

(34) definitely? probably? not likely? DK
 84 1 ☐ 2 ☐ 3 ☐ 4 ☐

15. Do you think that a person with high blood pressure should see a doctor regularly?

85 NO YES DK
 2 ☐ (35) 1 ☐ 3 ☐

16. What kinds of long-range benefits, if any, do you think people with high blood pressure should expect from receiving medical treatment for the high blood pressure? Do you think they should expect to have:

	NO 2	YES 1	DK 3
a. better vision?	(36) <input type="checkbox"/> 86	<input type="checkbox"/>	<input type="checkbox"/>
b. longer life?	(37) <input type="checkbox"/> 87	<input type="checkbox"/>	<input type="checkbox"/>
c. less chance of getting cancer?	(38) <input type="checkbox"/> 88	<input type="checkbox"/>	<input type="checkbox"/>
d. less chance of having a heart attack?	(39) <input type="checkbox"/> 89	<input type="checkbox"/>	<input type="checkbox"/>

17. The following is a list of things that have often been reported to be problems for some people in getting long term care for high blood pressure. Can you tell me how much of a problem each of these items is for YOU, at present, in getting care (or in preventing you from getting care) for YOUR blood pressure? As I read each item on the list, please tell me whether it's not a problem, it's a mild problem, or it's a serious problem.

INTERVIEWER: See M.O.O. for explanation of "N.A."

	Not a problem 1	A mild problem 2	A serious problem 3	N.A. 4
a. The cost of the blood pressure medicines	(40) <input type="checkbox"/> 90	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. The cost of the visits to the doctor, nurse, or clinic for blood pressure treatment	(41) <input type="checkbox"/> 91	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. The time it takes to visit the doctor, nurse, or clinic	(42) <input type="checkbox"/> 92	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. The time lost from work for visits to the doctor, nurse, or clinic	(43) <input type="checkbox"/> 93	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Forgetting to take blood pressure medicines	(44) <input type="checkbox"/> 94	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Forgetting to go back to the doctor, nurse, or clinic for blood pressure check-ups	(45) <input type="checkbox"/> 95	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. It's too much of a bother worrying about something that may not be making you feel bad	(46) <input type="checkbox"/> 96	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Difficulty getting to and from the doctor's office or clinic	(47) <input type="checkbox"/> 97	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. There is no doctor or clinic easily available to me	(48) <input type="checkbox"/> 98	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Side effects from the blood pressure medicines (the medicines make you feel bad)	(49) <input type="checkbox"/> 99	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

K. Are there any other problems?

NO ☐ (50) YES ☐ →
100

Describe: 101 ☐ 0/1 ☐ 102 (52) ☐
(51)

Now I would like to ask you about your health in general:

18. Compared with other people your own age, would you say your health is:

(53) excellent? 103 ☐ good? 2 ☐ fair? 3 ☐ poor? 4 ☐

19. Would you say you worry about your health:

(54) frequently? 104 ☐ occasionally? 2 ☐ never? 3 ☐

20. Do you have any health problems other than high blood pressure AT THE PRESENT TIME?

NO 105 ☐ DK 3 ☐ YES 1 ☐

(55)

Health Problem

Duration

(1) (56) 106 ☐ 0/1

(2)

(3)

The following questions ask about your medical history SINCE YOUR LAST SCHEDULED HOME VISIT. They are routine questions we ask everyone, and they may or may not apply to you.

21. SINCE YOUR LAST SCHEDULED HOME VISIT (_____) , have you been told by a doctor, nurse, therapist, or medical assistant that you had any of the following:

date of 5th Year Follow-Up

INTERVIEWER: For each "yes" or "suspect" response with a hospitalization overnight or longer, have participant sign an HP35B. Also initiate an HP37. Be sure all hospitalizations reported here are also recorded in item 23.

a. heart attack or coronary (myocardial infarction, coronary thrombosis, or coronary occlusion)?

NO (57) DK YES Suspect
2 ☐ 3 ☐ 1 ☐ 4 ☐
107

(1) When were you told this?

(58) Month Day Year
108,109 110,111 19 112,113

(2) Were you hospitalized overnight or longer for this?

NO YES
(59) 2 ☐ 114 1 ☐

☐ HP35B signed by participant and HP37 initiated

b. stroke or brain hemorrhage?

NO ☒ 2 **60** DK ☐ 3
115

YES ☐ 1 Suspect ☐ 4

(1) When were you told this? **61** Month ☐ 116,117 Day ☐ 118,119 Year ☐ 120,121

(2) Were you hospitalized overnight or longer for this? NO ☒ **62** YES ☐ 1

2 ☐ 122,1

☐ HP35B signed by participant and HP37 initiated

(3) Did you have weakness or paralysis? NO ☒ **63** YES ☐ 1 DK ☐ 3
2 ☐ 123

(4) Difficulty with speech? **64** ☐ 124 ☐ ☐

(5) Difficulty with vision? **65** ☐ 125 ☐ ☐

(6) Other difficulties? **66** ☐ 126 ☐ ☐
If yes, specify: **67** 127 ☐ 0/1

(7) Did any of these problems last longer than 24 hours? **68** ☐ 128 ☐ ☐

c. cancer?

NO ☐ 2 **69** DK ☐ 3
129

YES ☐ 1 Suspect ☐ 4

(1) When were you told this? **70** Month ☐ 130,131 Day ☐ 132,133 Year ☐ 134,135

(2) What part of the body was affected? Specify: **71** 136 ☐ 0/1

72 ☐ 137,138
Coordinating Center

(3) Were you hospitalized overnight or longer for this? NO ☒ **73** YES ☐ 1

2 ☐ 139

☐ HP35B signed by participant and HP37 initiated

(4) Have you been told you had any other type of cancer?

NO ☒ **74** DK ☐ 3 YES ☐ 1 Suspect ☐ 4
2 ☐ 140

(a) When were you told this? **75** Month ☐ 141,142 Day ☐ 143,144 Year ☐ 145,146

(b) What part of the body was affected? **76** ☐ 147,148
Coordinating Center

(c) Were you hospitalized overnight or longer for this? NO ☒ **77** YES ☐ 1

2 ☐ 149

NOTE: Parts of the body in fields 72 and 76 are coded from Drug Code List.

☐ HP35B signed by participant and HP37 initiated

d. kidney stones or other kidney disease?

NO ☒ 78 DK ☐ 3
2 ☐ 150 4 ☐

(1) When were you told this?

Month Day Year
79 15/152 19 155,156

(2) Were you hospitalized overnight or longer for this?

NO YES
80 ☐ 157 ☐ 1

☐ HP35B signed by participant and HP37 initiated

(3) (a) Have you ever been on renal dialysis? (artificial kidney treatment?)

NO ☒ 81 DK ☐ 3
2 ☐ 158 4 ☐

(b) Are you currently on renal dialysis? (artificial kidney treatment?)

NO YES DK
82 ☐ 159 ☐ 1 ☐ 3

(c) Have you ever had a kidney transplant?

NO YES DK
83 ☐ 160 ☐ 1 ☐ 3

22. SINCE YOUR LAST SCHEDULED HOME VISIT (_____), have you been told by a doctor, nurse, therapist, or medical assistant that you had the following:
date of 5th Year Follow-Up

a. Diabetes (sugar in your urine or high blood sugar)?

NO ☒ 84 DK ☐ 3
2 ☐ 161 4 ☐

Were you hospitalized overnight or longer for this?

NO ☒ 85 YES
2 ☐ 162 ☐ 1

☐ HP35B signed by participant

b. gout?

NO ☒ 86 DK ☐ 3
2 ☐ 163 4 ☐

Were you hospitalized overnight or longer for this?

NO ☒ 87 YES
2 ☐ 164 ☐ 1

☐ HP35B signed by participant

c. cirrhosis or liver disease?

NO DK ☒ 88 YES ☐ 1
2 ☐ 165 3 ☐ 4

Were you hospitalized overnight or longer for this?

NO ☒ 89 YES
2 ☐ 166 ☐ 1

☐ HP35B signed by participant

d. intestinal bleeding or ulcers?

NO DK ☒ 90 YES ☐ 1
2 ☐ 167 3 ☐ 4

Were you hospitalized overnight or longer for this?

NO ☒ 91 YES
2 ☐ 168 ☐ 1

☐ HP35B signed by participant

Now I would like to ask you about all hospitalizations SINCE YOUR LAST SCHEDULED HOME VISIT, including those we have already discussed plus any others.

23. a. SINCE YOUR LAST SCHEDULED HOME VISIT (_____), have you stayed overnight or longer in the hospital as a patient?
date of 5th Year Follow-Up

NO ☒ 92 YES
2 ☐ 169 ☐ 1

Skip to 24

How many times have you been hospitalized DURING THIS PERIOD?

93 ☐ 170,171 times

INTERVIEWER: Ask participant to list all hospitalizations, including those reported in items 21 and 22, since the last scheduled home visit. Complete an HP35B for each hospitalization.

Seq. No.	Date	Number of Nights	Location	REASON(S) FOR HOSPITALIZATION (check all that apply)
			Note: For check boxes at right, if box is checked, value is "1," if box is not checked, value is "blank."	M.I. Stroke Cancer Kidney Dis. Other
(330) 1	545	(94) 172, 173, 174		(95) 175 (331) 546 (332) 547 (333) 548 (334) 549
(335) 2	550	(96) 176, 177, 178		(97) 179 (336) 551 (337) 552 (338) 553 (339) 554
(340) 3	555	(98) 180, 181, 182		(99) 183 (341) 556 (342) 557 (343) 558 (344) 559
(345) 4	560	(100) 184, 185, 186		(101) 187 (346) 561 (347) 562 (348) 563 (349) 564
(350) 5	565	(102) 188, 189, 190		(103) 191 (351) 566 (352) 567 (353) 568 (354) 569
(355) 6	570	(104) 192, 193, 194		(105) 195 (356) 571 (357) 572 (358) 573 (359) 574

b. INTERVIEWER: If hospitalized for reason other than M.I., stroke, cancer, or kidney disease, specify here.
Reason for hospitalization: (106) 196 P 0/1

Now I would like to ask some questions about the past 12 months only.

24. WITHIN THE PAST 12 MONTHS, have you had any of the following:

	NO	YES	DK
a. skin rash or unusual bruising?	(107) 197	1	3
b. swelling or tenderness of your breasts? (for men, "around the nipples?")	(108) 198		
c. recurrent stomach pains?	(109) 199		
d. waking up too early and having difficulty getting back to sleep?	(110) 200		
e. black or tarry stools?	(111) 201		
f. bright red blood in your stools?	(112) 202		
g. frequent depression (felt sad or blue) so that it interfered with your work, recreation, or sleep?	(113) 203		
h. tiredness or fatigue?	(114) 204		
i. nightmares?	(115) 205		

25. WITHIN THE PAST 12 MONTHS, have you had any of the following:

	NO	YES	DK
a. an illness or injury which kept you in bed for a week or more, or sent you to the hospital?	(116) 206	1	3
b. attacks of headache, racing of your heart, and sweating all at once?	(117) 207		
c. headaches so bad that you had to stop what you were doing?	(118) 208		
d. faintness or light-headedness when you stand up quickly?	(119) 209		
e. your heart beating fast or skipping beats?	(120) 210		
f. blacking out or losing consciousness?	(121) 211		
g. a change in your physical appearance that worried you — for example, changes in your skin or development of a lump?	(122) 212		
h. worries about physical symptoms which a doctor could not explain?	(123) 213		

26. DURING THE PAST 12 MONTHS, THAT IS, SINCE _____, 19____, about how many days were you away from work or
(today's date)
unable to carry out your usual daily activities because of illness, disability, or injury?

(124) 214, 215, 216 days

27. a. Thinking about the things you do at work (or housework), how would you rate yourself as to the amount of physical activity you get compared with other men/women of your age? Would you say you are:

much more active? ☒ 125 somewhat more active? ☐ 2 about the same? ☐ 3 somewhat less active? ☐ 4 much less active? ☐ 5 not applicable ☐ 6

b. Now, thinking about the things you do outside of work (or housework), how would you rate yourself as to the amount of physical activity you get compared with other men/women of your age? Would you say you are:

much more active? ☒ 126 somewhat more active? ☐ 2 about the same? ☐ 3 somewhat less active? ☐ 4 much less active? ☐ 5 not applicable ☐ 6

Now I would like to take your pulse and blood pressure:

28. Pulse: number of beats in 30 seconds

x 2 = ☒ 127 beats/minute

29. Blood Pressure Readings:

Cuff size:

☒ 129 223

1 ☐ regular

2 ☐ large arm

3 ☐ thigh

4 ☐ pediatric

Pulse obliteration pressure: ☒ 128 222 P 0/1

+30

Peak Inflation level: (Baumanometer)

Maximum Zero

Peak Inflation level: (Random-Zero)

(1) (Std)

☒ 130 Systolic 224 225 226

☒ 131 Diastolic (5th phase) 227 228 229

(2) (R-Z)

☒ 132 230 231 232

☒ 133 233 234 235

Zero

☒ 134 236 237

☒ 135 238 239

Corrected

☒ 136 240 241 242

☒ 137 243 244 245

(3) (Std)

☒ 138 246 247 248

☒ 139 249 250 251

(4) (R-Z)

☒ 140 252 253 254

☒ 141 255 256 257

Zero

☒ 142 258 259

☒ 143 260 261

Corrected

☒ 144 262 263 264

☒ 145 265 266 267

SUM of Corrected Readings 2 & 4

☒ 146 268 269 270

☒ 147 271 272 273

Average of R-Z Readings = SUM of Corrected Readings 2 & 4 Divided by 2

Remarks:

Now I would like to ask you about your weight:

How much do you weigh: (without heavy clothes on)?

☒ 148 274 275 276 pounds

For males, skip to Item 32

31. a. INTERVIEWER; Was the participant postmenopausal (either naturally or surgically) at the Five Year Follow-Up (from HP25, Item 35)?

NO YES

2 ☐ 277 1 ☐ →

Skip to 31d

b. SINCE YOUR LAST SCHEDULED HOME VISIT (_____), have you been pregnant?
date of 5th Year Follow-Up

NO YES

2 ☐ 278 1 ☐

Skip to 31c

(1) How many times, since your last visit, have you been pregnant? 279 280

(2) What was/were the outcome(s) of this/these pregnancy/pregnancies?
(Check all that apply.)

Now Pregnant

281 1 ☐

Live Birth

2 ☐

Miscarriage or Stillbirth

3 ☐

Other

4 ☐

152

282 1 ☐ Single
2 ☐ Multiple

153

c. Are you currently taking birth control pills?

NO YES

2 ☐ 283 1 ☐

DK

3 ☐

d. Are you taking any (other) hormones?

2 ☐ NO 284 3 ☐ DK

1 ☐ YES

What type?

156 285 0/1

32. Since (_____), the beginning of this program, have you been told that you had a tumor, lump, or cancer of the breast (or nipple area for males)?
date of HP03

NO DK YES Suspect

2 ☐ 286 3 ☐ 157 1 ☐ 4 ☐

a. When were you told this?

158

Month

Day

Year

287, 288

289, 290

19 291, 292

b. Were you told it was malignant (cancerous)?

NO YES

2 ☐ 293 1 ☐

c. Were you hospitalized overnight or longer for this?

NO YES

2 ☐ 294 1 ☐



HP35B signed by participant and
HP37 initiated

The next several questions are concerned only with the past 12 months.

33. DURING THE PAST 12 MONTHS, have you CHANGED your usual level of physical activity (at work as well as during leisure time)?

NO YES
2 ☐ 295 1 ☐ (161)
↓
1 ☐ more activity
2 ☐ less activity
296 (162)

34. IN THE LAST 12 MONTHS, has a doctor, nurse, therapist, or medical assistant advised you to make any CHANGES in your diet?

NO YES
2 ☐ 297 1 ☐ (163)
↓
Were you asked to:

	NO 2	DK 3	YES 1
lose weight?	(164) <input type="checkbox"/> 298	<input type="checkbox"/>	<input type="checkbox"/>
reduce salt?	(165) <input type="checkbox"/> 299	<input type="checkbox"/>	<input type="checkbox"/>
reduce fat or cholesterol?	(166) <input type="checkbox"/> 300	<input type="checkbox"/>	<input type="checkbox"/>
other	(167) <input type="checkbox"/> 301	<input type="checkbox"/>	<input type="checkbox"/>

Specify:

302 P 0/1 (168)

5. WITHIN THE PAST 12 MONTHS, has there been a CHANGE in your sleeping habits?

NO YES
2 ☐ (169) 303 1 ☐

In what way?

(170) ☐ 1 more sleep
304 ☐ 2 less sleep
☐ 3 other, specify:

(171) 305 P 0/1

36. a. WITHIN THE PAST 12 MONTHS, has there been a CHANGE in your cigarette smoking habits?

NO YES
2 ☐ (172) 306 1 ☐

Do you smoke cigarettes at present?

No Yes
2 ☐ (173) 307 1 ☐

Skip to 37

How many cigarettes do you smoke per day?
(175) 309 310 cigarettes

Did you:

Stop? Cut down? Start? Smoke more?
1 ☐ (174) 308 2 ☐ 3 ☐ 4 ☐

How many cigarettes do you smoke per day?
(176) 311 312 cigarettes

- b. DURING THE PAST 12 MONTHS, has a doctor, nurse, therapist, or medical assistant advised you to stop smoking, smoke less, or switch from cigarettes to pipe or cigars?

(177) NO YES DK
2 ☐ 313 1 ☐ 3 ☐

37. INTERVIEWER: Has participant been employed at any time WITHIN THE PAST 12 MONTHS (from Item 10a)? (If in doubt, ask the participant.)

NO YES
 178 2 ☐ 314 1 ☐

WITHIN THE PAST 12 MONTHS, have you experienced any difficulties related to your job or work, such as:

	NO 2	DK 3	YES 1
a. troubles at work?	179 <input type="checkbox"/> 315	<input type="checkbox"/>	<input type="checkbox"/>
b. being fired or laid off work?	180 <input type="checkbox"/> 316	<input type="checkbox"/>	<input type="checkbox"/>
c. quitting your job?	181 <input type="checkbox"/> 317	<input type="checkbox"/>	<input type="checkbox"/>

Problems getting a new job?

NO	YES	DK
2	1	3
192 <input type="checkbox"/> 318	<input type="checkbox"/>	<input type="checkbox"/>

The following are routine questions we ask of everyone, and they may or may not apply to you directly.

38. WITHIN THE PAST 12 MONTHS, have you had any of the following:

	NO 2	YES 1	DK 3	NA 4
a. worries about financial security?	183 <input type="checkbox"/> 319	<input type="checkbox"/>	<input type="checkbox"/>	
b. concern over the health or behavior of a family member (major illnesses, accidents, drug addiction, disciplinary problems, etc.)?	184 <input type="checkbox"/> 320	<input type="checkbox"/>	<input type="checkbox"/>	
c. unusual difficulties with your spouse?	185 <input type="checkbox"/> 321	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. lost contact with, or separated on bad terms from your children?	186 <input type="checkbox"/> 322	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. made a personal decision which alienated you from your friends?	187 <input type="checkbox"/> 323	<input type="checkbox"/>	<input type="checkbox"/>	
f. a "breaking off" of a close friendship?	188 <input type="checkbox"/> 324	<input type="checkbox"/>	<input type="checkbox"/>	
g. feelings of intense loneliness?	189 <input type="checkbox"/> 325	<input type="checkbox"/>	<input type="checkbox"/>	
h. feelings of being uninvolved, distant from others, or very shy?	190 <input type="checkbox"/> 326	<input type="checkbox"/>	<input type="checkbox"/>	
i. more thoughts about dying than usual?	191 <input type="checkbox"/> 327	<input type="checkbox"/>	<input type="checkbox"/>	
j. unpleasant thoughts or images which keep coming back?	192 <input type="checkbox"/> 328	<input type="checkbox"/>	<input type="checkbox"/>	
k. made a major decision regarding your immediate future (retirement, school, marriage, divorce, working, etc.)?	193 <input type="checkbox"/> 329	<input type="checkbox"/>	<input type="checkbox"/>	
l. death of spouse, relative, or close friend?	194 <input type="checkbox"/> 330	<input type="checkbox"/>	<input type="checkbox"/>	

Now I want to talk to you about the kind of medical care you may have received IN THE PAST 12 MONTHS.

39. In general, how satisfied have you been with the care you have received when seeking medical help? (INTERVIEWER:

Read choices and check the one chosen.)

195 1 ☐ Very satisfied 4 ☐ Very dissatisfied
 331 2 ☐ Somewhat satisfied 5 ☐ Not applicable (no medical care)
 3 ☐ Somewhat dissatisfied

40. Now I will describe several conditions, and for each one asked please tell me how likely you would be to seek medical help if you had the condition. (INTERVIEWER: Read the choices and check the one chosen.)

	Definitely 1	Probably 2	Not Likely 3
a. Mild headache for a week	196 <input type="checkbox"/> 332	<input type="checkbox"/>	<input type="checkbox"/>
b. Pains in the chest several times a day for more than one day	<input type="checkbox"/> 333 197	<input type="checkbox"/>	<input type="checkbox"/>
c. Blood in your stools for several days	198 <input type="checkbox"/> 334	<input type="checkbox"/>	<input type="checkbox"/>
d. Shortness of breath when walking short distances	<input type="checkbox"/> 335 199	<input type="checkbox"/>	<input type="checkbox"/>
e. Feeling tired all the time for no apparent reason	200 <input type="checkbox"/> 336	<input type="checkbox"/>	<input type="checkbox"/>

41. Do you currently have any kind of health insurance that pays all or part of your medical bills?

NO (201) DK
2 ☐ 337 3 ☐
YES
1 ☐
↓

a. Does the insurance cover all or part of your doctor's bills when you are in the hospital?

NO YES DK
(202) 2 ☐ 338 1 ☐ 3 ☐

b. Does it cover all or part of your other hospital bills when you are in the hospital?

NO YES DK
(203) 2 ☐ 339 1 ☐ 3 ☐

c. Does it pay for any of the following when you are seen in the doctor's office or clinic:

	NO 2	YES 1	DK 3
Visits to the doctor?	<u>(204)</u> <input type="checkbox"/> 340	<input type="checkbox"/>	<input type="checkbox"/>
Laboratory tests?	<u>(205)</u> <input type="checkbox"/> 341	<input type="checkbox"/>	<input type="checkbox"/>
X-rays?	<u>(206)</u> <input type="checkbox"/> 342	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure medicine?	<u>(207)</u> <input type="checkbox"/> 343	<input type="checkbox"/>	<input type="checkbox"/>

d. What kind of health insurance do you have? (Check all that apply.)

	NO 2	YES 1
1. Medicaid	<u>(208)</u> <input type="checkbox"/> 344	<input type="checkbox"/>
2. Medicare	<u>(209)</u> <input type="checkbox"/> 345	<input type="checkbox"/>
3. Private insurance	<u>(210)</u> <input type="checkbox"/> 346	<input type="checkbox"/>
4. Other, specify name of company or program <u>(212)</u> 348 <u>0/1</u>	<u>(211)</u> <input type="checkbox"/> 347	<input type="checkbox"/>

42. Excluding payment by Medicare, Medicaid, or insurance, about how much do you pay personally, out of pocket, for an average revisit to the doctor for your blood pressure? (Do not include medicines; round off to the nearest dollar.)

(213)
\$ 349 350 351

43. DURING THE PAST 12 MONTHS, about how many times have you seen or talked to a medical doctor, nurse, therapist, or medical assistant for any of your own health reasons, including high blood pressure?

(214) 352 353 354 times

In the next few questions, I will ask about things that may have happened IN THE PAST FOUR WEEKS.

44. Altogether, IN THE PAST FOUR WEEKS, how many times have you seen a doctor, nurse, therapist, or medical assistant for any health reason? Please include visits for regular check-ups, immunizations, and the like, as well as for any illnesses you may have had, but do not include hospitalizations.

(215) 355 356 times

45. IN THE PAST FOUR WEEKS, how many times have you talked over the telephone with a doctor, nurse, therapist, or medical assistant for any health reason?

(216) 357 358 times

Now I would like to ask about any medical care you have received DURING THE PAST 12 MONTHS FOR YOUR BLOOD PRESSURE.

46. a. DURING THE PAST 12 MONTHS, about how many times have you seen a doctor, nurse, therapist, or medical assistant ABOUT YOUR BLOOD PRESSURE?

More than once 1 ☐ 359 2 ☐ 360 3 ☐ 361
 Once only 2 ☐ 362
 Never 3 ☐ 363
 Skip to 46b

Was there a reason you did not see a medical person about your blood pressure? (Record verbatim)

(219) 362 0/1

Did the same person (doctor, nurse, therapist, or medical assistant) treat you on each visit?

NO 2 ☐ 363 YES 1 ☐ 364 DK 3 ☐ 365

Skip to 46b

- b. Do you now have an appointment to see a medical person in the future about your blood pressure?

NO 2 ☐ 364 YES 1 ☐ 365
 When? Month 3 65 Day 3 66 Year 19 3 67 3 68

No specific date (223) 1 371

47. a. IN THE LAST 12 MONTHS, have you taken medicine prescribed by a medical person FOR YOUR BLOOD PRESSURE?

NO 2 ☐ 372 YES 1 ☐ 373
 Skip to 49

- b. At any time DURING THE LAST 12 MONTHS, have you had any reactions (side effects) to any medicine you were taking for your blood pressure?

NO 2 ☐ 373 DK 3 ☐ 374 YES 1 ☐ 375 Suspect 4 ☐ 376

Medication

Reaction (side effect)

Date

Stopped Taking Medication?

NO 2 YES, Doctor's Orders 1 YES, Own Decision 3

374	375	376
381	382	383
388	389	390
395	396	397

Coordinating Center

(1) (226)
 (2) (229)
 (3) (232)
 (4) (235)

377	378	379
384	385	386
391	392	393
398	399	400

Coordinating Center

(227)
 (230)
 (233)
 (236)

(228) 380
 (231) 387
 (234) 394
 (237) 401

NOTE: Medications in fields 226, 229, 232 and 235 and side effects in fields 227, 230, 233 and 236 are coded from Drug Code List.

c. Are you still taking medicines FOR YOUR BLOOD PRESSURE?

(238) NO ☐ YES ☒ 4021 ☐ Skip to part e.

d. What blood pressure medicines did you take? Why did you stop taking the medicine?

Medicine	Ran out; never refilled	Reactions (side effects); made feel bad	Cost too much	Doctor's orders	Other; Specify
	1	2	3	4	5
(239) (1) <u>403 404 405</u>	(240) <input type="checkbox"/> 406	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 407 <u>0/1</u> (241)
(242) (2) <u>408 409 410</u>	(243) <input type="checkbox"/> 411	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 412 <u>0/1</u> (244)
(245) (3) <u>413 414 415</u>	(246) <input type="checkbox"/> 416	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 417 <u>0/1</u> (247)
(248) (4) <u>418 419 420</u>	(249) <input type="checkbox"/> 421	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 422 <u>0/1</u> (250)

Coordinating Center

NOTE: Medications in fields 239, 242, 245, 248 are coded from Drug Code List.

e. For how many weeks during the past year did you take any blood pressure medicine?

(251) 423 424 weeks

f. How long has it been since you last took any blood pressure medication?

(252) 425 426 427 days

For Participants no longer taking blood pressure medication Skip to 49

48. a. Do you have all your current blood pressure medicine bottles around that I might see?

NO
2 ☐

YES
1 ☐

428

(253)

Check appropriate reason(s) for not seeing medicine.

- 1 ☐ Out of medicine
- 2 ☐ Participant could not find medicine
- 3 ☐ Participant refused to show medicine
- 4 ☐ Medicine not recorded for other reason; indicate:

429 (254)

INTERVIEWER:
List all Prescription
blood pressure medi-
cations currently
being taken in 48b

(255)

430 0/1

b. Can you tell me what blood pressure medicines you're now taking?

Record ALL prescription blood pressure medicines below. Be sure name and dosage are clearly recorded.

COORDINATING CENTER	(256) 1. 431 432 433	(257) 2. 434 438 436	(258) 3. 437 438 439	(259) 4. 440 441 442
Name of Medication	NOTE: Medications in fields 256-259 are coded from Drug Code List.			
Name of Pharmacy				
Pharmacy Phone No.				
Prescription No.				
Date of Prescription				
Recommended Dosage (Ask if not on label or call phar.)				
Were any pills taken today?	(260) NO YES 2 <input type="checkbox"/> 443 1 <input type="checkbox"/>	(261) NO YES 2 <input type="checkbox"/> 444 1 <input type="checkbox"/>	(262) NO YES 2 <input type="checkbox"/> 445 1 <input type="checkbox"/>	(263) NO YES 2 <input type="checkbox"/> 446 1 <input type="checkbox"/>
Were any pills taken yesterday?	(264) NO YES 2 <input type="checkbox"/> 447 1 <input type="checkbox"/>	(265) NO YES 2 <input type="checkbox"/> 448 1 <input type="checkbox"/>	(266) NO YES 2 <input type="checkbox"/> 449 1 <input type="checkbox"/>	(267) NO YES 2 <input type="checkbox"/> 450 1 <input type="checkbox"/>
Medication seen or not seen	(268) Seen Not Seen 1 <input type="checkbox"/> 451 2 <input type="checkbox"/>	(269) Seen Not Seen 1 <input type="checkbox"/> 452 2 <input type="checkbox"/>	(270) Seen Not Seen 1 <input type="checkbox"/> 453 2 <input type="checkbox"/>	(271) Seen Not Seen 1 <input type="checkbox"/> 454 2 <input type="checkbox"/>
Have you had any reactions (side effects) to this medicine?	(272) NO YES 2 <input type="checkbox"/> 455 1 <input type="checkbox"/>	(273) NO YES 2 <input type="checkbox"/> 456 1 <input type="checkbox"/>	(274) NO YES 2 <input type="checkbox"/> 457 1 <input type="checkbox"/>	(275) NO YES 2 <input type="checkbox"/> 458 1 <input type="checkbox"/>

Record this info. and call pharmacy only if name of medicine or dosage not printed on bottle.

If additional medications use additional page.

Be sure to have included ALL prescription blood pressure medicines, seen or not seen.

c. Do you have any other problems with your blood pressure medicine?

NO DK YES
2 ☐ 460 3 ☐ (277) 1 ☐

(1) Describe the problems for me. (IDENTIFY drug item number from 48b)

461 0/1
(278)

(276) 459 0/1

(2) Did you discuss these problems with the doctor, nurse, therapist, or medical assistant?

NO YES DK
2 ☐ 462 1 ☐ (279) 3 ☐

d. Excluding drug costs paid by insurance, Medicare, or Medicaid; about how much per month do you spend personally, out of pocket, for your blood pressure medicines? (Round off to nearest dollar.)

(280) \$ 463 464 465

e. In your opinion, has this blood pressure medicine improved your health?

NO YES DK
2 ☐ 466 1 ☐ (281) 3 ☐

Explain

(282) 467 0/1

49. a. Are you taking ANY OTHER prescription medicines? (Include insulin, even when it is not a prescription drug, as in some states.)

NO

2 ☐ 468



Skip to 50

YES

1 ☐ 283

Do you have the medicine bottles around that I might see?

YES

1 ☐ 469

284

NO

2 ☐

Can you tell me what (other) prescription medicines you're now taking?

List all other prescription medicines in 49b

List all other prescriptions — seen and not seen — in 49b.
Be sure name and dosage are clearly recorded.

COORDINATING CENTER	285 1. 470 471 472	286 2. 473 474 475	287 3. 476 477 478	288 4. 479 480 481
Name of Medication	NOTE: Medications in fields 285-288 are coded from Drug Code List.			
Name of Pharmacy				
Pharmacy Phone No.				
Prescription No.				
Date of Prescription				
Recommended Dosage (Ask if not on label or call Phar.)				
Were any pills taken today?	289 NO YES 2 <input type="checkbox"/> 482 1 <input type="checkbox"/>	290 NO YES 2 <input type="checkbox"/> 483 1 <input type="checkbox"/>	291 NO YES 2 <input type="checkbox"/> 484 1 <input type="checkbox"/>	292 NO YES 2 <input type="checkbox"/> 485 1 <input type="checkbox"/>
Were any pills taken yesterday?	293 NO YES 2 <input type="checkbox"/> 486 1 <input type="checkbox"/>	294 NO YES 2 <input type="checkbox"/> 487 1 <input type="checkbox"/>	295 NO YES 2 <input type="checkbox"/> 488 1 <input type="checkbox"/>	296 NO YES 2 <input type="checkbox"/> 489 1 <input type="checkbox"/>
Medication seen or not seen	297 Seen Not Seen 1 <input type="checkbox"/> 490 2 <input type="checkbox"/>	298 Seen Not Seen 1 <input type="checkbox"/> 491 2 <input type="checkbox"/>	299 Seen Not Seen 1 <input type="checkbox"/> 492 2 <input type="checkbox"/>	300 Seen Not Seen 1 <input type="checkbox"/> 493 2 <input type="checkbox"/>
Have you had any reactions (side effects) to this medicine?	301 NO YES 2 <input type="checkbox"/> 494 1 <input type="checkbox"/>	302 NO YES 2 <input type="checkbox"/> 495 1 <input type="checkbox"/>	303 NO YES 2 <input type="checkbox"/> 496 1 <input type="checkbox"/>	304 NO YES 2 <input type="checkbox"/> 497 1 <input type="checkbox"/>

Record this info. and call pharmacy only if name of medicine or dosage not printed on bottle.

Be sure to have included ALL prescription blood pressure medicines, seen or not seen.

If additional medications, use additional page.

50. a. Whom do you see for treatment or monitoring of your blood pressure?

1 ☐ 306

499

No source of care for blood pressure

Skip to 51

Name of Dr. or clinic:

500

0/2

307

Address:

No.

Street Name or RR No.

City or Town

State

Zip Code

Telephone Number:

Area Code

308

Month

309

Year

- b. When did you last see him/her for your blood pressure?

501 502

19

503 504

305
498
0/2

51. a. Where do you usually go for medical care?

(310) 1 ☐ No source of care specified → Skip to 53

505 2 ☐ Same as above (Item 50) → Skip to 52

Name of Dr. or clinic:

Address:

No.

Street or RR No.

City or Town

State

Zip Code

Telephone Number:

Area Code

(312)

Month

(313)

Year

b. When did you last go there for medical care?

507, 08

19

509, 10

52. a. Is this your personal physician?

(314)

NO

YES

2 ☐

511, 1

1 ☐

Skip to 53

b. Do you have a personal physician?

(315)

NO

YES

2 ☐

512, 1

1 ☐

Skip to 53

Name of Dr.:

Address:

No.

Street Name or RR No.

City or Town

State

Zip Code

Telephone Number:

Area Code

(317)

Month

(318)

Year

c. When did you last see him/her?

514, 15

19

516, 17

53. Does your family understand the need to treat high blood pressure?

NO

YES

NA

2 ☐

518

1 ☐

(319)

3 ☐

Why not?

(320)

1 ☐

too expensive?

2 ☐

don't understand a disease they can't see?

3 ☐

associate the name, hypertension, with "nerves" or even mental problems

4 ☐

other, describe:

520

0/1

(321)

54. a. Do you have any plans for moving soon?

NO

DK

YES

2 ☐

521

3 ☐

(322)

1 ☐

b. Do you know where you'd be moving?

NO

(323)

YES

2 ☐

522

1 ☐

Address:

House No.

Street Name or RR No.

Apt. No.

City or Town

State

Zip Code

55. Could we have the name, address, and telephone number of two people, not in your household, who will know where you are if we should need to contact you?

a. 325 524 0/2 / /
First Middle Last

If above person is a married female, record first name of husband: _____

House No. / Street No. or RR No. / Apt. No.
City or Town State Zip Code

Telephone No: /
Area Code

b. / /
First Middle Last

If above person is a married female, record first name of husband: _____

House No. / Street Name or RR No. / Apt. No.
City or Town State Zip Code

Telephone No: /
Area Code

326 Obsolete
525-529

327 Update Number
530-532

328 Date Form Received
533-538

329 Date Form Last Processed
539-544

Fields F35330- F35359 are on page HP35/8 !