

**Singapore Consortium of Cohort Studies (SCCS) – Multiethnic Cohort (MEC)
Health Screening Form**

Date Registered:
Not for Data Entry

**Visit ID
2nd Ref. Number**

Time Registered:

Participants:

- A Have you had a fever for the last 14 days? No Yes; do not proceed _____
Staff Initial
- B For ladies, are you pregnant? N.A No Yes; do not proceed
- C Have you eaten/drink for the last 10 hours? No Yes
- D Are you wearing contact lenses? No Yes; need to remove before any procedures
- E Do you have any known eye diseases/operations? No Yes; please specify: _____
- F Have you been taking any medications? No Yes; please specify: _____
- G Do you have any known drug allergy? No Yes; please specify: _____

For Data entry :

- 1 Have you taken any painkillers / antibiotics in the last 7 days / (for women) having menses currently? No Yes; do not collect urine
- 2 Do you have any known medical history? No Yes; ** High Cholesterol/ Cancer/ Diabetes/ Hypertension/ Heart disease/ Kidney failure/ Stroke/ Other chronic condition; Please specify: _____
- **Please circle**

I certify the above information given by me is correct

Participant 's Signature

Stations	Results	For Data Entry Investigator Code
<u>Station I</u>		
1 Height (cm)	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
2 Weight (kg)	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
3 Waist circumference (cm)	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/>	_____ Staff Initial/Date
4 Hip circumference (cm)	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
5 Blood pressure (mmHg)		
<input type="checkbox"/> Dinamap	Systolic / Diastolic	
<input type="checkbox"/> Digital	1 st <input type="text"/> / <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Manual	2 nd <input type="text"/> / <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
	3 rd <input type="text"/> / <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Take a 3rd reading if difference between 2 readings is >10 mmHg systolic or >5mmHg diastolic		_____ Staff Initial/Date
<u>Station II</u>		
1 Eye drops	<input type="checkbox"/> instilled, time instilled _____ <input type="checkbox"/> Refuse <input type="checkbox"/> Unable	<input type="text"/> <input type="text"/> <input type="text"/> _____ Staff Initial/Date
2 Retinal photography	<input type="checkbox"/> Taken <input type="checkbox"/> Refuse <input type="checkbox"/> Unable	<input type="text"/> <input type="text"/> <input type="text"/> _____ Staff Initial/Date

Stations	Results	For Data Entry Investigator Code										
Station III												
1 Monofilament 5.07 sensory test	No. of sensory points felt <table border="1" style="margin-left: auto; margin-right: auto;"> <tr><td style="padding: 2px;">R</td><td style="padding: 2px;">5</td><td style="width: 40px;"></td></tr> <tr><td style="padding: 2px;">L</td><td style="padding: 2px;">5</td><td></td></tr> </table>	R	5		L	5		<table border="1" style="width: 100%; height: 20px; margin-bottom: 10px;"></table> <hr style="width: 100%;"/> Staff Initial/Date				
R	5											
L	5											
2 Neurothesiometer Reading (Mv)	<table border="1" style="display: inline-table; margin-right: 20px;"> <tr><td style="padding: 2px;">Apex 1st</td><td style="padding: 2px;">R</td><td style="width: 40px;"></td></tr> <tr><td style="padding: 2px;">Med Mal.</td><td style="padding: 2px;">R</td><td></td></tr> </table> <table border="1" style="display: inline-table;"> <tr><td style="padding: 2px;">L</td><td style="width: 40px;"></td></tr> <tr><td style="padding: 2px;">L</td><td></td></tr> </table>	Apex 1 st	R		Med Mal.	R		L		L		<hr style="width: 100%;"/> Staff Initial/Date
Apex 1 st	R											
Med Mal.	R											
L												
L												
3 Brachial BP (mmHg) (systolic reading by Doppler)	1 <table border="1" style="width: 100px; height: 20px;"></table> 2 <table border="1" style="width: 100px; height: 20px;"></table>											
Arm used	<input type="checkbox"/> Left <input type="checkbox"/> Right											
Is this the dominant arm?	<input type="checkbox"/> Yes <input type="checkbox"/> No											
4 Ankle BP (mmHg) (systolic reading by Doppler)	<table style="display: inline-table; margin-right: 20px;"> <tr><td style="padding: 2px;">R1</td><td style="border: 1px solid black; width: 40px; height: 20px;"></td></tr> <tr><td style="padding: 2px;">R2</td><td style="border: 1px solid black; width: 40px; height: 20px;"></td></tr> </table> <table style="display: inline-table;"> <tr><td style="padding: 2px;">L1</td><td style="border: 1px solid black; width: 40px; height: 20px;"></td></tr> <tr><td style="padding: 2px;">L2</td><td style="border: 1px solid black; width: 40px; height: 20px;"></td></tr> </table>	R1		R2		L1		L2				
R1												
R2												
L1												
L2												
Station IV												
1 Blood sample	<input type="checkbox"/> Random <input type="checkbox"/> Fasting											
	Research [STN]											
	<input type="checkbox"/> Plain tube (10ml) <input type="checkbox"/> Refuse <input type="checkbox"/> Unable <input type="checkbox"/> CPT tube (8ml) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> EDTA tube(10ml) <input type="checkbox"/> <input type="checkbox"/>	<table border="1" style="width: 100%; height: 20px; margin-bottom: 10px;"></table> <hr style="width: 100%;"/> Staff Initial/Date										
	Screening [SGH]											
	<input type="checkbox"/> Plain (5ml) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> EDTA (3ml) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fluoride (6ml) <input type="checkbox"/> <input type="checkbox"/>											
2 Urine dipstick (PRO; g/L)	<input type="checkbox"/> Neg <input type="checkbox"/> 1 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Trace <input type="checkbox"/> 3 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 0.3 <input type="checkbox"/> ≥ 20 <input type="checkbox"/> <input type="checkbox"/>	<table border="1" style="width: 100%; height: 20px; margin-bottom: 10px;"></table> <hr style="width: 100%;"/> Staff Initial/Date										
Time of Discharge:	<table border="1" style="width: 100px; height: 20px;"></table>	<table border="1" style="width: 100%; height: 20px; margin-bottom: 10px;"></table> <hr style="width: 100%;"/> Staff Initial/Date										
To return copy of consent form to participant		<hr style="width: 100%;"/> Staff Initial/Date										
Remarks (For data entry only)												
Additional Notes (For site use only; not for data entry)												
<input type="checkbox"/> Time-chit-												
OGTT appt	Date <table border="1" style="width: 150px; height: 20px;"></table> Time <table border="1" style="width: 80px; height: 20px;"></table>	<input type="checkbox"/> Done <table border="1" style="width: 100px; height: 20px; margin-bottom: 10px;"></table> <input type="checkbox"/> Refuse <input type="checkbox"/> Not Applicable <hr style="width: 100%;"/> Staff Initial/Date										