HCHS/SOL
Personal Medical History (MHE)

ID NUMBER:									FORM CODE: MHE VERSION: 2, 12/15/2021	Contact Occasion	0	3	Occurrence	0	1

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ 0b. Staff ID: ☐☐☐

0c. Participant Sex Assigned at Birth: ☐ (1=Male; 2=Female) **[Prefilled from DEM1]** 0d. Age: ☐☐ **[At V3 from DEM3]**

0e. Last visit date: ☐☐/☐☐/☐☐☐☐ **[System prefilled]**

Instructions**:** *Enter the answer given by the participant for each response. Set CDART Field Status to 'Refused', 'No Response', 'Missing', etc. for those questions that do not list these values as possible answer choices.*

Introduction: *Next, I would like to update our records for any health issues you may have experienced. Some are questions we asked before, but we want to make sure we don't miss anything.*

I will ask you some questions that may make you feel uncomfortable. You may not feel like answering them completely or at all. Please, take your time to think through your answers. We want to understand these aspects of your health, and at the same time we want you to feel respected and comfortable. You are important to us, and your participation in the study is extremely valuable.

A. Since the last SOL visit, has a doctor said that you had any of the following medical problems?	**No**	**Yes**	**Unsure**
1. Heart attack?	0 ☐	1 ☐	9 ☐
2. A balloon angioplasty, a stent, or bypass surgery to the arteries in your heart to improve the blood flow to your heart?	0 ☐	1 ☐	9 ☐
3. Angina?	0 ☐	1 ☐	9 ☐
4. Heart Failure?	0 ☐	1 ☐	9 ☐
5. Stroke?	0 ☐	1 ☐	9 ☐
6. A mini-stroke or TIA (transient ischemic attack)?	0 ☐	1 ☐	9 ☐
7. A balloon angioplasty or surgery to the arteries of your neck to prevent or correct a stroke?	0 ☐	1 ☐	9 ☐
8. An aortic aneurysm, an AAA, or ballooning of your aorta? If NO skip to Q10	0 ☐	1 ☐	9 ☐
9. Have you had a repair of your aorta—the big artery in your abdomen?	0 ☐	1 ☐	9 ☐
10. Peripheral arterial disease (problems with circulation, blocked arteries to the legs)?	0 ☐	1 ☐	9 ☐
10a. IF YES to PAD, did you have leg surgery, a balloon angioplasty, or stent for this condition?	0 ☐	1 ☐	9 ☐
10b. IF YES to PAD, did you have amputation for this condition?	0 ☐	1 ☐	9 ☐

11. Liver disease? No 0 ☐ **Go to Question12** Yes 1 ☐ Unsure 9 ☐ **Go to Question12**

IF YES to liver disease, then what type of liver disease?

11a. Hepatitis No 0 ☐ → **Go to Question 11d** Yes 1 ☐

11b. What type? Type A 1 ☐ → **Go to Question 11d**

Type B 2 ☐ → **Go to Question 11d**

Type C 3 ☐ → **Go to Question 11c**

Don't know 9 ☐ → **Go to Question 11d**

11c. Has a doctor ever prescribed medicine to treat Hepatitis C? No 0 ☐ Yes 1 ☐ Unsure 9 ☐

11d. Cirrhosis No 0 ☐ Yes 1 ☐

	No	Yes	Unsure
12. Has a doctor ever told you that you had gallstones?	0 ☐	1 ☐	9 ☐
12a. IF YES, have you ever had medical treatment to dissolve or remove gallstones?	0 ☐	1 ☐	9 ☐
12b. IF YES, have you ever had gallbladder surgery?	0 ☐	1 ☐	9 ☐

12c. IF YES, at what AGE? ☐☐

13. Have you ever had weight loss surgery, also called bariatric surgery? 0 ☐ 1 ☐ 9 ☐

13a. IF YES, at what AGE? ☐☐

14. Since our last SOL visit with you on (date), has a doctor or health professional told you that you had emphysema, chronic bronchitis, or chronic obstructive pulmonary disease (COPD)? This does not include doctor's visits for tuberculosis or TB.

No 0 ☐ **Go to Question 15** Yes 1 ☐ Unsure 9 ☐ **Go to Question 15**

14a. Did the doctor or health care professional prescribe a medication, such as inhalers, oxygen or pills for your lungs or prescribing a steroid pill for your lungs?

No 0 ☐ Yes 1 ☐ Unsure 9 ☐

15. Since our last SOL visit with you on (date), has a doctor or health professional told you that you had asthma?

No 0 ☐ **Go to Question 16** Yes 1 ☐ Unsure 9 ☐ **Go to Question 16**

15a. Did the doctor or health care professional prescribe a medication, such as inhalers, oxygen or pills for your lungs or prescribing a steroid pill for your lungs?

No 0 ☐ Yes 1 ☐ Unsure 9 ☐

16. Since our last SOL visit with you, has a doctor or health professional told you that you had diabetes or high sugar in the blood?

No 0 ☐ **Go to Question 17** Yes 1 ☐ Unsure 9 ☐ **Go to Question 17**

16a. Did the doctor recommend any treatments?

No 0 ☐ **Go to Question 17** Yes 1 ☐ Unsure 9 ☐ **Go to Question 17**

16b. What treatment was recommended? (Do not prompt for specific response. Mark all that apply)

		No	Yes
b1.	Pills	0 ☐	1 ☐
b2.	Insulin alone	0 ☐	1 ☐
b3.	Insulin and pills	0 ☐	1 ☐
b4.	Referred for eye exam	0 ☐	1 ☐
b5.	Advice to change diet	0 ☐	1 ☐
b6.	Advice to stop smoking	0 ☐	1 ☐
b7.	Advice to increase exercise	0 ☐	1 ☐
b8.	Other	0 ☐	1 ☐ Specify:_____

17. Since our last SOL visit with you on (date), has a doctor or health professional told you that you had high blood pressure or hypertension?

No 0 ☐ **Go to Question 18** Yes 1 ☐ Unsure 9 ☐ **Go to Question 18**

17a. Did the doctor recommend any treatments?

No 0 ☐ **Go to Question 18** Yes 1 ☐ Unsure 9 ☐ **Go to Question 18**

17b. What treatment was recommended? *(Do not prompt for specific response. Mark all that apply)*

		No	**Yes**	
b1.	Start new medicine	0 ☐	1 ☐	
b2.	Increase dose of existing medicine	0 ☐	1 ☐	
b3.	Advice to lose weight	0 ☐	1 ☐	
b4.	Advice to change diet	0 ☐	1 ☐	
b5.	Advice to stop smoking	0 ☐	1 ☐	
b6.	Advice to increase exercise	0 ☐	1 ☐	
b7.	Other	0 ☐	1 ☐	Specify:_____

18. Since our last SOL visit with you on (date) has a doctor or health professional told you that you had high blood cholesterol?

No 0 ☐ **Go to Question 19** Yes 1 ☐ Unsure 9 ☐ **Go to Question 19**

18a. Did the doctor recommend treatments?

No 0 ☐ **Go to Question 19** Yes 1 ☐ Unsure 9 ☐ **Go to Question 19**

18b. What treatment was recommended? (Do not prompt for specific response. Mark all that apply.)

		No	**Yes**	
b1.	Start new medicine	0 ☐	1 ☐	
b2.	Increase dose of existing medicine	0 ☐	1 ☐	
b3.	Advice to lose weight	0 ☐	1 ☐	
b4.	Advice to change diet	0 ☐	1 ☐	
b5.	Advice to stop smoking	0 ☐	1 ☐	
b6.	Advice to increase exercise	0 ☐	1 ☐	
b7.	Other Specify_____	0 ☐	1 ☐	

B. In the Past 12 months, have you had any of the following problems?	**No**	**Yes**	**Unsure**
19. Do you often have swelling in your feet or ankles at the end of the day?	0 ☐	1 ☐	9 ☐
20. Do you have difficulty lying flat in bed or on a single pillow because this position makes you short of breath?	0 ☐	1 ☐	9 ☐
21. Are there times when you wake up at night because of difficulty breathing?	0 ☐	1 ☐	9 ☐
22. Are there times when you have difficulty breathing when you are not walking or active?	0 ☐	1 ☐	9 ☐

23. Has a doctor ever told you that you had any of the following conditions that affect the brain:	**No**	**Yes**
23a. Dementia?	0 ☐	1 ☐
23b. Alzheimer's disease?	0 ☐	1 ☐
23c. Vascular dementia or hardening of the arteries of the brain?	0 ☐	1 ☐

23d.	Mild Cognitive Impairment (or MCI)?	0 ☐	1 ☐
23e.	Parkinson's Disease?	0 ☐	1 ☐
23f.	Brain Tumor?	0 ☐	1 ☐

In the past 12 months have you:	**No**	**Yes**
24. Received dialysis (either hemodialysis or peritoneal dialysis)?	0 ☐	1 ☐
25. Received a kidney transplant?	0 ☐	1 ☐
In the past 12 months have you had or do you currently have:		
26. Pain in your face?	0 ☐	1 ☐
27. Pain in your jaw joint?	0 ☐	1 ☐

[Complete if Q26 and/or Q27=Yes]

In the past 6 months	**Never**	**Some days**	**Most days**	**Every day**
28. How often did you have pain?	0 ☐	1 ☐	2 ☐	3 ☐
29. How often did pain limit your life or work activities?	0 ☐	1 ☐	2 ☐	3 ☐

C. Other Health Questions

Now I'm going to ask you a few questions about getting tested for HIV. Remember, an HIV test checks whether someone has the virus that causes AIDS.

30. Have you ever had an HIV test?

No	0 ☐ **[End Form]**
Yes	1 ☐ **Go to Question 31**
Don't Know	9 ☐ **[End Form]**
Refuse to Answer	7 ☐ **[End Form]**

31. Have you ever tested positive for HIV, that is, do you have HIV?

No	0 ☐ **Go to Question 32**
Yes	1 ☐ **Go to Question 33**
Don't Know	9 ☐ **Go to Question 32**
Refuse to Answer	7 ☐ **[End Form]**

32. When did you have your most recent HIV test? Please tell me the month and year (Use *CDART Field Status for Don't know or Refusal answers).*

Date of most recent HIV test (mm/yyyy): ☐☐/☐☐☐☐ [**End Form]**

33. When did you first test positive? Please tell me the month and year (*Use CDART Field Status for Don't know or Refusal answers).*

Date of first positive test (mm/yyyy): ☐☐/☐☐☐☐