

## Diabetes Prevention Program INTERVAL HISTORY QUESTIONNAIRE

This form is completed at Major Follow-up Visits.  
Form Q08 records medical and cardiovascular interval history during the past 12 months. In addition, drinking, smoking, aspirin and routine medical care interval information is recorded.

### Part I / IDENTIFICATION

#### A. Participant Identification

1. Clinic number  CLINIC
2. Participant number  PATID
3. Participant's initials  INITS  
first last
4. Participant's date of birth  DOB  
month day year
5. Participant's sex Male  1  
Female  2 SEX

#### B. Visit Information

1. Date of visit  IVSTDT  
month day year
2. Week of visit  IVSTWK
3. Outcome visit  VISIT
4. End of Study Yes  1  
No  2 IVEOS

#### C. Instructions for Form Q08 Completion

Complete all sections of Form Q08.

Initials of person reviewing completed form

  
first last

Form entered in computer?

Participant's initials

first		last	

Date of birth

month	day	year

Date of visit

month	day	year

Part II / INTERVAL MEDICAL HISTORY

D. During the past 12 months has a doctor told you that you had any of the following?

- |                                                                                      | YES                        | NO                         |         |
|--------------------------------------------------------------------------------------|----------------------------|----------------------------|---------|
| 1. High blood pressure (hypertension)? .....                                         | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | IHYPER  |
| 2. Heart Attack (myocardial infarction, coronary occlusion, or coronary thrombosis)? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | IHMI    |
| 3. Angina? .....                                                                     | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | IHANGI  |
| 4. Stroke, transient ischemic attacks (TIA), or mini stroke? .....                   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | IHSTRK  |
| 5. Diabetes (sugar in blood or urine)? .....                                         | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | IHDIAB  |
| 6. High cholesterol (high blood fats)? .....                                         | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | IHLIPID |
| 7. Ulcer (stomach or duodenal), or intestinal bleeding? .....                        | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | IHULCR  |
| 8. Hepatitis? .....                                                                  | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | IHEPAT  |
| 9. Cancer? .....                                                                     | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | IHCNCR  |
| 10. Gallstones, gallbladder disease, or gallbladder surgery? .....                   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | IHGALL  |
| 11. Coronary artery bypass surgery (graft, CABG)? .....                              | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | IHCABG  |
| 12. Angioplasty of the coronary arteries? .....                                      | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | IHBLLN  |
| 13. Carotid endarterectomy or other procedure to open blood vessels in neck? .....   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | IHNECK  |
| 14. Bypass surgery of the lower extremities, to bypass blocked artery in leg? .....  | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | IHBYLEG |
| 15. Gout? .....                                                                      | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | IHGOUT  |
| 16. Thyroid disease? .....                                                           | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | IHTHYR  |
| 17. Other major diseases? .....                                                      | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | IHOTH   |

a. If YES, specify \_\_\_\_\_

E. During the past 12 months have you experienced any of the following?

- |                                                                                   | YES                        | NO                         |         |
|-----------------------------------------------------------------------------------|----------------------------|----------------------------|---------|
| 1. Skin rashes? .....                                                             | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | IHRASH  |
| 2. Frequent stomach pains, bloating, nausea, diarrhea, or loss of appetite? ..... | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | IHSTOM  |
| 3. Unexplained weight loss? .....                                                 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | IHLOSEW |
| 4. Increased thirst (drinking more liquids than usual)? .....                     | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | IHTHRST |
| 5. Urinating more often than usual? .....                                         | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | IHURINT |

Participant's initials

first		last	

Date of birth

month	day	year

Date of visit

month	day	year

Part III / INTERVAL CARDIOVASCULAR HISTORY

F. Thinking about the past 12 months please answer the following questions:

- |                                                          |                            |                            |        |
|----------------------------------------------------------|----------------------------|----------------------------|--------|
|                                                          | YES                        | NO                         |        |
| 1. Have you had any pain or discomfort in your chest?    | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | IRPAIN |
| 2. Have you had any pressure or heaviness in your chest? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | IRPRES |

If Questions 1 AND 2 are NO, skip to Section G.  
If either are YES, continue.

- |                                                                                                     |                                                     |                                                 |         |
|-----------------------------------------------------------------------------------------------------|-----------------------------------------------------|-------------------------------------------------|---------|
| a. Do you get it when you walk uphill or hurry?                                                     | YES<br><input type="checkbox"/> 1                   | NO<br><input type="checkbox"/> 2                | IRHURRY |
| b. Do you get it when you walk at an ordinary pace on the level?                                    | <input type="checkbox"/> 1                          | <input type="checkbox"/> 2                      | IRLEVEL |
| c. When you get it in your chest, what do you do?                                                   | Stop<br><input type="checkbox"/> 1                  | Slow down<br><input type="checkbox"/> 2         | IRDO    |
|                                                                                                     | Continue at same pace<br><input type="checkbox"/> 3 |                                                 |         |
| d. Does it go away when you stand still?                                                            | YES<br><input type="checkbox"/> 1                   | NO<br><input type="checkbox"/> 2                | IRSTILL |
| If YES,                                                                                             |                                                     |                                                 |         |
| i. How Soon?                                                                                        | 10 min. or less<br><input type="checkbox"/> 1       | more than 10 min.<br><input type="checkbox"/> 2 | IRSOON  |
| e. Where do you get this pain or discomfort:                                                        | YES                                                 | NO                                              |         |
| i. Sternum (central chest)?                                                                         | <input type="checkbox"/> 1                          | <input type="checkbox"/> 2                      | IRSTER  |
| ii. Left anterior chest?                                                                            | <input type="checkbox"/> 1                          | <input type="checkbox"/> 2                      |         |
| iii. Left arm?                                                                                      | <input type="checkbox"/> 1                          | <input type="checkbox"/> 2                      |         |
| f. Have you ever had a severe pain across the front of your chest lasting for half an hour or more? | YES<br><input type="checkbox"/> 1                   | NO<br><input type="checkbox"/> 2                | IR30MIN |

Participant's initials

first		last	

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G. Stroke / TIA

1. During the past 12 months, have you had any sudden feeling of numbness, tingling, or loss of feeling in either arm, hand, leg, foot, or face? YES  1 NO  2 ISNUMB
- If YES,
- a. How long did the symptoms last?
- < 1 hour  1
- 1 - 24 hour(s)  2 ISNUMBT
- > 24 hours  3
- 
2. During the past 12 months, have you had any sudden attacks of paralysis, or loss of use of either arm, hand, leg, or foot? YES  1 NO  2 ISPARL
- If YES,
- a. How long did the symptoms last?
- < 1 hour  1
- 1 - 24 hour(s)  2 ISPARLT
- > 24 hours  3
- 
3. During the past 12 months, have you had any sudden loss of eyesight or blurring of vision for a short period of time? YES  1 NO  2 ISBLUR
- If YES,
- a. How long did the symptoms last?
- < 1 hour  1
- 1 - 24 hour(s)  2 ISBLURT
- > 24 hours  3
- 
4. During the past 12 months, have you had any sudden attacks of changes in speech, loss of speech or inability to say words for more than two minutes? YES  1 NO  2 ISLUR
- If YES,
- a. How long did the symptoms last?
- < 1 hour  1
- 1 - 24 hour(s)  2 ISLURT
- > 24 hours  3
- 
5. During the past 12 months, have you had any spells or dizziness, difficulty in walking, lightheadedness or loss of balance? YES  1 NO  2 ISOIZY

Participant's initials

first		last	

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Date of visit

month	day	year

Part IV / INTERVAL DRINKING, SMOKING, ASPIRIN, & ROUTINE CARE HISTORY

H. Drinking Status

1. During the past 12 months, have you consumed an average of at least one alcoholic beverage per week?

YES

NO

IDWK

If YES, for the most recent normal (i.e., usual) week:

a. How many 12 oz bottles of beer did you consume during the past 7 days?

--	--

12 oz Bottles IDBEER

b. How many 4 oz glasses of wine did you consume during the past 7 days?

--	--

4 oz Glasses IDWINE

c. How many 1.5 oz shots of hard liquor or mixed drinks did you consume during the past 7 days?

--	--

1.5 oz Shots IDMIXD

2. During the past 12 months have you ever consumed 7 or more alcoholic beverages (including mixed drinks, shots, beer, and/or wine) within a 24-hour period?

YES

NO

IDBINGE

If YES,

a. About how often is this (that you have had 7 or more drinks within a 24-hour period)?

Once a week or more

No answer

Less than once a month

1 - 3 times per month

IDBTIME

I. Smoking Status

1. During the past 30 days have you ever smoked cigarettes?

YES

NO

IDSMOK

If YES,

a. On average, how many cigarettes per day?

--	--

cigarettes per day

IDSDAY

Participant's initials

first		last	

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Date of visit

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J. Aspirin Status

1. During an average week, how often do you take one or more aspirin tablets?

- Never  1
- Less than 1 day per week  2
- 1 or 2 days per week  3 IASPIR
- 3 to 4 days per week (includes every other day)  4
- 5 or 6 days per week  5
- Every day  6

K. Routine Medical Care

1. During the past 3 months, how many times have you outside the DPP: (none = 0)

- a. called a health care provider?  time(s) IMCHSD
- b. had a regularly scheduled out-patient visit(s)?  time(s) IMCOPV
- c. had urgent care visit(s)?  time(s) IMUCV
- d. had emergency room visit(s)?  time(s) IMCERV

2. During the past 3 months, how many days have you lost from school, work, or household activities due to illness or injury or medical care including visits related to the DPP? (round to nearest half day)

		.		day(s)
<span style="color: blue;">IMCLOST</span>				