40862

VITAL OBS 6

Please use a ballpoint pen to complete the form.

DATE OF BIRTH: ☐☐ / ☐☐ / ☐☐ We use **DATE OF BIRTH (DOB)** to verify the identity of the person providing information.

Is the DOB above correct? ○ Yes ○ No → **IF NO, what is your correct date of birth?** ☐☐ / ☐☐ / ☐☐

1. IN THE PAST YEAR, have you been NEWLY DIAGNOSED with any of the following?
IF YES, please provide the month/year of the NEW diagnosis or procedure.
(Please complete either No / Yes for each item)

		Diagnosis MO/YR
a. Hypertension (high blood pressure)	○ No ○ Yes →	☐☐ / ☐☐
b. Diabetes	○ No ○ Yes →	☐☐ / ☐☐
c. Cancer (NOT including skin cancer) **IF YES, specify type:** _____	○ No ○ Yes →	☐☐ / ☐☐
d. Skin cancer **IF YES, specify type:** e.○ melanoma ○ squamous or basal cell ○ not sure	○ No ○ Yes →	☐☐ / ☐☐
f. Heart attack or myocardial infarction	○ No ○ Yes →	☐☐ / ☐☐
g. Coronary bypass surgery	○ No ○ Yes →	☐☐ / ☐☐
h. Coronary angioplasty or stent (balloon used to unblock an artery)	○ No ○ Yes →	☐☐ / ☐☐
i. Chest pain (angina) **IF YES, were you <u>hospitalized?</u>** ○ No ○ Yes	○ No ○ Yes →	☐☐ / ☐☐
j. Stroke	○ No ○ Yes →	☐☐ / ☐☐
k. Mini-stroke (TIA)	○ No ○ Yes →	☐☐ / ☐☐
l. Atrial fibrillation	○ No ○ Yes →	☐☐ / ☐☐
m. Other irregular heart rhythm	○ No ○ Yes →	☐☐ / ☐☐
n. Heart failure or congestive heart failure **IF YES, were you <u>hospitalized?</u>** ○ No ○ Yes	○ No ○ Yes →	☐☐ / ☐☐
o. Kidney failure or dialysis	○ No ○ Yes →	☐☐ / ☐☐
p. Underactive thyroid (hypothyroidism)	○ No ○ Yes →	☐☐ / ☐☐
q. Overactive thyroid (hyperthyroidism)	○ No ○ Yes →	☐☐ / ☐☐
r. Pneumonia **IF YES, were you <u>hospitalized?</u>** ○ No ○ Yes	○ No ○ Yes →	☐☐ / ☐☐
s. Intermittent claudication (pain in legs while walking due to blocked arteries)	○ No ○ Yes →	☐☐ / ☐☐
t. Peripheral artery surgery / stenting (procedure to unblock arteries in legs)	○ No ○ Yes →	☐☐ / ☐☐
u. Carotid stenosis (blocked arteries in neck)	○ No ○ Yes →	☐☐ / ☐☐
v. Carotid artery surgery / stenting (procedure to unblock arteries in neck)	○ No ○ Yes →	☐☐ / ☐☐
w. Deep vein thrombosis (blood clot in legs)	○ No ○ Yes →	☐☐ / ☐☐
x. Pulmonary embolism (blood clot in lungs)	○ No ○ Yes →	☐☐ / ☐☐

OFFICE USE ONLY: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

PLEASE CONTINUE ON THE NEXT PAGE

1. (continued) NEWLY DIAGNOSED WITHIN THE PAST YEAR?

		Diagnosis MO/YR
y. Parkinson's disease	O No O Yes →	☐☐/☐☐
z. Cataract surgery (extraction)	O No O Yes →	☐☐/☐☐
aa. Macular degeneration	O No O Yes →	☐☐/☐☐
bb. Dry eye syndrome or dry eye disease	O No O Yes →	☐☐/☐☐
cc. Periodontal disease (gum disease)	O No O Yes →	☐☐/☐☐
dd. Colon or rectal polyp	O No O Yes →	☐☐/☐☐
IF YES: Did your doctor ask you to come back for a repeat colonoscopy or sigmoidoscopy in 5 years or less?	O No O Yes O Not sure	
ee. Coronavirus (COVID-19)	O No O Yes →	☐☐/☐☐
IF YES: a. Was this confirmed by a positive COVID-19 test?	O No O Yes	
b. Were you hospitalized for COVID-19? →	O No O Yes →	☐☐/☐☐
c. Did you require treatment in an Intensive Care Unit (ICU) for COVID-19?	O No O Yes	

2. IN THE PAST YEAR, have you received any of the following vaccines?

O COVID-19 O Influenza (flu) O Respiratory Syncytial Virus (RSV) O Shingles O Pneumonia

3. What is your CURRENT weight? ☐☐☐ **pounds**

4. In general, would you say your health is: O Excellent O Very good O Good O Fair O Poor

5. Do you CURRENTLY smoke cigarettes? O No O Yes

6. Have you EVER been diagnosed with sleep apnea? O No O Yes

IF YES: →
- a. When were you diagnosed? O Before 2012 O 2012-2017 O After 2018
- b. Did you receive treatment? O No O Yes
  - **IF YES,** which treatment? O CPAP / pressure device O Other device or treatment

7. Have you EVER been diagnosed with fatty liver disease? O No O Yes

IF YES: →
- a. MO/YR of diagnosis: ☐☐ / ☐☐
- b. Confirmed by liver biopsy? O No O Yes
- c. Confirmed by liver imaging? O No O Yes → Type: O CT scan O Ultrasound O MRI

8. Have you EVER been diagnosed with cirrhosis of the liver or other severe liver disease? O No O Yes

9. Have you EVER been diagnosed with chronic viral hepatitis? O No O Yes

10. NOT including your diet, how much <u>TOTAL vitamin D do you take each day from nutritional supplements</u> such as single tablets of vitamin D, multivitamins, calcium supplements (Calcium+D) or drugs that may include vitamin D (Ex: Fosamax+D)? Referring to package labels, please add up ALL your non-diet sources of vitamin D.

O None O 400 IU or less/day O 401-800 IU/day O 801-1000 IU/day O 1001-2000 IU/day

O 2001-3000 IU/day O 3001-4000 IU/day O greater than 4000 IU/day

11. Do you regularly take individual supplements of fish oil or omega-3 (EPA and/or DHA)? O No O Yes
Please include prescription fish oil, cod liver oil, krill oil, other fish oil (over-the-counter).

IF YES: →

a. Indicate which type(s): O Lovaza O Vascepa (icosapent ethyl) O Other prescription fish oil
O EPA AND DHA fish oil O EPA only fish oil O DHA only fish oil
O Eye supplements containing omega-3 O Cod liver oil O Krill oil

b. What dose are you taking? O 1g or less/day O 2g/day O 3g/day O 4g or more/day

12. Are you CURRENTLY taking any of the following drugs regularly?
Please answer No or YES on each line.

a. Aspirin (Ex: Bayer, Bufferin, Anacin, Excedrin)	O No	O Yes
b. Other non-steroidal anti-inflammatory agent (Ex: ibuprofen, Motrin, Advil, Nuprin, naproxen, Naprosyn, Aleve)	O No	O Yes
c. Antiplatelet medication (Ex: clopidogrel, Plavix, prasugrel, Effient, ticagrelor, Brilinta)	O No	O Yes
d. Anticoagulant / blood thinner 1. warfarin / Coumadin / heparin	O No	O Yes
2. Pradaxa / dabigatran / Xarelto / rivaroxaban / Savaysa / Eliquis	O No	O Yes
e. Statin drug to lower cholesterol (Ex: Lipitor, Zocor, Mevacor, Pravachol, Crestor)	O No	O Yes
f. Non-statin drug to lower cholesterol 1. Nexletol / Lopid / Questran / Colestid / Zetia	O No	O Yes
2. Praluent / Repatha	O No	O Yes
g. Lithium	O No	O Yes
h. Estrogen, alone or with progestin (do NOT include vaginal estrogen)	O No	O Yes
i. Serotonin reuptake inhibitor (Ex: Celexa, Lexapro, Cipralex, Esertia, Prozac, Zoloft)	O No	O Yes
j. Aromatase inhibitor (Ex: Arimidex, Aromasin, Femara)	O No	O Yes
k. Diabetes medication(s)	O No	O Yes
IF YES, mark ALL that apply: O Insulin injection O Glucophage (metformin) O SGLT2 inhibitors (Ex: Jardiance, Farxiga, Invokana) O Non-insulin injection (Ex: exenatide, Trulicity, Ozempic, Victoza, Adlyxin, Mounjaro) Other oral drugs: O Rybelsus O Avandia O Glucotrol O Prandin O Januvia O Starlix O Actos Combination pills: O Invokamet O Xigduo O Synjardy O Glyxambi O Other oral medication		
l. Prescription weight loss medications (Ex: Wegovy, Mounjaro)	O No	O Yes
m. Medications for high blood pressure	O No	O Yes
n. Bone loss or osteoporosis medications	O No	O Yes
IF YES, mark ALL that apply: O Fosamax (alendronate) O Reclast or Zometa (zoledronic acid) O Prolia (denosumab) O Other medication		

13. In the PAST YEAR, have you been hospitalized for heart failure or congestive heart failure? O No O Yes
IF YES, how many times in the past year? O 1 O 2 O 3 or more

14. In the PAST YEAR, have you been treated in the emergency room (but not hospitalized) for heart failure or congestive heart failure? O No O Yes **IF YES, how many times in the past year?** O 1 O 2 O 3 or more

15. In the PAST YEAR, has your memory changed? O No O Yes
IF YES: Which best describes the change? O My memory is BETTER
O My memory is WORSE but this does not worry me O My memory is WORSE and this worries me

The following 2 questions deal with mood. If you have concerns about your answers to questions #16-17, please share with your health care provider. Also, refer to information at the following web site: http://www.nimh.nih.gov/health/publications/depression/complete-index.shtml

16. Over the PAST 2 WEEKS, how often have you been bothered by any of the following?

	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	O	O	O	O
b. Feeling down, depressed, or hopeless	O	O	O	O

17. In the PAST YEAR, have you had a diagnosis of depression? O No O Yes **IF YES:** Have you regularly taken antidepressants or had counseling for depression in the past year? O No O Yes

18. In the PAST YEAR, have you had an unintentional fall (coming to rest on the ground, floor or lower surface)? O No O Yes **IF YES,** number of falls in the past year: O 1 O 2 O 3 or more

19. In the PAST YEAR, has a doctor or other health care provider told you that you had broken a bone? O No O Yes

IF YES: →

a. Which bone (Mark ALL that apply)?
O Hip O Pelvis O Spine O Wrist / Forearm O Upper arm / Shoulder O Other

b. Please provide the date (month/year) when the break occurred: ☐☐/☐☐

20. DURING THE PAST YEAR, what was your approximate AVERAGE TIME PER WEEK spent at each of the following recreational activities? Please answer on each line.

	AVERAGE TIME PER WEEK							
	Zero	1-19 min.	20-59 min.	1 hour	1.5 hours	2-3 hours	4-6 hours	7+ hours
a. Walking or hiking (include walking to work)	O	O	O	O	O	O	O	O
b. Jogging (slower than 10 minute miles)	O	O	O	O	O	O	O	O
c. Running (10 minute miles or faster)	O	O	O	O	O	O	O	O
d. Bicycling (include stationary bike)	O	O	O	O	O	O	O	O
e. Aerobic exercise / aerobic dance / exercise	O	O	O	O	O	O	O	O
f. Lower intensity exercise / yoga / stretching / toning	O	O	O	O	O	O	O	O
g. Tennis, squash, or raquetball	O	O	O	O	O	O	O	O
h. Lap swimming	O	O	O	O	O	O	O	O
i. Weight lifting / strength training	O	O	O	O	O	O	O	O
j. Other: Please specify activity: _____	O	O	O	O	O	O	O	O

21. PLEASE COMPLETE YOUR CONTACT INFORMATION BELOW. IT WILL NOT BE SHARED. IT IS USED ONLY BY OUR STUDY STAFF.

YOUR PREFERRED CONTACT PHONE: (☐☐☐) - ☐☐☐ - ☐☐☐☐ This is my: O Home phone O Cell phone

YOUR E-MAIL ADDRESS: **This is the e-mail address we have on file:**

If it has changed, or you would now be willing to share your e-mail address , please provide your updated e-mail address below:

_____

Thank you! Please return the questionnaire in the pre-paid envelope provided.