



National Institutes of Health

National Institute of Neurological Disorders and Stroke
National Institute on Aging

MarkVCID2 Case Report Form Package: Baseline Visit

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MarkVCID Consortium

By the MarkVCID Clinical Data, Physiological Data & Cognitive Assessments Subcommittee (Deborah Blacker, MD, ScD, Chair) and Coordinating Center (PI Steven Greenberg, MD, PhD).

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ENROLLMENT CRITERIA

Source of recruitment:

Clinic-based

Community-based

MarkVCID1 research study

Other research study (specify name of study): _____

Other source of recruitment (specify): _____

If research study (MarkVCID1 or other), specify original source if known:

Clinic-based

Community-based

Other original source of recruitment (specify): _____

Unknown

Fill out the Eligibility Criteria below at the time of screening. If any criteria are not confirmed during the baseline visit (e.g., a participant is found to have a confounding condition that was not previously known), update the response below accordingly.

Inclusion Criteria - all inclusion criteria must be present ("Yes" is selected)	No	Yes
1. Age 60 years to 90 years	<input type="checkbox"/>	<input type="checkbox"/>
2. Has a diagnosis of normal cognition, subjective cognitive decline, mild cognitive impairment, or mild dementia <i>Note: All participants with normal cognition must also meet at least one criterion for vascular risk (i.e., diabetes OR "hypertension plus" OR an MRI-based risk factor)</i>	<input type="checkbox"/>	<input type="checkbox"/>
3. Fluent in English or Spanish	<input type="checkbox"/>	<input type="checkbox"/>

Exclusion Criteria- all exclusion criteria must be absent ("No" is selected)	No	Yes
1. The participant has confounding neurologic, psychiatric, or medical disease (see page 5 for guidance on exclusionary diseases)	<input type="checkbox"/>	<input type="checkbox"/>
2. The participant has contraindications to MRI	<input type="checkbox"/>	<input type="checkbox"/>
3. The participant has contraindications to study procedures	<input type="checkbox"/>	<input type="checkbox"/>

Indicate the preliminary cognitive diagnosis at the time of screening below, even if it differs from the confirmed cognitive diagnosis:

Please specify the participant's preliminary cognitive diagnosis at the time of screening: See next page for guidance on diagnostic criteria	<input type="checkbox"/> Normal cognition (subjective and objective) <input type="checkbox"/> Subjective cognitive decline (SCD) <input type="checkbox"/> Mild cognitive impairment (MCI) <input type="checkbox"/> Mild dementia
If participant has a preliminary diagnosis of subjective cognitive decline, specify the screening method:	<input type="checkbox"/> Single self-report question (see below) <input type="checkbox"/> Short eCog-12 score \geq 3, based on administration to participant
Single self-report question for screening for SCD:	"Do you think your memory or thinking has gotten worse over the past few years?"

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Criteria for Cognitive Diagnoses	
Normal cognition:	<p>Participant has normal cognition and does not have behavioral or language issues sufficient to diagnose MCI or dementia due to FTD or DLB.</p> <p>Normal cognition is defined as:</p> <ol style="list-style-type: none"> 1.) No diagnosis of SCD, MCI, or dementia; AND 2.) CDR: Sum of Boxes = 0 AND neuropsychological testing within normal range.
SCD, preliminary diagnosis:	<p>Select if the referral source (prior research study, community physician) and/or participant indicate normal cognition and:</p> <ol style="list-style-type: none"> 1.) The Short eCog-12 score ≥ 3 (based on administration to participant), OR 2.) The participant responds "yes" to the single self-report question regarding change in memory/cognition
SCD, confirmed diagnosis:	<p>Select if the participant has:</p> <ol style="list-style-type: none"> 1.) Cognitive concerns based on a Short eCog-12 score ≥ 3 (based on administration to participant), AND 2.) Normal cognition (neuropsychological testing within normal range)
MCI:	<p>Review the criteria listed below to determine whether the subject meets the clinical and cognitive criteria for MCI:</p> <ul style="list-style-type: none"> • Is there a cognitive concern?, i.e., is the subject, the co-participant, or a clinician concerned about a change in cognition compared to the subject's previous level? • Is there impairment in one or more cognitive domains (memory, language, executive function, attention, and visuospatial skills) that is greater than would be expected for the patient's age and educational background? • Is there largely preserved independence in functional abilities (no change from prior level of functioning or requires only extra effort minimal aids or assistance)? • Is there no evidence of dementia (cognitive changes are mild and there is no evidence of a significant impairment in social or occupational functioning)?
Mild Dementia:	<p>Review the criteria listed below to determine whether the subject meets the criteria for all-cause dementia. These criteria are modified from the McKhann all-cause dementia criteria (2011) to allow a single domain to be affected.</p> <p>The subject has cognitive or behavioral (neuropsychiatric) symptoms that meet all of the following criteria:</p> <ul style="list-style-type: none"> • Interfere with ability to function as before at work or at usual activities? • Represent a decline from previous levels of functioning? • Are not explained by delirium or major psychiatric disorder? • Include cognitive impairment detected and diagnosed through a combination of 1) history-taking and 2) objective cognitive assessment (bedside or neuropsychological testing)? <p>AND Impairment in one* or more of the following domains.</p> <ul style="list-style-type: none"> - Impaired ability to acquire and remember new information - Impaired reasoning and handling of complex tasks, poor judgment - Impaired visuospatial abilities - Impaired language functions - Changes in personality, behavior, or comporment <p>* In the event of single-domain impairment (e.g., language in PPA, behavior in bvFTD, posterior cortical atrophy), the subject must not fulfill criteria for MCI.</p> <p>Select if the participant:</p> <ol style="list-style-type: none"> 1.) Meets the criteria for dementia, AND 2.) CDR: Global Score = 0.5 or 1

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Confounding Neurologic, Psychiatric, or Medical Disease

Neurologic diseases excluded based on available data and investigator's impression (exclude those with confounding neurologic disease that would interfere with test performance or with biomarker analysis:

- Frontotemporal lobar degeneration (FTLD)
- Lewy body dementia (LBD)
- Parkinson's disease
- Multi system atrophy
- Traumatic brain injury (TBI)-related cognitive impairment
- TBI that interferes with MRI biomarker analysis (e.g., large volume traumatic lesion)
- Non-small vessel strokes that interfere with test performance (e.g. post-stroke cognitive impairment or aphasia)
- Non-small vessel strokes that interfere with MRI biomarker analysis (e.g., large volume strokes)
- CADASIL (Cerebral Autosomal Dominant Arteriopathy with Sub-cortical Infarcts and Leukoencephalopathy)
- Other neurologic conditions that interfere with test performance or biomarker analysis

Neurologic diseases NOT excluded:

- Alzheimer's (mild dementia CDR score ≤ 1)
- Small Vessel Disease strokes (e.g. lacunar infarcts)
- Non-small vessel strokes or TBI that does not interfere with test performance or MRI

Confounding medical and psychiatric conditions (exclude those with medical and psychiatric conditions that would confound the course or interfere with test performance):

- Schizophrenia or other active/severe psychotic disorders
- Medical or psychiatric conditions likely to interfere with participation or retention (e.g., metastatic or malignant CNS cancer, active /severe depression or anxiety, HIV-Associated Neurocognitive Disorder)
- Contraindications to study procedures (claustrophobia, cardiac pacemaker, intracranial clips/metal implants etc.)

Medical and psychiatric conditions NOT excluded:

- Well controlled depression or anxiety
- Substance use in remission for ≥ 2 years

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VASCULAR RISK CRITERIA

This form must be filled out prior to enrollment for all participants with normal cognition (subjective and objective) to determine eligibility.

Was the subject evaluated for vascular risk criteria? No Yes

Reason not evaluated: _____

Clinical Risk Factor Criteria (choose all that apply based on the subject's medical or research record)

1. Diabetes Was the participant assessed for this vascular risk criterion? No Yes

"Present" must be selected for at least one of the following to meet the "diabetes" criterion:

1a. Fasting (8 hour fast, usually overnight) blood sugar \geq 126 mg/dL (\geq 7 mmol/L, or \geq 1260 mg/L) in the last 5 years	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Unknown
---	---------------------------------	----------------------------------	----------------------------------

If present:

Blood sugar: _____ mg/dL mmol/L mg/L

Date of fasting blood sugar measurement: ____ / ____ / _____

1b. Random or Post-prandial blood sugar \geq 200 mg/dL (\geq 11.11 mmol/L, or \geq 2000 mg/L) in the last 5 years	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Unknown
--	---------------------------------	----------------------------------	----------------------------------

If present:

Blood sugar: _____ mg/dL mmol/L mg/L

Date of blood sugar measurement: ____ / ____ / _____

1c. HbA1c \geq 6.5% (or \geq 47.5412 mmol/mol) in the last 5 years	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Unknown
--	---------------------------------	----------------------------------	----------------------------------

If present:

HbA1c: _____ % mmol/mol

Date of HbA1c measurement: ____ / ____ / _____

1d. Treatment with an anti-diabetic medicine	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Unknown
--	---------------------------------	----------------------------------	----------------------------------

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Clinical Risk Factor Criteria (continued)

2. "Hypertension plus" Was the participant assessed for this vascular risk criterion? No Yes

"Present" must be selected for at least **two** of the following to meet the "hypertension plus" criterion:

2a. Use of anti-hypertensive medications for lowering blood pressure for ≥ 10 years	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Unknown
--	---------------------------------	----------------------------------	----------------------------------

2b. Current use of two or more anti-hypertensive medications for lowering blood pressure	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Unknown
--	---------------------------------	----------------------------------	----------------------------------

2c. One measured blood pressure in a research or clinical setting in the last 2 years with SBP ≥ 140 or DBP ≥ 90	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Unknown
--	---------------------------------	----------------------------------	----------------------------------

If present:
 Blood pressure: ____ / ____ mmHg
 Date of BP measurement: ____ / ____ / _____

2d. A second measured blood pressure in a research or clinical setting on a different date in the last 2 years with SBP ≥ 140 or DBP ≥ 90	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Unknown
---	---------------------------------	----------------------------------	----------------------------------

If present:
 Blood pressure: ____ / ____ mmHg
 Date of BP measurement: ____ / ____ / _____

2e. Evidence of likely HTN end organ damage (e.g., LVH, albuminuria, eGFR <60 , CHF)	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Unknown
--	---------------------------------	----------------------------------	----------------------------------

If present:
 Description of clinical evidence and type of organ damage:

 Date of documented evidence: ____ / ____ / _____

MRI Risk Factor Criteria (choose all that apply based on the subject's pre-existing MRI)

Was the participant assessed for MRI-based vascular risk criteria? No Yes

If yes, date of pre-existing MRI: ____ / ____ / _____

1. Peri-Ventricular Fazekas Extent Grade or Deep Fazekas Extent Grade ≥ 2	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Unknown
--	---------------------------------	----------------------------------	----------------------------------

2. 1 or more microbleeds	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Unknown
--------------------------	---------------------------------	----------------------------------	----------------------------------

3. 1 or more lacunar infarcts	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Unknown
-------------------------------	---------------------------------	----------------------------------	----------------------------------

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ENROLLMENT CONFIRMATION CHECKLIST

Does the participant satisfy all inclusion and exclusion criteria? No Yes

If the participant has normal cognition, do they meet at least one criterion for vascular risk? No Yes N/A

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DEMOGRAPHICS AND RELATED ELEMENTS

Collected? No Yes

Reason not collected: _____

Date of Collection: _ _ / _ _ / _ _ _ _ (MM/DD/YYYY)

Sex: Male Female

Year of birth: _____

Does the subject report being of Hispanic/Latino ethnicity (i.e., having origins from a mainly Spanish-speaking Latin American country), regardless of race? No Yes Unknown

If yes, what are the subject's reported origins?

Read or show the choices, if required, and allow only one category choice

- | | | |
|--|---|---|
| <input type="checkbox"/> Mexican, Chicano, or Mexican-American | <input type="checkbox"/> Puerto Rican | <input type="checkbox"/> Cuban |
| <input type="checkbox"/> Dominican | <input type="checkbox"/> Central American | <input type="checkbox"/> South American |
| <input type="checkbox"/> Other (specify): _____ | | <input type="checkbox"/> Unknown |

What does the subject report as his or her race?

*NIH defines race and Hispanic ethnicity separately; therefore, please do not enter "Hispanic" or the subject's specific Hispanic origins. If the subject identifies only as Hispanic, select **Unknown**. If the subject reports their race as multiracial, select **Other (specify)**, and specify "multiracial". Allow only one category choice; there will be an opportunity to record other applicable race categories in the following questions*

- | | |
|---|--|
| <input type="checkbox"/> White | <input type="checkbox"/> Black or African American |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Native Hawaiian or other Pacific Islander |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Unknown | |

What additional race does the subject report?

If the subject or co-participant reports an additional race for the subject, select the box that corresponds to this additional race. Do not record a race that was already provided in the previous question.

- | | |
|---|--|
| <input type="checkbox"/> White | <input type="checkbox"/> Black or African American |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Native Hawaiian or other Pacific Islander |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> None reported | <input type="checkbox"/> Unknown |

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DEMOGRAPHICS AND RELATED ELEMENTS (continued)

What additional race, beyond those reported above, does the subject report?

Do not record a race that was already provided in the previous two questions.

- | | |
|---|--|
| <input type="checkbox"/> White | <input type="checkbox"/> Black or African American |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Native Hawaiian or other Pacific Islander |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> None reported | <input type="checkbox"/> Unknown |

Subject's primary language:

Record the language that the subject (or co-participant) speaks and writes best.

- | | | |
|--|----------------------------------|-----------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> Spanish | <input type="checkbox"/> Mandarin |
| <input type="checkbox"/> Cantonese | <input type="checkbox"/> Russian | <input type="checkbox"/> Japanese |
| <input type="checkbox"/> Other primary language (specify): _____ | <input type="checkbox"/> Unknown | |

If English is not the subject's primary language, is the subject fluent in English? No Yes Unknown

Is the subject left- or right-handed (for example, which hand would s/he normally use to write or throw a ball)?

- | | | | |
|--------------------------------------|---------------------------------------|---------------------------------------|----------------------------------|
| <input type="checkbox"/> Left-handed | <input type="checkbox"/> Right-handed | <input type="checkbox"/> Ambidextrous | <input type="checkbox"/> Unknown |
|--------------------------------------|---------------------------------------|---------------------------------------|----------------------------------|

Subject's current marital status:

***Living as married** may be applied to either heterosexual or same-sex relationships. Select **Unknown** only if the subject or co-participant is unable or unwilling to identify the subject's marital status.*

- | | |
|-----------------------------------|---|
| <input type="checkbox"/> Married | <input type="checkbox"/> Never married (or marriage was annulled) |
| <input type="checkbox"/> Widowed | <input type="checkbox"/> Living as married/domestic partner |
| <input type="checkbox"/> Divorced | <input type="checkbox"/> Separated <input type="checkbox"/> Unknown |

What is the subject's living situation?

- Lives alone
- Lives with one other person: a spouse or partner
- Lives with one other person: a relative, friend, or roommate
- Lives with caregiver who is not spouse/partner, relative, or friend
- Lives with a group (related or not related) in a private residence
- Lives in group home (e.g., assisted living, nursing home, convent)
- Unknown

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DEMOGRAPHICS AND RELATED ELEMENTS (continued)

What is the subject's level of independence?

Select the box for the category that most accurately describes the level of activity the subject is able to do. If the subject or co-participant indicates that the subject is able to perform complex activities but is not doing the activities because of her/his living situation, the subject is still considered to be able to live independently.

- Able to live independently
- Requires some assistance with complex activities
- Requires some assistance with basic activities
- Completely dependent
- Unknown

ZIP Code (first three digits) of subject's primary residence: _____ Unknown

Occupation during most of working career:

*Using the Hollingshead Index found in the appendix, first identify the category (1-7) of the subject's occupation, based on their skill level and experience. Then, within that category, select the occupation that most closely corresponds to the subject's reported occupation. If a suitable occupation is not listed, select the **Other, specify** option within the appropriate category, and record the occupation in the space provided.*

Occupation Category Number: _____

Occupation: _____

If other, specify: _____

Subject's years of education — use the codes below to report the level achieved; if an attempted level is not completed, enter the number of years completed: _____ Unknown

(12 years = high school or GED, 16 years = bachelor's degree, 18 years = master's degree, 20 years = doctorate) If the subject has not completed a level, enter the total number of years of education completed toward that level.

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MEDICAL AND NEUROLOGICAL HISTORY

Collected? No Yes

Reason not collected: _____

Date of Collection: ____ / ____ / ____ (MM/DD/YYYY)

HISTORY OF CIGARETTE SMOKING	No	Yes	Unknown
1. Has the subject smoked within the last 30 days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Has the subject smoked more than 100 cigarettes in her/his life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*If No or Unknown, skip to question to **Cardiovascular Disease** section*

2a. Total years smoked: ____ [Range: 0-87] Unknown

If the exact number of years smoked is unknown, ask the subject and/or co-participant to estimate.

2b. Average number of packs smoked per day:

<input type="checkbox"/> 1 cigarette to less than ½ pack	<input type="checkbox"/> ½ pack to less than 1 pack
<input type="checkbox"/> 1 pack to less than 1½ packs	<input type="checkbox"/> 1½ packs to less than 2 packs
<input type="checkbox"/> 2 packs or more	<input type="checkbox"/> Unknown

2c. If the subject has quit smoking, specify that age at which he/she last smoked (i.e., quit): ____ N/A Unknown

*If the exact age is unknown, ask the subject and/or co-participant to estimate. If he/she still smokes, select **N/A**. If he/she cannot estimate, select **Unknown** checkbox.*

*For the sections below, record the presence or absence of a **history** of these conditions **at this visit**, as determined by the clinician's best judgment following the medical history interview with the subject and informant. A condition should be considered....*

- **Absent** IF it is not indicated by information obtained from the subject and co-participant interview.
- **Recent/ active** IF it happened within the last year or still requires active management and is consistent with information obtained from the subject and co-participant interview.
- **Remote/ inactive** IF it existed or occurred in the past (more than one year ago) but was resolved or there is no treatment currently under way.
- **Unknown** IF there is insufficient information available from the subject and co-participant interview.

CARDIOVASCULAR DISEASE	Absent	Recent/active	Remote/inactive	Unknown
1. Heart attack/cardiac arrest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1a. If not Absent or Unknown, more than one heart attack?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown	
1b. Age at most recent heart attack: ____	<input type="checkbox"/> Unknown			

*If the exact age is unknown, ask the subject and/or co-participant to estimate. If he/she cannot estimate, select **Unknown** checkbox.*

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CARDIOVASCULAR DISEASE (cont.)	Absent	Recent/active	Remote/inactive	Unknown
2. Atrial fibrillation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Angioplasty/ endarterectomy/ stent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Cardiac bypass procedure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Pacemaker and/or defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Heart valve replacement or repair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type of replacement/repair (select all that apply):	<input type="checkbox"/> Mitral <input type="checkbox"/> Aortic <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify): _____			
Type of replacement (select all that apply):	<input type="checkbox"/> Bioprosthetic <input type="checkbox"/> Mechanical <input type="checkbox"/> Unknown <input type="checkbox"/> N/A			
<i>For Questions 9-11, ask whether the subject has any cardiovascular disease other than those listed in Questions 1-8. If no, select Absent. If yes, record the condition in the space provided and select the appropriate box to specify whether Recent/ active or Remote/ inactive.</i>				
<i>For other cardiovascular disease, enter 'N/A' if absent</i>	Absent	Recent/active	Remote/inactive	Unknown
9. Other cardiovascular disease (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Other cardiovascular disease (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Other cardiovascular disease (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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CEREBROVASCULAR HISTORY

History of Symptomatic Stroke/ Acute Vascular Event? No Yes Unknown

*This question is focused on reported history of stroke. Include stroke reported during the interview with the subject and/or co-participant. Imaging evidence of a stroke or evidence from a physical exam are not required as this question is focused on reported history. For 'Age at Event', if the exact age is unknown, ask the subject and/or co-participant to estimate. If s/he cannot estimate, select **Unknown** checkbox.*

*To answer whether the event is temporally associated with persistent worsening of cognition, temporal relationship is defined in two ways: either 1) when the event occurred, there was a stepwise decline in cognition; or 2) the event was followed by cognitive decline noted within three to six months. Select **Yes** if either of these two conditions is present. Select **No** if there is a no history of cognitive decline within six months the event.*

If yes, complete the following:

Event	Age at Event	Type of Symptomatic Stroke/Acute Vascular Event	Temporally associated with persistent worsening of cognition?
Stroke/Acute Vascular Event 1	<p style="text-align: center;">_ _ _</p> <input type="checkbox"/> Unknown	<input type="checkbox"/> Ischemic <input type="checkbox"/> Stroke type unknown <input type="checkbox"/> TIA with clear ischemic mechanism <input type="checkbox"/> Hemorrhagic	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Stroke/Acute Vascular Event 2	<p style="text-align: center;">_ _ _</p> <input type="checkbox"/> Unknown	<input type="checkbox"/> Ischemic <input type="checkbox"/> Stroke type unknown <input type="checkbox"/> TIA with clear ischemic mechanism <input type="checkbox"/> Hemorrhagic	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Stroke/Acute Vascular Event 3	<p style="text-align: center;">_ _ _</p> <input type="checkbox"/> Unknown	<input type="checkbox"/> Ischemic <input type="checkbox"/> Stroke type unknown <input type="checkbox"/> TIA with clear ischemic mechanism <input type="checkbox"/> Hemorrhagic	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Stroke/Acute Vascular Event 4	<p style="text-align: center;">_ _ _</p> <input type="checkbox"/> Unknown	<input type="checkbox"/> Ischemic <input type="checkbox"/> Stroke type unknown <input type="checkbox"/> TIA with clear ischemic mechanism <input type="checkbox"/> Hemorrhagic	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Stroke/Acute Vascular Event 5	<p style="text-align: center;">_ _ _</p> <input type="checkbox"/> Unknown	<input type="checkbox"/> Ischemic <input type="checkbox"/> Stroke type unknown <input type="checkbox"/> TIA with clear ischemic mechanism <input type="checkbox"/> Hemorrhagic	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown

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NEUROLOGIC CONDITIONS

Condition	Absent	Recent/active	Remote/inactive	Unknown
1. Essential tremor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Pseudobulbar affect (i.e., crying or laughing that appears involuntary and out-of-proportion to the situation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Traumatic brain injury (TBI)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Include any reported TBI, including mild TBI and TBI without loss of consciousness

If TBI recent/active or remote/inactive:

- | | | |
|--|--|----------------------------------|
| a. TBI with brief loss of consciousness (< 5 minutes) | <input type="checkbox"/> No | <input type="checkbox"/> Single |
| | <input type="checkbox"/> Repeated/multiple | <input type="checkbox"/> Unknown |
| b. TBI with extended loss of consciousness (≥ 5 minutes) | <input type="checkbox"/> No | <input type="checkbox"/> Single |
| | <input type="checkbox"/> Repeated/multiple | <input type="checkbox"/> Unknown |
| c. TBI without loss of consciousness (as might result from military detonations or sports injuries)? | <input type="checkbox"/> No | <input type="checkbox"/> Single |
| | <input type="checkbox"/> Repeated/multiple | <input type="checkbox"/> Unknown |

*If the subject has experienced multiple TBIs with loss of consciousness, but the time unconscious is unknown for all instances, select **Unknown** for Questions 2a and 2b. If for any of questions 2a, 2b, or 2c, the subject knows there has definitely been at least a single instance, but is unsure whether there has been more than one, select **Single**, and revise the entry on this form to **Repeated/multiple** at a future date if more specific information is available at a future date.*

d. Age at most recent TB: ___ ___ Unknown

*If exact age is unknown, ask the subject and/or co-participant to estimate. If he/she cannot estimate, select **Unknown** checkbox.*

MEDICAL CONDITIONS

If any of the conditions still require active management and/or medications, please select "Recent/active."

Condition	Absent	Recent/active	Remote/inactive	Unknown
1. Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1a. If recent/active or remote/inactive, which type?	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Other type (latent autoimmune diabetes/ type 1.5, gestational diabetes) <input type="checkbox"/> Unknown			
1b. Age of onset: ___ ___	<input type="checkbox"/> Unknown			
2. Diagnosis of hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2a. Is hypertension treated?	<input type="checkbox"/> No <input type="checkbox"/> Yes			
2b. Age of onset: ___ ___	<input type="checkbox"/> Unknown			

MarkVCID2 CRF Package: Baseline Visit

Patient ID: _ _ _ _ _

MEDICAL CONDITIONS (continued)

Condition	Absent	Recent/active	Remote/inactive	Unknown
3. Hypercholesterolemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3a. Age of onset: _ _ <input type="checkbox"/> Unknown				
4. B12 deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6a. Type of arthritis: <input type="checkbox"/> Rheumatoid <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown				
<i>If subject has both rheumatoid arthritis and osteoarthritis, select Rheumatoid.</i>				
6b. Region(s) affected (check all that apply): <input type="checkbox"/> Upper extremity <input type="checkbox"/> Lower extremity <input type="checkbox"/> Spine <input type="checkbox"/> Unknown				
7. Incontinence – urinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Incontinence – bowel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9a. Age of onset: _ _ <input type="checkbox"/> Unknown				
10. REM sleep behavior disorder (RBD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Hyposomnia/insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SUBSTANCE ABUSE

	Absent	Recent/active	Remote/inactive	Unknown
1. Alcohol abuse: clinically significant impairment occurring over a 12-month period manifested in one of the following areas: work, driving, legal, or social	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Other abused substances: clinically significant impairment occurring over a 12-month period manifested in one of the following areas: work, driving, legal, or social	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2a. If recent/active or remote/inactive, specify abused substance: _____				
<i>If multiple substances other than alcohol were used in the past, and at least one of the substances was used in the last 12 months, and it resulted in impairment in work, driving, legal, or social situations, select Recent/active and describe the abused substances in the space provided. If multiple substances were used but not within the past 12 months, select Remote/inactive and describe the substances in the space provided.</i>				

MarkVCID2 CRF Package: Baseline Visit

Patient ID: ___ ___ ___ ___ ___ ___ ___ ___ ___

FAMILY HISTORY

Collected? No Yes

Reason not collected: _____

Date of Collection: ___ ___ / ___ ___ / ___ ___ ___ ___ (MM/DD/YYYY)

FAMILY HISTORY

	No	Yes	Unknown
--	----	-----	---------

1. STROKE/TIA: Is there a family history in a first degree relative of symptomatic stroke or TIA with clear ischemic mechanism?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

*Select **Yes** if there are biological parents, full siblings, or biological children who have a history of symptomatic stroke and/or TIA with clear ischemic mechanism*

If yes:

1a. Any cases with onset before age 55?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

1b. Is there a pattern suggestive of an autosomal dominant family history?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

*Select **Yes** if history of stroke and/or TIA with clear ischemic mechanism appears in every known generation of one side of the family (e.g., mother's family or father's family)*

2. ACQUIRED COGNITIVE IMPAIRMENT: Is there a family history in a first degree relative of cognitive impairment or dementia or Alzheimer's disease?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

*Select **Yes** if there are biological parents, full siblings, or biological children who are affected by dementia, Alzheimer's disease, or have history of cognitive impairment*

If yes:

2a. Any report of a case in the family with autopsy confirmation of Alzheimer's disease?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

2b. Any report of cases with autopsy confirmation of another cause of dementia?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

2c. Any cases with onset before age 65?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

2d. Is there a pattern suggestive of an autosomal dominant family history?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

*Select **Yes** if history of acquired cognitive impairment appears in every known generation of one side of the family (e.g., mother's family or father's family)*

3. **If yes** to EITHER autosomal dominant questions above (1b, 2d), complete the following:

3a. Is there a known mutation? No Yes

3b. If yes, please indicate which one: PSEN1 APP PSEN2 CADASIL

Other, specify gene if known: _____

Specify mutation if known: _____

*Although blood relatives might have evidence for more than one genetic mutation, indicate the predominant mutation only. Evidence may be provided via family report, test, or other report or documentation. First, specify the gene. Then, indicate the mutation, if known. If the gene is not listed, select **Other** and specify the gene.*

3c. Does this individual carry the mutation? No Yes Unknown

MarkVCID2 CRF Package: Baseline Visit

Patient ID: _____

GENERAL PHYSICAL MEASURES

Were General Physical Measures performed? No Yes

If No, please provide the primary reason: Physical problem Cognitive/behavior problem
 Verbal refusal Other problem (specify): _____

Date of Collection: ____ / ____ / ____ (MM/DD/YYYY)

VITAL SIGNS

If any vitals cannot be obtained, skip and select 'Not Done' in the EDC.

1. Blood Pressure Measurement 1: ____ / ____ mmHg Not Done
 Blood Pressure Measurement 2: ____ / ____ mmHg Not Done
 Blood Pressure Measurement 3: ____ / ____ mmHg Not Done

Measure seated at rest. Take 3 consecutive BP readings. Average will be calculated in EDC. If blood pressure cannot be obtained, skip and select 'Not Done' in the EDC.

2. Pulse: ____ beats/minute Not Done

3. Height: ____ . ____ cm in Not Done

4. Weight: ____ . ____ kg lb Not Done

ADDITIONAL PHYSICAL OBSERVATIONS

No

Yes

Unknown

1. With or without corrective lenses, is the subject's vision functionally normal?

*Select **No** if any functional impairment exists (reduced ability to do everyday activities such as reading or watching television).*

2. With or without a hearing aid(s), is the subject's hearing functionally normal?

*Select **No** if any functional impairment exists (reduced ability to do everyday activities such as listening to the radio or television, talking with family or friends).*

SHORT PHYSICAL PERFORMANCE BATTERY

Please refer to the MarkVCID Short Physical Performance Battery Training Manual for detailed instructions on the administration of this assessment.

KEY: If the subject cannot complete any of the following exams, please give the reason by entering one of the following codes:

95 = Physical problem

96 = Cognitive/behavior problem

97 = Other problem

98 = Verbal refusal (not for any of the reasons 95-97)

1. Balance Test Score: (*Side-by-side, semi-tandem, tandem*) ____ [0-4, 95-98]

2. Gait Speed Test Score: ____ [0-4, 95-98]

3. Chair Stand Test Score: ____ [0-4, 95-98]

MarkVCID2 CRF Package: Baseline Visit

Patient ID: _____

NEUROLOGICAL EXAM

INSTRUCTIONS: This form must be completed by a clinician with experience in assessing the neurological signs listed below and in attributing the observed findings to a particular syndrome. Please use your best clinical judgment in assigning the syndrome.

Use the information obtained at the neurological exam to indicate the neurological findings, using your best clinical judgment to ascribe those symptoms to a particular clinical syndrome.

Please complete the appropriate sections below, using your best clinical judgment in selecting findings that indicate the likely syndrome(s) that is/are present.

Was the Neurological Exam performed? No Yes

If No, please provide the primary reason: Physical problem Cognitive/behavior problem
 Verbal refusal Other problem (specify): _____

Date of Collection: ____ / ____ / ____ (MM/DD/YYYY)

PARKINSONIAN FEATURES

Were Parkinsonian signs present? No Yes

*If any of the parkinsonian signs listed below are present, select **Yes**. Otherwise, select **No** and skip to **Cerebrovascular Features** section*

Resting tremor – arm: *a definite rest tremor, even if only intermittent, is sufficient to select **Yes***

Slowing of fine motor movements: *refers to movements such as finger tapping, hand pronation-supination, or foot- or toe-tapping. Significant slowing, even if slight or mild, is sufficient to select **Yes**.*

Rigidity – arm: *rigidity should be judged on passive movement of major joints with patient relaxed in sitting position; cogwheeling and paratonia (gegenhalten) to be ignored. Any degree of rigidity is sufficient to select **Yes**.*

Bradykinesia: *includes combining slowness, hesitancy, decreased arm swing, small amplitude, and poverty of movement in general. Any degree of overall bradykinesia is sufficient to select **Yes**.*

Parkinsonian gait disorder: *features include slowing of gait, shuffling, festination, unilateral or bilateral decreased arm swing and/or tremor, slowness and difficulty on turning, and/or freezing during walking. Any degree of parkinsonian gait is sufficient to select **Yes**.*

Postural instability: *involves inadequate response to sudden, strong posterior displacement produced by pull on shoulders while patient is erect with eyes open and feet slightly apart; patient is prepared. Taking more than two steps or requiring the examiner to catch the subject are examples of postural instability. Any degree of postural instability is sufficient to select **Yes**.*

MarkVCID2 CRF Package: Baseline Visit

Patient ID: _ _ _ _ _ _ _ _ _ _

Parkinsonian Signs: LEFT	No	Yes	Not Assessed
1. Resting tremor – arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Slowing of fine motor movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Rigidity – arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parkinsonian Signs: RIGHT	No	Yes	Not Assessed
4. Resting tremor – arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Slowing of fine motor movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Rigidity – arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parkinsonian Signs:	No	Yes	Not Assessed
7. Bradykinesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Parkinsonian gait disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Postural instability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CEREBROVASCULAR FEATURES			
Were neurological signs considered by examiner to be most likely consistent with cerebrovascular disease present? <input type="checkbox"/> No <input type="checkbox"/> Yes			
<i>If any of the signs consistent with CVD below are present, select Yes; otherwise, select No and skip to Other Findings section.</i>			
Cortical cognitive deficit (e.g., aphasia, apraxia, neglect) Lateralized motor weakness: indicate as present if it is suspected that there is acquired proximal or distal extremity weakness attributable to cerebrovascular ischemia. Lateralized abnormal reflexes (to include pathologically brisk deep tendon reflexes, Babinski signs, others): Indicate as present if it is suspected that there are brisk reflexes or increased tone attributable to cerebrovascular ischemia. Cortical visual field loss: involves homonymous hemianopsia or quadrantanopsia, or cortical blindness, excluding visual field loss due to optic nerve disease or injury. Somatosensory loss: involves sensory loss due to involvement of the cerebrum or brain stem, excluding sensory loss due to spinal-cord injury or peripheral neuropathy.			
Findings consistent with stroke / cerebrovascular disease	No	Yes	Not Assessed
1. Cortical cognitive deficit (e.g., aphasia, apraxia, neglect)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Findings consistent with stroke / cerebrovascular disease: LEFT SIDE OF BODY	No	Yes	Not Assessed
2. Lateralized motor weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Lateralized abnormal reflexes (to include pathologically brisk deep tendon reflexes, Babinski signs, others)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Cortical visual field loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Somatosensory loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MarkVCID2 CRF Package: Baseline Visit

Patient ID: _ _ _ _ _

Findings consistent with stroke / cerebrovascular disease: RIGHT SIDE OF BODY	No	Yes	Not Assessed
6. Lateralized motor weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Lateralized abnormal reflexes (to include pathologically brisk deep tendon reflexes, Babinski signs, others)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Cortical visual field loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Somatosensory loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OTHER FINDINGS	No	Yes	Not Assessed
1. Patient demonstrates spontaneous, disproportionate or involuntary crying or laughing on examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Is magnetic gait apraxia present?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Indicate whether gait apraxia characteristic of normal-pressure hydrocephalus or bilateral subcortical ischemia is present by selecting Yes. This determination should be made based on the neurological exam and does not require an MRI.</i>			
3. Higher cortical visual problem suggesting posterior cortical atrophy (e.g., prosopagnosia, simultagnosia, Balint's syndrome) or apraxia of gaze	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Findings suggestive of progressive supranuclear palsy (PSP), corticobasal syndrome (CBS), or other related disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Findings suggesting ALS (e.g., muscle wasting, fasciculations, upper motor neuron and/or lower motor neuron signs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MarkVCID2 CRF Package: Baseline Visit

Patient ID: _____

COGNITIVE DIAGNOSIS

Evaluated? No Yes

Reason not evaluated: _____

Date of Evaluation: ____ / ____ / _____ (MM/DD/YYYY)

SYNDROMIC DIAGNOSIS
(see page 4 for diagnostic criteria)

Normal Cognition
 Subjective cognitive decline (SCD)

Mild cognitive impairment (MCI)
 Mild dementia

Age of Onset of SCD, MC,I or mild dementia: ____ years Unknown

If any of the diseases listed below are present, select **Present** and indicate whether it is a **Contributing** cause, or **not contributing** to the cognitive impairment. If any disease is present but the subject has normal cognition, select **Present** and select the **Non-contributing** box.

RELATED DIAGNOSES	Present		Contributing	Non-contributing
	No	Yes		
Alzheimer's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vascular brain injury (based on clinical or imaging evidence)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If present , indicate type of vascular brain injury (select all that apply): <input type="checkbox"/> Small vessel stroke(s) <input type="checkbox"/> Non-small vessel stroke that does not interfere with test performance or MRI <input type="checkbox"/> Non-small vessel stroke that interferes with test performance (e.g., post-stroke cognitive impairment or aphasia)* <input type="checkbox"/> Non-small vessel stroke that interferes with MRI biomarker analysis (e.g., large volume strokes)*				
Traumatic brain injury (TBI)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If present , indicate severity (select all that apply): <input type="checkbox"/> TBI that does not interfere with test performance or MRI <input type="checkbox"/> TBI that interferes with test performance (e.g., post-TBI cognitive impairment or aphasia)* <input type="checkbox"/> TBI that interferes with MRI biomarker analysis (e.g., large volume traumatic lesion)*				
Depression or anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If present: <input type="checkbox"/> Mild/well-controlled <input type="checkbox"/> Severe/incompletely controlled*				
Alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If present: Current alcohol abuse <input type="checkbox"/> No <input type="checkbox"/> Yes* <input type="checkbox"/> Unknown				
Hydrocephalus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CNS neoplasm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If present: <input type="checkbox"/> Benign <input type="checkbox"/> Malignant*				
Delirium	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post-traumatic stress disorder (PTSD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Diagnosis at this severity excluded at baseline; may appear at follow-up visit

MarkVCID2 CRF Package: Baseline Visit

Patient ID: _____

RELATED DIAGNOSES (Diagnoses excluded at baseline; may appear at follow-up visit)	Present	Contributing	Non-contributing
Multiple system atrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frontotemporal lobar degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Huntington's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prion disease (CJD, other)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV-Associated Neurocognitive Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia or other psychosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lewy body disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OTHER DIAGNOSES	Present	Contributing	Non-contributing
Other psychiatric disease (specify): _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other neurologic, genetic, or infectious conditions not listed above (specify): _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Systemic disease/medical illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cognitive impairment due to medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cognitive impairment NOS: _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MarkVCID2 CRF Package: Baseline Visit

Patient ID: _____

MoCA (MONTREAL COGNITIVE ASSESSMENT)

Please refer to the MarkVCID Evaluator's Instructions Manual for detailed instructions on the administration of this assessment

Was any part of the MoCA administered? No Yes

If No, please provide the primary reason: Physical problem Cognitive/behavior problem Verbal refusal Other problem (specify): _____

Date of Examination: ____ / ____ / ____ (MM/DD/YYYY)

Method of Administration: In-person Video

Language of test administration: English Spanish Other (specify): _____

KEY: If the subject cannot complete any of the following exams, please give the reason by entering one of the following codes:

95 = Physical problem
97 = Other problem
96 = Cognitive/behavior problem
98 = Verbal refusal (not for any of the reasons 95-97)

Score is 'Not Assessed' if any of the MoCA items that contribute to the score are missing (i.e., items 1-6, 8-14, and 17-22). Items 7, 15, and 16 are not part of the MoCA score calculation; therefore, these items can have missing values (95, 96, 97, or 98). The MoCA Score will still be computed in the EDC as long as items 1-6, 8-14, and 17-22 are all non-missing.

Scores for items 1-5 correspond to the Visuospatial / executive section on the MoCA worksheet

1. Visuospatial/ executive — Trails: ____ [0-1, 95-98]

2. Visuospatial/ executive — Cube: ____ [0-1, 95-98]

3. Visuospatial/ executive — Clock contour: ____ [0-1, 95-98]

4. Visuospatial/ executive — Clock numbers: ____ [0-1, 95-98]

5. Visuospatial/ executive — Clock hands: ____ [0-1, 95-98]

Score for item 6 corresponds to the Naming section on the MoCA worksheet

6. Language — Naming: ____ [0-3, 95-98]

Score for item 7 corresponds to the Memory section on the MoCA worksheet

7. Memory — Registration (two trials): ____ [0-10, 95-98]

Scores for items 8-10 correspond to the Attention section on the MoCA worksheet

8. Attention — Digits: ____ [0-2, 95-98]

9. Attention — Letter A: ____ [0-1, 95-98]

10. Attention — Serial 7s: ____ [0-3, 95-98]

MarkVCID2 CRF Package: Baseline Visit

Patient ID: ___ ___ ___ ___ ___ ___ ___ ___ ___

MoCA (continued)

Scores for items 11-12 correspond to the Language section on the MoCA worksheet

11. Language — Repetition: ___ ___ [0-2, 95-98]

12. Language — Fluency: ___ ___ [0-1, 95-98]

Score for item 13 corresponds to the Abstraction section on the MoCA worksheet

13. Abstraction: ___ ___ [0-2, 95-98]

Scores for items 14-16 correspond to the Delayed Recall section on the MoCA worksheet

14. Delayed recall — No cue: ___ ___ [0-5, 95-98]

(if not completed, enter reason code and skip to question 17)

15. Delayed recall — Category cue: ___ ___ [0-5, 95-98]

16. Delayed recall — Recognition: ___ ___ [0-5, 95-98]

Scores for items 17-22 correspond to the Orientation section on the MoCA worksheet

17. Orientation — Date: ___ ___ [0-1, 95-98]

18. Orientation — Month: ___ ___ [0-1, 95-98]

19. Orientation — Year: ___ ___ [0-1, 95-98]

20. Orientation — Day: ___ ___ [0-1, 95-98]

21. Orientation — Place: ___ ___ [0-1, 95-98]

22. Orientation — City: ___ ___ [0-1, 95-98]

MarkVCID2 CRF Package: Baseline Visit

Patient ID: _ _ _ _ _ _ _ _ _ _

Blind MoCA (MONTREAL COGNITIVE ASSESSMENT)

Please refer to the MarkVCID Evaluator's Instructions Manual for detailed instructions on the administration of this assessment

Was any part of the Blind MoCA administered? No Yes

If No, please provide the primary reason: Physical problem Cognitive/behavior problem
 Verbal refusal Other problem (specify): _____

Date of Examination: ___ ___ / ___ ___ / ___ ___ ___ ___ (MM/DD/YYYY)

Method of Administration: In-person Phone

Language of test administration: English Spanish
 Other (specify): _____

KEY: If the subject cannot complete any of the following exams, please give the reason by entering one of the following codes:

95 = Physical problem 96 = Cognitive/behavior problem
97 = Other problem 98 = Verbal refusal (not for any of the reasons 95-97)

Score is 'Not Assessed' if any of the Blind MoCA items that contribute to the score are missing (i.e., items 8-14 and 17-22). Items 7, 15, and 16 are not part of the Blind MoCA score calculation; therefore, these items can have missing values (95, 96, 97, or 98). The Blind MoCA Score will still be computed as long as items 8-14, and 17-22 are all non-missing.

Score for item 7 corresponds to the Memory section on the Blind MoCA worksheet

7. Memory — Registration (two trials): ___ ___ [0-10, 95-98]

Scores for items 8-10 correspond to the Attention section on the Blind MoCA worksheet

8. Attention — Digits: ___ ___ [0-2, 95-98]

9. Attention — Letter A: ___ ___ [0-1, 95-98]

10. Attention — Serial 7s: ___ ___ [0-3, 95-98]

Scores for items 11-12 correspond to the Language section on the Blind MoCA worksheet

11. Language — Repetition: ___ ___ [0-2, 95-98]

12. Language — Fluency: ___ ___ [0-1, 95-98]

Score for item 13 corresponds to the Abstraction section on the Blind MoCA worksheet

13. Abstraction: ___ ___ [0-2, 95-98]

MarkVCID2 CRF Package: Baseline Visit

Patient ID: _ _ _ _ _ _ _ _ _ _

Blind MoCA (continued)

Scores for items 14-16 correspond to the Delayed Recall section on the Blind MoCA worksheet

14. Delayed recall — No cue: _____ [0-5, 95-98]

(if not completed, enter reason code and skip to question 17)

15. Delayed recall — Category cue: _____ [0-5, 95-98]

16. Delayed recall — Recognition: _____ [0-5, 95-98]

Scores for items 17-22 correspond to the Orientation section on the Blind MoCA worksheet

17. Orientation — Date: _____ [0-1, 95-98]

18. Orientation — Month: _____ [0-1, 95-98]

19. Orientation — Year: _____ [0-1, 95-98]

20. Orientation — Day: _____ [0-1, 95-98]

21. Orientation — Place: _____ [0-1, 95-98]

22. Orientation — City: _____ [0-1, 95-98]

MarkVCID2 CRF Package: Baseline Visit

Patient ID: _____

NEUROPSYCHOLOGICAL TESTING BATTERY

Please refer to the MarkVCID Evaluator's Instructions Manual for detailed instructions on the administration of this assessment

Was any part of the Neuropsychological Testing Battery administered? No Yes

If No, please provide the primary reason: Physical problem Cognitive/behavior problem
 Verbal refusal Other problem (specify): _____

Date of Examination: ____ / ____ / ____ (MM/DD/YYYY)

Language of test administration: English Spanish
 Other (specify): _____

Indicate the primary language used when administering the remainder of the tests.

KEY: If the subject cannot complete any of the following exams, please give the reason by entering one of the following codes:

- 94 = Test not administered as part of battery at this session (where applicable)
- 95 = Physical problem
- 96 = Cognitive/behavior problem
- 97 = Other problem
- 98 = Verbal refusal (not for any of the reasons 94-97)

Scores for item 1 correspond to the Craft Store 21 Recall (Immediate) Worksheets

1. Craft Story 21 Recall (Immediate):
 - a) If test not completed, enter reason code and skip to question 2a: ____ [95-98]
 - b) Total story units recalled, verbatim scoring: ____ [0-44]
 - c) Total story units recalled, paraphrase scoring: ____ [0-25]Method of Administration: In-person Video Phone

Scores for item 2 correspond to the Craft Store 21 Recall (Delayed) Worksheets

2. Craft Story 21 Recall (Delayed):
 - a) If test not completed, enter reason code and skip to question 3a: ____ [95-98]
 - b) Total story units recalled, verbatim scoring: ____ [0-44]
 - c) Total story units recalled, paraphrase scoring: ____ [0-25]
 - d) Delay time (minutes): Unknown ____ [0-85]
 - e) Cue ("boy") needed: No Yes

MarkVCID2 CRF Package: Baseline Visit

Patient ID: _ _ _ _ _ _ _ _ _ _

Scores for items 3-4 correspond to the Number Span Test (Forward & Backward) Worksheets

3. Number Span Test — Forward:

a) If test not completed, enter reason code and skip to question 4a: _ _ _ [95-98]

b) Number of correct trials: _ _ _ [0-14]

c) Longest span forward: _ _ _ [0, 3-9]

Method of Administration: In-person Video Phone

4. Number Span Test — Backward:

a) If test not completed, enter reason code and skip to question 5a: _ _ _ [95-98]

b) Number of correct trials: _ _ _ [0-14]

c) Longest span backward: _ _ _ [0, 2-8]

Scores for item 5 correspond to the Category Fluency Worksheets

5. Category Fluency – Animals:

a) If test not completed, enter reason code and skip to question 6a: _ _ _ [95-98]

b) Total number of animals named in 60 seconds: _ _ _ [0-77]

Method of Administration: In-person Video Phone

Scores for item 6 correspond to the Verbal Fluency Worksheets, administered as part of the MoCA

6. Verbal Fluency – Phonemic Tests (words beginning with F):

a) If test not completed, enter reason code and skip to question 7a: _ _ _ [95-98]

b) Number of correct F-words generated in 1 minute: _ _ _ [0-40]

c) Number of F-words repeated in 1 minute: _ _ _ [0-15]

d) Number of non-F-words and rule violation errors in 1 minute: _ _ _ [0-15]

Scores for items 7-8 correspond to the Trail Making A & B Worksheets

7. Trail Making Test A:

a) If test not completed, enter reason code and skip to question 8a: _ _ _ [94-98]

b) Total number of seconds to complete (if not finished by 150 seconds, enter 150) _ _ _ [0-150]

i. Number of commission errors: _ _ _ [0-40]

ii. Number of correct lines: _ _ _ [0-24]

8. Trail Making Test B:

a) If test not completed, enter reason code and skip to question 9a: _ _ _ [94-98]

b) Total number of seconds to complete (if not finished by 300 seconds, enter 300): _ _ _ [0-300]

i. Number of commission errors: _ _ _ [0-40]

ii. Number of correct lines: _ _ _ [0-24]

MarkVCID2 CRF Package: Baseline Visit

Patient ID: _ _ _ _ _ _ _ _ _ _

*Scores for item 9 correspond to the Multilingual Naming Test (MINT) Worksheets
If no semantic cues were given, select N/A for Question 9e.
If no phonemic cues were given, select N/A for Question 9g.*

9. Multilingual Naming Test (MINT):

- a) If test not completed, enter reason code and skip to question 10a: ___ [94-98]
- b) Total score (9c + 9e): ___ [0-32]
- c) Total correct without any cues (Uncued): ___ [0-32]
- d) Semantic cues – Number given: ___ [0-32]
- e) Semantic cues – Number correct with cue: N/A ___ [0-32]
- f) Phonemic cues – Number given: ___ [0-32]
- g) Phonemic cues – Number correct with cue: N/A ___ [0-32]
- Method of Administration: In-person Video

Scores for item 10 correspond to your sites specific scoring instructions for the CVLT, CVLT-SF, HVLTL, SEVLT, or other with list learning with immediate/delay/recognition

10. Word list learning with immediate/delay/recognition:

- a) Name of test: HVLTL CVLT
 CVLT-SF SEVLT [Spanish]
 Other (specify): _____
- b) Total number of words on list: ___
- c) If test not completed, enter reason code and skip to question 11a: ___ [95-98]
- d) Learning Trial 1: ___
- e) Learning Trial 2: ___
- f) Learning Trial 3: ___
- g) Learning Trial 4: N/A ___
- h) Learning Trial 5: N/A ___
- i) Delay duration (if multiple options choose longest): ___
- j) Delayed recall (if multiple delay options, choose longest): ___
- k) Recognition hits: ___
- l) Recognition false positives: ___
- Method of Administration: In-person Video Phone

MarkVCID2 CRF Package: Baseline Visit

Patient ID: _ _ _ _ _ _ _ _ _ _

Scores for item 11 correspond to the Verbal Naming Test Worksheet

11. Verbal Naming:

- a) If test not completed, enter reason code and skip to question 12a: ___ ___ [94-98]
b) Total correct without a cue: ___ ___ [0-50]
c) Total correct with phonemic cue: ___ ___ [0-50]

Scores for items 12-13 correspond to the Oral Trail Making Test Parts A & B Worksheets

12. Oral Trail Making Test A:

- a) If test not completed, enter reason code and skip to question 13a: ___ ___ [94-98]
b) Total number of seconds to complete: ___ ___ ___ [0-100]
(if not finished by 100 seconds, enter 100)
i. Number of errors: ___ ___ [0-25]
ii. Total number correct: ___ ___ [0-25]

Method of Administration: In-person Video Phone

13. Oral Trail Making Test B:

- a) If test not completed, enter reason code: ___ ___ [94-98]
b) Total number of seconds to complete: ___ ___ ___ [0-300]
(if not finished by 300 seconds, enter 300)
i. Number of errors: ___ ___ [0-25]
ii. Total number correct: ___ ___ [0-25]

MarkVCID2 CRF Package: Baseline Visit

Patient ID: _ _ _ _ _

CO-PARTICIPANT/INFORMANT QUESTIONNAIRE

Collected? No Yes

If No, please provide reason: _____

Date Collected: _ _ / _ _ / _ _ _ _ (MM/DD/YYYY)

Language of test administration: English Spanish Other (specify): _____

What is co-participant's relationship to the subject?	<input type="checkbox"/> Spouse, partner, or companion (include ex-spouse, ex-partner, fiancé(e), boyfriend, girlfriend) <input type="checkbox"/> Child (by blood or through marriage or adoption) <input type="checkbox"/> Sibling (by blood or through marriage or adoption) <input type="checkbox"/> Other relative (by blood or through marriage or adoption) <input type="checkbox"/> Friend, neighbor, or someone known through family, friends, work, or community (e.g., church) <input type="checkbox"/> Paid caregiver, health care provider, or clinician
How long has the co-participant known the subject?	<input type="checkbox"/> 1 year or less <input type="checkbox"/> 2-5 years <input type="checkbox"/> 6-9 years <input type="checkbox"/> 10+ years
Does the co-participant live with the subject?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If no, approximate frequency of in-person visits?	<input type="checkbox"/> Daily <input type="checkbox"/> At least three times per week <input type="checkbox"/> Weekly <input type="checkbox"/> At least three times per month <input type="checkbox"/> Monthly <input type="checkbox"/> Less than once a month
If no, approximate frequency of telephone contact?	<input type="checkbox"/> Daily <input type="checkbox"/> At least three times per week <input type="checkbox"/> Weekly <input type="checkbox"/> At least three times per month <input type="checkbox"/> Monthly <input type="checkbox"/> Less than once a month

MarkVCID2 CRF Package: Baseline Visit

Patient ID: _ _ _ _ _

CDR (CLINICAL DEMENTIA RATING)

Please refer to the MarkVCID Evaluator's Instructions Manual for detailed instructions on the administration of this assessment

Was the CDR administered? No Yes

If No, please provide the primary reason: Physical problem Cognitive/behavior problem
 Verbal refusal Other problem (specify): _____

Date of Evaluation: ___ / ___ / _____ (MM/DD/YYYY)

Method of Administration: In-person Video Phone

Language of test administration: English Spanish Other (specify): _____

Section 1: Standard CDR

<i>Please enter score below:</i>	IMPAIRMENT				
	None - 0	Questionable - 0.5	Mild - 1	Moderate - 2	Severe - 3
1. Memory ____	No memory loss, or slight inconsistent forgetfulness	Consistent slight forgetfulness; partial recollection of events; "benign" forgetfulness	Moderate memory loss, more marked for recent events; defect interferes with everyday activities	Severe memory loss; only highly learned material retained; new material rapidly lost	Severe memory loss; only fragments remain
2. Orientation ____	Fully oriented	Fully oriented except for slight difficulty with time relationships	Moderate difficulty with time relationships; oriented for place at examination; may have geographic disorientation elsewhere	Severe difficulty with time relationships; usually disoriented to time, often to place	Oriented to person only
3. Judgment and problem solving ____	Solves everyday problems, handles business and financial affairs well; judgment good in relation to past performance	Slight impairment in solving problems, similarities, and differences	Moderate difficulty in handling problems, similarities, and differences; social judgment usually maintained	Severely impaired in handling problems, similarities, and differences; social judgment usually impaired	Unable to make judgments or solve problems
4. Community affairs ____	Independent function at usual level in job, shopping, volunteer and social groups	Slight impairment in these activities	Unable to function independently at these activities, although may still be engaged in some; appears normal to casual inspection	No pretense of independent function outside the home; appears well enough to be taken to functions outside the family home	No pretense of independent function outside the home; appears too ill to be taken to functions outside the family home

MarkVCID2 CRF Package: Baseline Visit

Patient ID: _ _ _ _ _

Section 1: Standard CDR (continued)

Please enter score below:	IMPAIRMENT				
	None - 0	Questionable - 0.5	Mild - 1	Moderate - 2	Severe - 3
5. Home and hobbies _ . _	Life at home, hobbies, and intellectual interests well maintained	Life at home, hobbies, and intellectual interests slightly impaired	Mild but definite impairment of function at home; more difficult chores abandoned; more complicated hobbies and interests abandoned	Only simple chores preserved; very restricted interests, poorly maintained	No significant function in the home
6. Personal care _ . 0	Fully capable of self-care (= 0).		Needs prompting	Requires assistance in dressing, hygiene, keeping of personal effects	Requires much help with personal care; frequent incontinence
7. _ _ _ STANDARD CDR SUM OF BOXES (auto-calculated in EDC)					
8. _ _ _ STANDARD GLOBAL CDR					

Section 2: Supplemental CDR

Please enter score below:	IMPAIRMENT				
	None - 0	Questionable - 0.5	Mild - 1	Moderate - 2	Severe - 3
9. Behavior, comporment, and personality _ . _	Socially appropriate behavior	Questionable changes in comporment, empathy, appropriateness of actions	Mild but definite changes in behavior	Moderate behavioral changes, affecting interpersonal relationships and interactions in a significant manner	Severe behavioral changes, making interpersonal interactions all unidirectional
10. Language _ . _	No language difficulty, or occasional mild tip-of-the tongue	Consistent mild word-finding difficulties; simplification of word choice; circumlocution; decreased phrase length; and/or mild comprehension difficulties	Moderate word-finding difficulty in speech; cannot name objects in environment; reduced phrase length and/or agrammatical speech and/or reduced comprehension in conversation and reading	Moderate to severe impairments in either speech or comprehension; has difficulty communicating thoughts; writing may be slightly more effective	Severe comprehension deficits; no intelligible speech

MarkVCID2 CRF Package: Baseline Visit

Patient ID: _ _ _ _ _

GDS (GERIATRIC DEPRESSION SCALE)

Please refer to the MarkVCID Evaluator's Instructions Manual for detailed instructions on the administration of this assessment

Was the GDS administered? No Yes

If No, please provide the primary reason: Physical problem Cognitive/behavior problem
 Verbal refusal Other problem (specify): _____

Date of Evaluation: ___ / ___ / _____ (MM/DD/YYYY)

Language of test administration: English Spanish Other (specify): _____

Scores for items 1-15 correspond to the Geriatric Depression Scale (GDS) Worksheet

	Yes	No	Did not answer
1. Are you basically satisfied with your life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you dropped many of your activities and interests?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you feel that your life is empty?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you often get bored?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you in good spirits most of the time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you afraid that something bad is going to happen to you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you feel happy most of the time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you often feel helpless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you prefer to stay at home, rather than going out and doing new things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you feel you have more problems with memory than most people?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you think it is wonderful to be alive?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you feel pretty worthless the way you are now?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you feel full of energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Do you feel that your situation is hopeless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you think that most people are better off than you are?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MarkVCID2 CRF Package: Baseline Visit

Patient ID: _____

ECOG-12 (EVERYDAY COGNITION): PARTICIPANT

Please refer to the MarkVCID Evaluator's Instructions Manual for detailed instructions on the administration of this assessment

Was the ECOG-12 Participant Form administered? No Yes

If No, please provide the primary reason: Physical problem Cognitive/behavior problem
 Verbal refusal Other problem (specify): _____

Date of Evaluation: ____ / ____ / ____ (MM/DD/YYYY)

Language of test administration: English Spanish Other (specify): _____

Are you worried or believe that you are having problems with your attention, concentration, or memory? No Yes

Compared to 10 years ago, have there been any changes in your ability to...	Better or no change	Questionable or occasionally worse	Consistently a little worse	Consistently much worse	Don't Know or N/A
1. Remember where you have placed things (i.e glasses, keys)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Remember the current date or day of the week?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Communicate thoughts in a conversation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Understand spoken directions or instructions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Read a map and help with directions when someone else is driving?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Find one's way around a house/building that you have visited many times?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Anticipate weather changes and planning accordingly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Think ahead?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Keep your living and workspace organized?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Balance your checkbook/account without error?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Do two things at once?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Cook or work, and talk at the same time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Was the questionnaire discontinued? No Yes

If yes, reason for discontinuation: Refusal Task difficulty (i.e., could not understand)
 Impairment (i.e., visual, hearing, limb/motor problem)

MarkVCID2 CRF Package: Baseline Visit

Patient ID: _____

ECOG-12 (EVERYDAY COGNITION): INFORMANT

Please refer to the MarkVCID Evaluator's Instructions Manual for detailed instructions on the administration of this assessment

Was the ECOG-12 Informant Form administered? No Yes

If No, please provide the primary reason: Physical problem Cognitive/behavior problem
 Verbal refusal Other problem (specify): _____

Date of Evaluation: ____ / ____ / ____ (MM/DD/YYYY)

Language of test administration: English Spanish Other (specify): _____

How long have you known the participant? <10 years At least 10 years

Are you worried or believe that he/she is having problems with their attention, concentration, or memory? No Yes

Compared to 10 years ago, have there been any changes in their ability to...	Better or no change	Questionable or occasionally worse	Consistently a little worse	Consistently much worse	Don't Know or N/A
1. Remember where they have placed things (glasses, keys)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Remember the current date or day of the week?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Communicate thoughts in a conversation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Understand spoken directions or instructions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Read a map and help with directions when someone else is driving?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Find their way around a house/building that you have visited many times?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Anticipate weather changes and planning accordingly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Think ahead?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Keep their living and workspace organized?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Balance their checkbook/account without error?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Do two things at once?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Cook or work, and talk at the same time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Was the questionnaire discontinued? No Yes

If yes, reason for discontinuation: Refusal Task difficulty (i.e., could not understand)
 Impairment (i.e., visual, hearing, limb/motor problem)

MarkVCID2 CRF Package: Baseline Visit

Patient ID: _ _ _ _ _ _ _ _ _ _

NEUROPSYCHIATRIC INVENTORY QUESTIONNAIRE (NPI-Q) – INFORMANT ASSESSMENT

Please refer to the MarkVCID Evaluator's Instructions Manual for detailed instructions on the administration of this assessment

Was the NPI-Q administered? No Yes

If No, please provide the primary reason: Physical problem Cognitive/behavior problem
 Verbal refusal Other problem (specify): _____

Date of Evaluation: ___ / ___ / _____ (MM/DD/YYYY)

Language of test administration: English Spanish Other (specify): _____

NPI co-participant: Spouse Child Other (specify): _____

Question	Yes	No	Unknown	If Yes, Severity
1. Delusions — Does the patient have false beliefs, such as thinking that others are stealing from him/her or planning to harm him/her in some way?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unknown
2. Hallucinations — Does the patient have hallucinations such as false visions or voices? Does he or she seem to hear or see things that are not present?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unknown
3. Agitation/aggression — Is the patient resistive to help from others at times, or hard to handle?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unknown
4. Depression/dysphoria — Does the patient seem sad or say that he/she is depressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unknown
5. Anxiety — Does the patient become upset when separated from you? Does he/she have any other signs of nervousness such as shortness of breath, sighing, being unable to relax, or feeling excessively tense?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unknown
6. Elation/euphoria — Does the patient appear to feel too good or act excessively happy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unknown
7. Apathy/ indifference — Does the patient seem less interested in his/her usual activities or in the activities and plans of others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unknown

MarkVCID2 CRF Package: Baseline Visit

Patient ID: _ _ _ _ _

Question	Yes	No	Unknown	If Yes, Severity
8. Disinhibition — Does the patient seem to act impulsively, for example, talking to strangers as if he/she knows them, or saying things that may hurt people’s feelings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unknown
9. Irritability/lability — Is the patient impatient and cranky? Does he/she have difficulty coping with delays or waiting for planned activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unknown
10. Motor disturbance — Does the patient engage in repetitive activities such as pacing around the house, handling buttons, wrapping string, or doing other things repeatedly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unknown
11. Nighttime behaviors — Does the patient awaken you during the night, rise too early in the morning, or take excessive naps during the day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unknown
12. Appetite/eating — Has the patient lost or gained weight, or had a change in the type of food he/she likes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unknown

MarkVCID2 CRF Package: Baseline Visit

Patient ID: _____

LABORATORY TESTS

Were Laboratory Test results recorded? No Yes

Reason not collected: _____

Only enter test results from labs conducted within the last 3 months.

If fasting conditions are unknown, mark "not fasting".

*All tests denoted with * are required. Cholesterol related labs, blood sugar, and homocysteine should be collected under fasting conditions when possible.*

PHYSIOLOGIC MEASURES

Not Done	Measure	Date of Collection	Fasting	Result	Unit
<input type="checkbox"/>	1. HS-CRP	___/___/_____	N/A	---	<input type="checkbox"/> nmol/L <input type="checkbox"/> g/L <input type="checkbox"/> mg/L
<input type="checkbox"/>	2. HbA1c*	___/___/_____	N/A	---	<input type="checkbox"/> mmol/mol <input type="checkbox"/> %
<input type="checkbox"/>	3. Blood Sugar	___/___/_____	<input type="checkbox"/> Fasting >8 hours <input type="checkbox"/> Not fasting	---	<input type="checkbox"/> mmol/L <input type="checkbox"/> mg/dL <input type="checkbox"/> mg/L
<input type="checkbox"/>	4. Serum cholesterol*	___/___/_____	<input type="checkbox"/> Fasting >8 hours <input type="checkbox"/> Not fasting	---	<input type="checkbox"/> mg/dL <input type="checkbox"/> mmol/L
<input type="checkbox"/>	5. HDL cholesterol*	___/___/_____	<input type="checkbox"/> Fasting >8 hours <input type="checkbox"/> Not fasting	---	<input type="checkbox"/> mg/dL <input type="checkbox"/> mmol/L
<input type="checkbox"/>	6. LDL cholesterol*	___/___/_____	<input type="checkbox"/> Fasting >8 hours <input type="checkbox"/> Not fasting	---	<input type="checkbox"/> mg/dL <input type="checkbox"/> mmol/L
<input type="checkbox"/>	7. Triglycerides*	___/___/_____	<input type="checkbox"/> Fasting >8 hours <input type="checkbox"/> Not fasting	---	<input type="checkbox"/> mg/dL <input type="checkbox"/> mmol/L
<input type="checkbox"/>	8. Homocysteine	___/___/_____	<input type="checkbox"/> Fasting >8 hours <input type="checkbox"/> Not fasting	---	<input type="checkbox"/> mg/dL <input type="checkbox"/> umol/L <input type="checkbox"/> mg/L
<input type="checkbox"/>	9. Serum creatinine*	___/___/_____	N/A	---	<input type="checkbox"/> mg/dL <input type="checkbox"/> umol/L
<input type="checkbox"/>	10. Serum cystatin C	___/___/_____	N/A	---	<input type="checkbox"/> mg/L <input type="checkbox"/> mg/dL

GENETICS

Have any genetic tests been performed? No Yes

If yes:

APOE genotype: E2/E2 E2/E3 E2/E4 E3/E3
 E3/E4 E4/E4 Not Done

Has a GWAS been completed? No Yes

MarkVCID2 CRF Package: Baseline Visit

Patient ID: _ _ _ _ _

SAMPLE COLLECTION: PLASMA COLLECTION

Status: Collected Not Collected

Reason not collected: _____

Date Plasma Samples Collected: ___ / ___ / _____ (MM/DD/YYYY)

Time since last meal: ___ (hours)

Time Collected: ___ : ___ (24 hour clock)

Collector's Initials: ___ (enter dash if no middle name)

Number of 0.25 mL plasma aliquots: ___

Plasma cryovials used: Wheaton CryoElite
 Simport Micrewtube
 VWR Screw-Cap Microcentrifuge tubes
 Other (specify): _____

Plasma cryovial volume: 0.5 ml Other (specify): _____

Number of 1 mL packed cell aliquots for DNA: ___ °

Temperature of Centrifugation: ___ °C

Did plasma remain pink after centrifugation, indicating hemolysis? No Yes

Storage temperature: ___ °C

Were there any deviations? No Yes

If YES, indicate deviations below (select all that apply):

- Sample tube was not inverted 5-10 times
- Sample not spun within 2 hours of collection
 - Spun 2-3 hours after collection
 - Spun 3-4 hours after collection
 - Spun 4+ hours after collection
- Sample not spun at 2000g
 - Spun slower than 2000g
 - Spun faster than 2000g
- Sample not spun for 10 minutes
 - Spun <10 minutes
 - Spun >10 minutes
- Sample not placed on dry ice or in -80° C freezer immediately after aliquoting
 - Placed on dry ice or in freezer within 30 minutes of aliquoting
 - Placed on dry ice or in freezer 30-60 minutes after aliquoting
 - Placed on dry ice or in freezer 60+ minutes after aliquoting
- Other deviation (specify): _____

MarkVCID2 CRF Package: Baseline Visit

Patient ID: _ _ _ _ _

SAMPLE COLLECTION: SERUM COLLECTION

Status: Collected Not Collected

Reason not collected: _____

Date Serum Samples Collected: ___ / ___ / _____ (MM/DD/YYYY)

Time since last meal: ___ (hours)

Time Collected: ___ : ___ (24 hour clock)

Collector's Initials: ___ (enter dash if no middle name)

Number of 0.25 mL aliquots: ___

Serum cryovials used: Wheaton CryoElite
 Simport Micrewtube
 VWR Screw-Cap Microcentrifuge tubes
 Other (specify): _____

Serum cryovial volume: 0.5 ml Other (specify): _____

Temperature of Centrifugation: ___ °C

Did serum remain pink after centrifugation, indicating hemolysis? No Yes

Storage temperature: ___ °C

Were there any deviations? No Yes

If YES, indicate deviations below (select all that apply):

- After collection, sample not allowed to sit in vertical position for 30-60 minutes
(select all that apply):
 - Sample not kept vertical
 - Sample did not sit for 30-60 minutes after collection
 - Sample sat <30 minutes
 - Sample sat >60 minutes
- Sample not spun at 2000g
 - Spun slower than 2000g
 - Spun faster than 2000g
- Sample not spun for 10 minutes
 - Spun <10 minutes
 - Spun >10 minutes
- Sample not placed on dry ice or in -80° C freezer immediately after aliquoting
 - Placed on dry ice or in freezer within 30 minutes of aliquoting
 - Placed on dry ice or in freezer 30-60 minutes after aliquoting
 - Placed on dry ice or in freezer 60+ minutes after aliquoting
- Other deviation (specify): _____

MarkVCID2 CRF Package: Baseline Visit

Patient ID: _____

IMAGING

Was an MRI performed at this visit? No Yes

If no, please provide reason: Claustrophobia
 Other reason: _____

Date of Imaging: ___ / ___ / _____ (MM/DD/YYYY)

Was a Fazekas score assigned? No Yes

Peri-Ventricular Fazekas Extent Grade:	<input type="checkbox"/> Grade 0 - No lesions <input type="checkbox"/> Grade 1 - Caps or pencil-thin lining <input type="checkbox"/> Grade 2 - Smooth haloing <input type="checkbox"/> Grade 3 - Irregular WMH extending into DWM <input type="checkbox"/> Unknown/ N/A
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Deep Fazekas Extent Grade:	<input type="checkbox"/> Grade 0 - No lesions <input type="checkbox"/> Grade 1 - Punctate lesions <input type="checkbox"/> Grade 2 - Beginning confluent lesions <input type="checkbox"/> Grade 3 - Confluent lesions <input type="checkbox"/> Unknown/ N/A
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Deep Fazekas Lesion Count Grade:	<input type="checkbox"/> Grade 0 - No lesions <input type="checkbox"/> Grade 1 - 1-4 lesions <input type="checkbox"/> Grade 2 - 5-9 lesions <input type="checkbox"/> Grade 3 - >9 lesions <input type="checkbox"/> Unknown/ N/A
----------------------------------	---

Overall Fazekas Score : _____ *(Maximum score of Peri-Ventricular Fazekas Extent Grade, Deep Fazekas Extent Grade, Deep Fazekas Lesion Count Grade)*

MarkVCID2 CRF Package: Baseline Visit

Patient ID: _ _ _ _ _

MEDICATIONS

Were the patient's medications recorded? No Yes

If not collected, reason not collected: _____

Date of Collection: _ _ / _ _ / _ _ _ _ (MM/DD/YYYY)

Is the patient currently taking any medications? No Yes

Currently Taking	Medication Name
<input type="checkbox"/>	acetaminophen-Hydrocodone (Vicodin)
<input type="checkbox"/>	Albuterol (Proventil, Ventolin, Volmax)
<input type="checkbox"/>	alendronate (Fosamax)
<input type="checkbox"/>	allopurinol (Aloprim, Lopurin, Zyloprim)
<input type="checkbox"/>	alprazolam (Niravam, Xanax)
<input type="checkbox"/>	amlodipine (Norvasc)
<input type="checkbox"/>	atenolol (Senormin, Tenormin)
<input type="checkbox"/>	atorvastatin (Lipitor)
<input type="checkbox"/>	benazepril (Lotensin)
<input type="checkbox"/>	bupropion (Budeprion, Wellbutrin, Zyban)
<input type="checkbox"/>	calcium acetate (Calphron, PhosLo)
<input type="checkbox"/>	carbidopa-levodopa (Atamet, Sinemet)
<input type="checkbox"/>	carvedilol (Coreg, Carvedilol)
<input type="checkbox"/>	celecoxib (Celebrex)
<input type="checkbox"/>	cetirizine (Zyrtec)
<input type="checkbox"/>	citalopram (Celexa)
<input type="checkbox"/>	clonazepam (Klonopin)
<input type="checkbox"/>	clopidogrel (Plavix)

Currently Taking	Medication Name
<input type="checkbox"/>	conjugate estrogens (Cenestin, Premarin)
<input type="checkbox"/>	cyanocobalamin (Neuroforte-R, Vitamin B12)
<input type="checkbox"/>	digoxin (Digitek, Lanoxin)
<input type="checkbox"/>	diltiazem (Cardizem, Tiazac)
<input type="checkbox"/>	donepezil (Aricept)
<input type="checkbox"/>	duloxetine (Cymbalta)
<input type="checkbox"/>	enalapril (Vasotec)
<input type="checkbox"/>	ergocalciferol (Calciferol, Disdol, Vitamin D)
<input type="checkbox"/>	escitalopram (Lexapro)
<input type="checkbox"/>	esomeprazole (Nexium)
<input type="checkbox"/>	estradiol (Estrace, Estrogel, Fempatch)
<input type="checkbox"/>	ezetimibe (Zetia)
<input type="checkbox"/>	ferrous sulfate (FeroSul, Iron Supplement)
<input type="checkbox"/>	fexofenadine (Allegra)
<input type="checkbox"/>	finasteride (Propecia, Proscar)
<input type="checkbox"/>	fluoxetine (Prozac)
<input type="checkbox"/>	fluticasone (Flovent)
<input type="checkbox"/>	fluticasone nasal (Flonase, Veramyst)

MarkVCID2 CRF Package: Baseline Visit

Patient ID: _ _ _ _ _

Currently Taking	Medication Name
<input type="checkbox"/>	fluticasone-salmeterol (Advair)
<input type="checkbox"/>	furosemide (Lasix)
<input type="checkbox"/>	gabapentin (Neurontin)
<input type="checkbox"/>	galantamine (Razadyne, Reminyl)
<input type="checkbox"/>	glipizide (Glucotrol)
<input type="checkbox"/>	hydrochlorothiazide (Esidrix, Hydrodiuril)
<input type="checkbox"/>	hydrochlorothiazide-triamterene (Dyazide)
<input type="checkbox"/>	latanoprost ophthalmic (Xalatan)
<input type="checkbox"/>	levothyroxine (Levothroid, Levoxyl, Synthroid)
<input type="checkbox"/>	lisinopril (Prinivil, Zestril)
<input type="checkbox"/>	lorazepam (Ativan)
<input type="checkbox"/>	losartan (Cozaar)
<input type="checkbox"/>	lovastatin (Altacor, Mevacor)
<input type="checkbox"/>	meloxicam (Meloxicam, Mobic)
<input type="checkbox"/>	memantine (Namenda)
<input type="checkbox"/>	metformin (Glucophage, Riomet)
<input type="checkbox"/>	metoprolol (Lopressor, Toprol-XL)
<input type="checkbox"/>	mirtazapine (Remeron)
<input type="checkbox"/>	montelukast (Singulair)
<input type="checkbox"/>	naproxen (Aleve, Anaprox, Naprosyn)
<input type="checkbox"/>	niacin (Niacor, Nico-400, Nicotinic Acid)
<input type="checkbox"/>	nifedipine (Adalat, Procardia)
<input type="checkbox"/>	nitroglycerin (Nitro-Bid, Nitro-Dur, Nitrostat)

Currently Taking	Medication Name
<input type="checkbox"/>	omega-3 polyunsaturated fatty acids (Omacor, Lovaza)
<input type="checkbox"/>	omeprazole (Prilosec)
<input type="checkbox"/>	oxybutynin (Ditropan, Urotrol)
<input type="checkbox"/>	pantoprazole (Protonix)
<input type="checkbox"/>	paroxetine (Paxil, Paxil CR, Pexeva)
<input type="checkbox"/>	potassium chloride (K-Dur 10, K-Lor, Slow-K)
<input type="checkbox"/>	pravastatin (Pravachol)
<input type="checkbox"/>	quetiapine (Seroquel)
<input type="checkbox"/>	ranitidine (Zantac)
<input type="checkbox"/>	rivastigmine (Exelon)
<input type="checkbox"/>	rosuvastatin (Crestor)
<input type="checkbox"/>	sertraline (Zoloft)
<input type="checkbox"/>	simvastatin (Zocor)
<input type="checkbox"/>	tamsulosin (Flomax)
<input type="checkbox"/>	terazosin (Hytrin)
<input type="checkbox"/>	tramadol (Ryzolt, Ultram)
<input type="checkbox"/>	trazodone (Desyrel)
<input type="checkbox"/>	valsartan (Diovan)
<input type="checkbox"/>	venlafaxine (Effexor)
<input type="checkbox"/>	warfarin (Coumadin, Jantoven)
<input type="checkbox"/>	zolpidem (Ambien)

MarkVCID COMMON DATA ELEMENTS

HOLLINGSHEAD INDEX

1 - Major Professionals/ Higher Executives/ Proprietors of Large Concerns
Administrator of Business
Architects
Bank Presidents
Business Owners
Certified Public Accountant
Chief Executive/CEO, CFO, COO
Clergy
Commissioned Officers in the Military
Dentists
Economists
Engineers/ Masters level and above
Executive Vice President
Lawyers/ Judges
Major Contractors
Physicians
President of a Large Company
Professor/ University Teachers
Psychologists
Research Scientists/ PhD
Veterinarians
VP of Large Business
Other/unknown major professional etc.
2 - Lesser Professionals/ Business Managers of Medium-Sized Businesses
Accountants
Advertising Executives
Art Director
Branch Managers
Building Contractors
Business Managers
Chiropractors
Computer Programmer

Database Developer
Engineers- no advanced degree
Executive Managers
Farm Owners
Furniture Business
Gallery Instructor- Museum, Art gallery
Government Officials
Jewelers
Labor Relations Consultant
Librarians
Manufacturing Owners
Mathematician
Musicians
Nurses
Office Managers
Opticians
Personnel Managers
Pharmacists
Police Chief/ Sheriff
Postmaster
Production Managers/ TV/ Radio
Public Health Officers
Purchasing Managers
Real Estate Brokers
Research Assistants
Sales Engineers
Sales Managers
School Guidance Counselor
Social Workers
Teachers/ Elementary & High School
Theatre Owners
Other or unknown lesser professional etc.
3 - Administrative Personnel, Small Business Owners, Minor Professionals
Actors
Administrative Assistants
Advertising Agents

Artists
Auto Claims Supervisor
Bakers
Beauty Shop Owners
Chefs
Chief Clerks
Clerk- not professionally trained
Court Reporters
Credit Managers
Department Store Manager
Deputy Sheriffs
Dispatchers
Federal and State Government Officials
Florists
Funeral Directors
Government Officials
Insurance Agents
Laboratory Assistants
Landscape Planners
Mechanical Inspector
Military NCO/Sgts
Morticians
Newspaper/ TV Reporters
Nutritionist
Oral Hygienists
Photographers
Piano Teachers
Plumbers
Quality Control
Radio/ TV Announcers
Real Estate Agents
Restaurant Owners
Sales Representatives
Service Managers
Small Business Owners
Store Managers
Surveyors
Title Searchers

MarkVCID COMMON DATA ELEMENTS

Tool Designers
Traffic Managers
Travel Agents
Veterinary Assistant
Yard Masters/ Rail Road
Other or unknown admin etc.
4 - Clerical and Sales Workers, Technicians, Owners of Little Businesses
Bank Tellers
Bill Collectors
Bookkeepers
Clerk
Claims Examiners
Dental Technician
Draftsman
Driving Teacher
Factory Supervisors
Farmers
Flower Shop Worker
Human Resource Interviewer
Laboratory Technicians
Medical Secretary
Newsstand Operator
Post Office Clerk
R.R. Conductors
Railroad Train Engineers
Retail Clerks
Route Managers
Sales
Sales Clerks
Secretaries/ Stenographers
Shipping Clerks
Tailor
Tax Clerks
Telephone Company Worker
Telephone Operators
Timekeepers
Toll Collectors
Tower Operators
Truck Dispatchers
Typists

Utility Worker
Warehouse Clerks
Window Store Trimmers
Other or unknown clerical etc.
5 - Skilled Manual Employees
Auto Body Repairs
Barbers
Blacksmiths
Boiler Repairmen
Bookbinders
Brewers
Bulldozer Operators
Cabinet Makers
Carpenters
Cement Layers/ Finishers
Cheese Makers
Construction Foreman
Diemakers
Electricians
Engravers
Exterminators
Firemen
Gardner's/ Landscape
Glassblowers
Glaziers
Gun Smiths
Hair Stylists
Home Repairmen
Kitchen Workers/ Cooks
Locksmiths
Machinists
Mailmen
Maintenance Foreman
Masons
Mechanics
Millwrights
Painters
Paperhangers
Patrolmen
Piano Builders
Piano Tuners

Plumbers
Policemen
Postmen
Printers
Radio/ TV Maintenance
Rail Road Brakeman
Repair
Sheet metal Workers
Ship smiths
Shoe Repairmen
Tile Layers
Tool Makers
Upholsterers
Utility Linemen
Watchmakers
Weavers
Welders
Other or unknown skilled manual etc.
6 - Machine Operators and Semiskilled Employees
Apprentices (Electrician/Printers/etc.)
Assembly Line Workers
Bartenders
Building Superintendent
Bus Drivers
Cab/ Taxi Drivers
Cashiers
Cooks- Short Order
Delivery men
Dry Cleaning Pressers
Elevator Operators
Enlisted Military Personnel
Factory Machine Operators
Factory Workers
Foundry Workers
Garage and Gas Station Assistants
Greenhouse Workers
Guards, Security Watchmen
Housekeepers
Machine Operators and semiskilled

MarkVCID COMMON DATA ELEMENTS

Meat Cutters/ Packers
Meter Readers
Oil Delivery Men
Practical Nurses
Pump Operators
Receivers and Checkers
Roofers
Seamstresses
Signal Men- Rail Road
Testers
Trucker Driver
Waiters/ Waitresses
Wine Bottlers
Wood Workers
Wrappers- Stores and Factories
Other or unknown semi-skilled manual etc.
7 - Unskilled Employees
Amusement Park Workers
Cafeteria Workers
Car Cleaners
Construction Laborers
Dairy Workers
Deck Hands
Domestics
Farm Helpers
Fishermen
Freight Handlers
Grave Diggers
Homemaker
Hospital Housekeepers
Janitors
Junk/ Recycle Sorters
Laundry Workers
Messengers
Peddlers
Porters
Roofer Laborers
Shoe Shiners
Stagehands
Stock Handlers
Street Cleaners

Unemployed
Unskilled Factory Workers
Unspecified Laborers
Window Cleaners
Woodchoppers
Other or unknown unskilled