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Dear \_\_\_\_\_,

Thank you for agreeing to participate in the Hispanic Community Health Study/Study of Latinos (HCHS/SOL). Your appointment at the HCHS/SOL Study Center has been scheduled for:

Day: \_\_\_\_\_

Date: \_\_\_\_\_

In case you need to re-schedule your appointment, please call our clinic at **305-243-1828** between 8:00 A.M. and 5:00 P.M., Monday through Friday. On the day of your appointment, **please be ready at 7:00 AM**, when our clinic driver WILL PICK YOU UP. For any emergencies that day before your pick up, please call our driver at **(305) 213- 9152**.

**PLEASE READ THE FOLLOWING INSTRUCTIONS CAREFULLY.**

- ◆ **FASTING** - Unless you have been instructed to the contrary, you should fast. This means that you **should not eat or drink anything (except water) from 12 a. m. (midnight) until your appointment the following morning. Please eat as usual the day before your appointment.** We ask you to do this because the clinic staff will be drawing your blood that morning. A snack will be provided during your visit.
- ◆ **BLOOD DRAWING** - Do not donate blood during the week before your clinic appointment. If it becomes necessary to give a pint of blood or plasma within 7 days of your appointment, please call us and reschedule your appointment.
- ◆ **SMOKING AND PHYSICAL ACTIVITY** - Refrain from smoking or vigorous physical activity at least **one hour** before your appointment.
- ◆ **CLOTHING** - Be prepared to change into a hospital scrub suit or a gown after your arrival; bring or wear comfortable shoes or slippers that are easy to take on and off. Wear loose fitting underwear and leave necklaces at home.
- ◆ **MEDICATIONS** – If you are under the care of a health professional, and he/she has indicated to you to take medications in the morning for your **blood pressure (hypertension) or some heart problems** we ask that you do that. In other words, **take your blood pressure o heart medicine before you come to the clinic, so your blood pressure will be controlled during your visit.**

If you take medications for **diabetes**, we ask that you do **NOT take them that morning**, but bring them to the clinic. We ask that you do this in order to avoid a drop in your sugar during your visit since you will be fasting. Once the clinic staff has taken a blood sample, you will receive a snack, and at this time you can take your medications. If you use insulin, please bring it to the clinic, as well as your syringes, strips to examine blood sugar, and your device to measure your sugar levels.

If you use an **inhalator for asthma or emphysema or another chronic pulmonary illness**, you can use them that morning. If possible, use them at least 2 hours before your appointment. Note the hour that you used them and notify the person who is going to do your lung function exam.

Be sure to bring all your medications and supplements in their original containers that you have used in the past 4 weeks, even if you did not take them regularly. Bring all your medications that have been prescribed by your doctor and also non-prescribed medications and supplements recommended to you by other people. Also bring teas, powders, lotions, syrups or other herbal products or natural remedies that you are accustomed to using even if you got them outside the U.S. Even if you have finished the medications or supplements in the last 4 weeks, please bring the labels or bottles with you to your appointment. (See the Medication Instruction Sheet)

- ◆ **GLASSES** - If you normally wear glasses for reading, please bring them with you and keep them throughout your visit.
- ◆ **PHYSICIAN CONTACT** - Please write down the name and address of your primary care physician on the Contract Information Sheet and bring with you to the HCHS/SOL clinic.
- ◆ **GLUCOSE TOLERANCE TEST** - If you choose to do this test you will not be offered any food or drink once you have consumed the glucola drink, until you have your second blood draw two hours later.
- ◆ **TRACKING INFORMATION**  
On the enclosed Contact Information Sheet, please record the names, addresses and telephone numbers of two contact people to help us keep current on how to locate you in the future.

To help you move through the clinic on schedule, it is most important that you be on time for your appointment. Here is a list of activities for your visit.

Reception  
Urine Specimen  
Blood Pressure Measurement  
Blood Drawing  
Glucose Tolerance Test  
Anthropometry (Body Measurement)

Hearing Test  
Interviews  
Electrocardiogram (ECG)  
Snack  
Dental Exam  
Lung Function Test

**Total Exam Time – 6 to 7 hours**

If you have any questions or a problem with your appointment, please call the clinic at **305-243-1828** between 8:00 A.M. and 5:00 P.M., Monday through Friday.

## HCHS/SOL – BRINGING MEDICATIONS TO THE CLINIC

In the bag we provided, please bring with you to your HCHS/SOL clinic visit all medications you have used within the past four weeks. This includes:

- ◆ Prescription drugs from your physician (either from US or outside US)
- ◆ Prescription drugs you have been given by a friend or a relative
- ◆ Non-prescription drugs (over-the-counter medicines) that you obtained from a drug store, supermarket, or by mail, such as aspirin, cold remedies, vitamins, or the like.
- ◆ Supplements, teas, powders, lotions, syrups or other herbal products or natural remedies purchased in the US or outside of the US.

In order to be sure you have included everything, think about the past four weeks. Have you been ill or did you visit a physician or dentist who might have given you medication? For your convenience a list of typical medications or medical conditions requiring medications is presented below to help you remember any medications to bring with you.

### Medical Conditions

Allergies  
Arthritis, joint problems (for example: cortisone-type medicines, anti-inflammatory drugs)  
Birth Control  
Cancer  
Constipation  
Coughs and colds  
Diabetes (for example: insulin)  
Fever  
Flu, pneumonia  
Headaches  
Heart problems, angina or chest pain (for example: digitalis, nitroglycerin)  
High blood pressure  
Hot flashes  
Infections (for example: penicillin, sulfas, other antibiotics)  
Lung problems (such as asthma, lung disease, emphysema, shortness of breath, wheezing)  
Menstrual problems  
Nausea  
Seizures  
Skin problems  
Thyroid  
Tranquilizers  
  
Ulcers, stomach problems, digestion  
Vascular problems, blood thinning (for example: dicumarol, Coumadin)  
Weight reduction

### Medications

Antacids: liquids, tablets  
Anti-anxiety, anti-depressants  
  
Antihistamine  
Appetite suppressants  
Calcium supplements  
Cholesterol lowering agents  
Cough suppressants  
Decongestants  
Diet pills  
Digestive aids  
Eye, ear, or nose: drops, ointments, sprays  
  
Fish oils  
Hemorrhoidal suppositories  
Herbs or folk remedies  
  
Hormones  
  
Iron or anemia medicines (for example: Geritol)  
Laxatives  
Vitamin or mineral supplements  
Muscle relaxants  
Oral contraceptives  
Pain relievers (for example: Codeine, Darvon, Percodan, Tylenol #3/#4)  
Shots or pills to reduce water in the body  
Sleeping pills  
  
Steroids, cortisone: inhalants, ointments, pills, sprays

## CONTACT INFORMATION SHEET

**YOUR NAME:** \_\_\_\_\_

If you would like us to, we will provide the results of your tests to your doctor. Please fill out the information below and bring it with you to our study center.

**DOCTOR OR CLINIC NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

\_\_\_\_\_

**TELEPHONE NUMBER:** \_\_\_\_\_

If you prefer that we not send the results of your tests to your doctor please, please check the corresponding box when you sign your informed consent form in our study center.

Since we will be contacting you for several more years, we would like to update our information to help us locate you in the future if you move from your current address. Remember that all information is confidential and that anyone we might contact will be told only that we are trying to locate you for this health study.

Please complete the name, address, and telephone number of two close friends or relatives who you are likely to keep in touch with (**BUT WHO DO NOT LIVE WITH YOU**), and who are not planning to move anytime soon. Thank you.

### CONTACT PERSON 1

**NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

\_\_\_\_\_

**TELEPHONE NUMBER:** \_\_\_\_\_

### CONTACT PERSON 2

**NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

\_\_\_\_\_

**TELEPHONE NUMBER:** \_\_\_\_\_