

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 Clinic has been scheduled for:

Day: _____ Date: _____ Time: ____:____ A.M.

Please come to **450 4th Ave. Suite 311, Chula Vista, CA**. A map and directions are attached. For questions, you may call **Johanne Hernandez at 619-205-1923**, between 9am to 4pm, Monday through Friday.

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**. We ask you to do this because the clinic staff will be drawing your blood that morning. A light lunch 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 for the morning session; bring or wear comfortable shoes or slippers that are easy to take on and off. Wear loose fitting underwear and leave jewelry, especially 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 or heart medicine (with water only) 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 examination.

Be sure to bring all 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 Contact 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 locate you in the future.

It is very important that you arrive on time to your appointment. The following activities have been scheduled for your visit, once authorized by you.

Reception	Hearing Test
Collection of a Urine Specimen	Interviews
Blood Pressure Measurement	Electrocardiogram (ECG)
Blood Drawing	Light lunch
Glucose Tolerance Test	Dental Exam
Measurement of height, weight and hips	Lung Function Test

Total Exam Time – Approximately 6 to 7 hours

If you have any questions or a problem with your appointment, please call the clinic at **619-205-1923**, between 9:00 A.M. and 4:00 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. We are very interested in getting a complete record of the medications and supplements you have taken during the past four weeks since they can affect the results of your blood tests. 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; and
- ◆ 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

MEDICAL PROFESSIONAL DESIGNATED BY YOU TO RECEIVE THE RESULTS OF THE TESTS DONE AS PART OF YOUR HCHS/SOL VISIT

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. If instead you prefer that your test results NOT be sent to you physician or usual care professional, please indicate so on this page, record the corresponding name and address, and bring this information to our clinic.

DOCTOR OR CLINIC NAME: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

I PREFER THAT THE RESULTS OF MY TESTS OF THIS HCHS/SOL VISIT BE SENT TO:

NAME: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

If you have indicated that we should not send the results of your tests to your doctor please, check the corresponding box when you sign your informed consent form.

CONTACT INFORMATION

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: _____