61384

Request

# VITAL R 2 YR

**Use ball-point pen to complete the form.**

**1. Birth date:** ☐☐ / ☐☐ / ☐☐ (month / day / year) → **Last 4 digits of social security number (for identification purposes ONLY )** XXX-XX-☐☐☐☐

**2. 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.**

| | | | Diagnosis MO/YR |
|---|---|---|---|
| a. Hypertension (high blood pressure) | O No | O Yes | ☐☐/☐☐ |
| b. Diabetes | O No | O Yes | ☐☐/☐☐ |
| c.Cancer (NOT including skin cancer) | O No | O Yes | ☐☐/☐☐ |
| **IF YES, specify type:** _____ | | | |
| d.Skin cancer | O No | O Yes | ☐☐/☐☐ |
| **IF YES, specify type:** e. O melanoma O squamous or basal cell O not sure | | | |
| f. Heart attack or myocardial infarction | O No | O Yes | ☐☐/☐☐ |
| g. Coronary bypass surgery | O No | O Yes | ☐☐/☐☐ |
| h. Coronary angioplasty or stent (balloon used to unblock an artery) | O No | O Yes | ☐☐/☐☐ |
| i. Chest pain (angina) | O No | O Yes | ☐☐/☐☐ |
| **IF YES, were you hospitalized?** | O No | O Yes | |
| j. Stroke | O No | O Yes | ☐☐/☐☐ |
| k. Mini-stroke (TIA) | O No | O Yes | ☐☐/☐☐ |
| l. Atrial fibrillation | O No | O Yes | ☐☐/☐☐ |
| m Other irregular heart rhythm | O No | O Yes | ☐☐/☐☐ |
| n. Heart failure or congestive heart failure | O No | O Yes | ☐☐/☐☐ |
| **IF YES, were you hospitalized?** | O No | O Yes | |
| o. Kidney stones | O No | O Yes | ☐☐/☐☐ |
| p. Kidney failure or dialysis | O No | O Yes | ☐☐/☐☐ |
| q. High levels of calcium in the blood (hypercalcemia) | O No | O Yes | ☐☐/☐☐ |
| r. Any thyroid condition | O No | O Yes | ☐☐/☐☐ |
| s. Any **para**thyroid condition | O No | O Yes | ☐☐/☐☐ |

(Note: This is **NOT** thyroid disease -- answer the **previous** question (r) to report a thyroid condition)

| | | | |
|---|---|---|---|
| t. Pneumonia | O No | O Yes | ☐☐/☐☐ |
| **IF YES, were you hospitalized?** | O No | O Yes | |
| u. Cirrhosis of the liver or other severe liver disease | O No | O Yes | ☐☐/☐☐ |
| v. Tuberculosis (active) | O No | O Yes | ☐☐/☐☐ |
| w. Sarcoid or Wegener's (granulomatosis) | O No | O Yes | ☐☐/☐☐ |
| x. Intermittent claudication (pain in legs while walking due to blocked arteries) | O No | O Yes | ☐☐/☐☐ |
| y. Peripheral artery surgery / stenting (procedure to unblock arteries in legs) | O No | O Yes | ☐☐/☐☐ |
| z. Carotid stenosis (blocked arteries in neck) | O No | O Yes | ☐☐/☐☐ |
| aa. Carotid artery surgery / stenting (procedure to unblock arteries in neck) | O No | O Yes | ☐☐/☐☐ |
| bb. Deep vein thrombosis (blood clot in legs) | O No | O Yes | ☐☐/☐☐ |
| cc. Pulmonary embolism (blood clot in lungs) | O No | O Yes | ☐☐/☐☐ |
| dd. Colon or rectal polyps | O No | O Yes | ☐☐/☐☐ |
| ee. Parkinson's disease | O No | O Yes | ☐☐/☐☐ |
| ff. Multiple sclerosis | O No | O Yes | ☐☐/☐☐ |
| gg. Cataract surgery (extraction) | O No | O Yes | ☐☐/☐☐ |
| hh. Macular degeneration | O No | O Yes | ☐☐/☐☐ |
| ii. Gastric bypass surgery | O No | O Yes | ☐☐/☐☐ |
| jj. Fibrocystic or other benign breast disease **(women only)** | O No | O Yes | ☐☐/☐☐ |
| **IF YES: Confirmed by breast biopsy?** | O No | O Yes | |
| **Confirmed by aspiration?** | O No | O Yes | |
| kk. Periodontal disease | O No | O Yes | ☐☐/☐☐ |

ll. Have you had any OTHER MAJOR ILLNESS in the past year?
O No O Yes → IF YES, please specify below and provide MO/YR of diagnosis.

_____

OFFICE USE: O

**PLEASE ANSWER ALL ITEMS IN BOTH COLUMNS**

OFFICE USE: Ca: O ep O not ep O bl



**PLEASE CONTINUE ON THE NEXT PAGE**

**3. In general, would you say your health is:** ○ Excellent ○ Very good ○ Good ○ Fair ○ Poor

**4. IN THE PAST YEAR, have you experienced any of the following? Please answer ALL ITEMS in BOTH COLUMNS.**

| | | | | | |
|---|---|---|---|---|---|
| a. Stomach upset or pain | ○ No | ○ Yes | h. Frequent nosebleeds | ○ No | ○ Yes |
| b. Nausea | ○ No | ○ Yes | i. Easy bruising | ○ No | ○ Yes |
| c. Constipation | ○ No | ○ Yes | j. Blood in urine | ○ No | ○ Yes |
| d. Diarrhea | ○ No | ○ Yes | k. Gastrointestinal bleeding | ○ No | ○ Yes |
| e. Skin rash | ○ No | ○ Yes | IF YES: Did you have a transfusion? | ○ No | ○ Yes |
| f. Colds or upper respiratory infections | ○ No | ○ Yes | Were you hospitalized? | ○ No | ○ Yes |
| g. Flu-like symptoms | ○ No | ○ Yes | l. Bad taste in mouth | ○ No | ○ Yes |
| | | | m. Increased burping | ○ No | ○ Yes |

**5. For each study capsule, please describe your compliance during a "typical month" during the past year:**

| | | | |
|---|---|---|---|
| a. LARGE capsule: (in a typical month) | ○ Missed 0 days (took all) | ○ Missed 1-5 days | ○ Missed 6-10 days |
| | ○ Missed 11-15 days | ○ Missed 16-29 days | ○ Missed all (took none) |
| b. SMALL capsule: (in a typical month) | ○ Missed 0 days (took all) | ○ Missed 1-5 days | ○ Missed 6-10 days |
| | ○ Missed 11-15 days | ○ Missed 16-29 days | ○ Missed all (took none) |

**c. If you missed taking your study capsules more than 10 days in a "typical month", what was the main reason(s)?**

○ Traveling and forgot calendar pack ○ Surgery ○ Illness ○ Other (Specify: _____)

**d. Have you <u>stopped</u> taking the capsules?** ○ No ○ Yes → Which? ○ Large capsule ○ Small capsule ○ Both capsules

**6. <u>NOT including your study pills</u> and 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, multi-vitamins, calcium supplements (Calcium+D) or drugs that may include vitamin D (Example: Fosamax+D)? Referring to package labels, please add up ALL your non-diet sources of vitamin D.**

○ None ○ 400 IU or less/day ○ 401-800 IU/day ○ 801-1000 IU/day ○ 1001-2000 IU/day
○ 2001-3000 IU/day ○ 3001-4000 IU/day ○ greater than 4000 IU/day

**7. <u>NOT including your study capsules</u>, do you regularly take individual supplements of fish oil (including cod liver oil, krill oil)?**

○ No ○ Yes → <u>If in the form of cod liver oil or krill oil</u>, indicate which type(s): ○ cod liver oil ○ krill oil

**8. Do you take a calcium supplement daily such as Os-Cal, Caltrate, Citracal, Calcium+D?** ○ No ○ Yes

**IF YES: How much <u>TOTAL calcium do you take each day from nutritional supplements</u> such as single tablets of calcium and multi-vitamins. Referring to package labels, please add up ALL your non-diet sources of calcium.**

○ 500 mg or less/day ○ 501-1200 mg/day ○ 1201-1500 mg/day ○ greater than 1500 mg/day

**9. Do you take an individual supplement of vitamin A (retinol, pre-formed vitamin A)?** ○ No ○ Yes

**10. Are you CURRENTLY taking medications for high blood pressure?** ○ No ○ Yes → **If YES,** mark all that apply below.

○ Beta-blockers (Example: propranolol, atenolol, metoprolol) ○ ACE-inhibitors (Example: lisinopril, enalapril)
○ Calcium-blockers (Example: amlodipine, diltiazem, verapamil) ○ Angiotensin receptor blockers (Example: valsartan, irbesartan)
○ Diuretics (Example: hydrochlorothiazide, furosemide) ○ Alpha-blockers (Example: terazosin, doxazosin)
○ NOT SURE ○ Other class of blood pressure medication (not listed above)

**11. Are you CURRENTLY taking any of the following drugs for prevention or treatment of bone loss? (Mark ALL that apply)**

- O Fosamax (alendronate)
- O Evista (raloxifene)
- O Actonel (risedronate)
- O Reclast (zoledronic acid)
- O Prolia (denosumab)
- O Forteo (teriparatide injection)
- O Miacalcin or Fortical (calcitonin-salmon)
- O other osteoporosis medication, not listed above
- O I do NOT take any medications for bone loss treatment/prevention

**12. Are you CURRENTLY taking any of the following drugs regularly? Please answer ALL ITEMS in BOTH COLUMNS.**

| | | |
|---|---|---|
| a. Aspirin (Ex: Bayer, Bufferin, Anacin, Excedrin) | O No | O Yes |
| IF YES: In the past month, on how many DAYS did you take it? O 1-3 days O 4-10 days O 11-20 days O 21+ days | | |
| b. Clopidogrel (Plavix) | O No | O Yes |
| c. Anti-coagulant/blood thinner (Ex: warfarin, Coumadin, heparin, Pradaxa, dabigatran, Xarelto, rivaroxaban) | O No | O Yes |
| d. Calcitriol (Rocaltrol, Calcijex, Vectical) or Paricalcitol (Zemplar) | O No | O Yes |
| e. Statin drugs to lower cholesterol (Ex: Lipitor, Zocor, Mevacor, Pravachol, Crestor) | O No | O Yes |
| f. **Non-statin** drugs to lower cholesterol (Ex: Niacin, Lopid, Questran, Colestid, Zetia) | O No | O Yes |
| g. Estrogen, alone or with progestin (do NOT include vaginal estrogen) | O No | O Yes |
| h. Tamoxifen (Ex: Nolvadex) | O No | O Yes |
| i. Serotonin reuptake inhibitor (Ex: Celexa, Lexapro, Cipralex, Esertia, Prozac, Zoloft, Zelmid) | O No | O Yes |
| j. Aromatase inhibitor (Ex: Arimidex, Aromasin, Femara) | O No | O Yes |
| k. Lithium | O No | O Yes |
| l. Corticosteroids or prednisone | O No | O Yes |
| m. Diabetes medication(s) - Mark ALL that apply: O NONE O Insulin injection O Non-insulin injection (EX: Exenatide, Byetta) O Glucophage (metformin) O Other oral drugs (EX: Avandia, Glucotrol, Prandin, Januvia, Starlix, Actos) | | |

**PLEASE COMPLETE THE IMPORTANT CONTACT INFORMATION BELOW. IT WILL NOT BE SHARED AND WILL BE USED BY STUDY STAFF ONLY.**

**Please provide us with your phone numbers in the event that we need to reach you to clarify any of your responses.**

HOME PHONE ( ) -

CELL PHONE ( ) -

WORK PHONE ( ) -

**What is your preferred method of contact:**

- O **Home phone**
- O **Cell phone**
- O **Work phone**
- O **No difference**

**Please provide us with the names and phone numbers of 2 individuals (not living in your household) whom we have permission to contact in the event that we are not able to contact you directly:**

**CONTACT 1**

**Name:**_____

**Phone number:**_____

**Relationship (circle): Family Friend Neighbor Other**

**CONTACT 2**

**Name:**_____

**Phone number:**_____

**Relationship (circle): Family Friend Neighbor Other**

**If you would like to receive information about the study by e-mail, please provide your e-mail address on the line below:**

_____

**PLEASE CONTINUE ON THE NEXT PAGE**

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**Use ball-point pen to complete the form.**

# VITAL R 2 YR

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

**14. In the PAST YEAR, have you been NEWLY DIAGNOSED with any of the following autoimmune diseases? Please answer NO/YES for each item. IF YES, please provide the month/year of the NEW diagnosis.**

| | | | Diagnosis MO/YR |
|---|---|---|---|
| a. Autoimmune thyroid disease (includes Graves' disease, Hashimoto's thyroiditis, underactive or overactive thyroid, but NOT thyroid nodule or cancer) | ○ No | ○ Yes | ☐☐/☐☐ |
| b. Inflammatory bowel disease (Crohn's disease or ulcerative colitis, but NOT irritable bowel syndrome) | ○ No | ○ Yes | ☐☐/☐☐ |
| c. Polymyalgia rheumatica (PMR), temporal arteritis or giant cell arteritis | ○ No | ○ Yes | ☐☐/☐☐ |
| d. Rheumatoid arthritis (NOT osteoarthritis, degenerative arthritis or gout) | ○ No | ○ Yes | ☐☐/☐☐ |
| e. Psoriasis or psoriatic arthritis | ○ No | ○ Yes | ☐☐/☐☐ |
| f. Other autoimmune disease (Please specify:_____) | ○ No | ○ Yes | ☐☐/☐☐ |

*The following questions deal with mood. If you have any concerns about your answers to questions #15-18, 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***

**15. 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 | ○ | ○ | ○ | ○ |
| b. Feeling down, depressed, or hopeless | ○ | ○ | ○ | ○ |
| c. Trouble falling or staying asleep, or sleeping too much | ○ | ○ | ○ | ○ |
| d. Feeling tired or having little energy | ○ | ○ | ○ | ○ |
| e. Poor appetite or overeating | ○ | ○ | ○ | ○ |
| f. Feeling bad about yourself or that you are a failure or have let yourself or your family down | ○ | ○ | ○ | ○ |
| g. Trouble concentrating on things like reading the paper or watching TV | ○ | ○ | ○ | ○ |
| h. Moving or speaking so slowly that others could have noticed. Or the opposite -- being fidgety, restless, or moving a lot more than usual | ○ | ○ | ○ | ○ |

**16. In the PAST YEAR, have you had a diagnosis of depression?** ○ No ○ Yes

**IF YES:** Have you regularly taken antidepressants or had counseling for depression in the past year? ○ No ○ Yes

**17. In the PAST YEAR, have you had 2 weeks or more during which you felt sad, blue, or depressed or lost pleasure in things that you usually cared about or enjoyed?** ○ No ○ Yes

**18. Have you had 2 or more consecutive years of feeling depressed or sad most days, even if you felt OK sometimes?** ○ No ○ Yes

**19. How much help (if any) do you need to do the following routine activities for yourself? Help is defined as getting assistance from another person or using a device.**

| | By myself without help | With some help | Completely unable to do this by myself |
|---|---|---|---|
| a. Can you feed yourself? | ○ | ○ | ○ |
| b. Can you dress and undress yourself? | ○ | ○ | ○ |
| c. Can you get in and out of bed by yourself? | ○ | ○ | ○ |
| d. Can you take a bath or shower? | ○ | ○ | ○ |



**PLEASE CONTINUE ON THE NEXT PAGE**

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# VITAL R 2 YR

**20. IN THE PAST YEAR, have you had any of the following exams, tests, procedures? Please answer ALL ITEMS in BOTH COLUMNS.**

| | | | | | |
|---|---|---|---|---|---|
| a. Rectal exam | O No | O Yes | f. Blood pressure measured | O No | O Yes |
| b. Test for blood in your stool (hemoccult, guaiac) | O No | O Yes | g. Eye exam | O No | O Yes |
| c. Colonoscopy | O No | O Yes | h. PSA test(s) **(men only)** | O No | O Yes |
| d. Sigmoidoscopy | O No | O Yes | i. Mammogram(s) **(women only)** | O No | O Yes |
| e. Barium enema x-ray | O No | O Yes | j. Breast biopsy **(women only)** | O No | O Yes |

**21. 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 Spine O Forearm / shoulder O Other
b. Please provide the date (month/year) when the break occurred: ☐☐ / ☐☐

**22. 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:** →
a. Number of falls in the past year: O 1 O 2 O 3 or more
b. How many of these falls caused an injury and limited your regular activity for at least a day or made you see a doctor?
O None O 1 O 2 O 3 or more
c. Were you evaluated by a health care provider or admitted to the hospital following any of the injuries? O No O Yes

**23. In the PAST YEAR, have you had a NEW DIAGNOSIS of anemia (low red blood cell count)?** O No O Yes

**IF YES:** →
a. What was the date (month/year) of this new diagnosis? ☐☐ / ☐☐
b. Did you have a blood transfusion for your anemia? O No O Yes

**24. In the PAST YEAR, were you evaluated by a hematologist (blood specialist)?** O No O Yes

**25. During the past 3 months, how often have you typically leaked urine, even a small amount?**

O Never: skip to question #27 O Less than monthly O Monthly (once or more each month)
O Weekly (once or more each week) O Daily (once or more each day)

**26. If you have leaked urine, under what circumstances does your leakage most often occur (choose only one)?**

O When I cough, sneeze, laugh, lift, stand up or exercise, etc. O When I am sleeping, napping or dozing
O When I have the urge to urinate and can't get to the toilet fast enough O Other O Don't know

**DO NOT WRITE IN THE SPACE BELOW. PLEASE CONTINUE ON THE LAST PAGE.** →

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1 ☐☐☐☐☐☐☐ – ☐☐☐☐
2 ☐☐☐☐☐☐☐ – ☐☐☐☐
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6 ☐☐☐☐☐☐☐ – ☐☐☐☐

**27. How often are your eyes dry (not wet enough)?** ○ Constantly ○ Often ○ Sometimes ○ Never

**28. How often are your eyes irritated?** ○ Constantly ○ Often ○ Sometimes ○ Never

**29. In the PAST YEAR, have you been diagnosed (by a clinician) with dry eye syndrome or dry eye disease?** ○ No ○ Yes

**30a. In the PAST YEAR, have you been hospitalized for heart failure or congestive heart failure?** ○ No ○ Yes

**IF YES,** how many times in the past year? ○ 1 ○ 2 ○ 3 or more

**30b. In the PAST YEAR, have you been treated in the emergency room (but not hospitalized) for heart failure or congestive heart failure?** ○ No ○ Yes **IF YES**, how many times in the past year? ○ 1 ○ 2 ○ 3 or more

**31. In the PAST YEAR have you experienced any of the following? If YES, please provide the month/year of the event/procedure.**

| | | | MO/YR |
|---|---|---|---|
| a. Been told by a physician that you have urinary tract or kidney infection | ○ No | ○ Yes | ☐☐/☐☐ |
| b. Been told by a physician that you have eczema, including atopic dermatitis | ○ No | ○ Yes | ☐☐/☐☐ |
| c. Been told by a physician that you have skin infection, including cellulitis | ○ No | ○ Yes | ☐☐/☐☐ |
| d. Received influenza vaccine (seasonal flu shot) | ○ No | ○ Yes | ☐☐/☐☐ |
| e. Received pneumococcus vaccine (Pneumovax) | ○ No | ○ Yes | ☐☐/☐☐ |
| f. Been treated with an antibiotic for an acute infection | ○ No | ○ Yes | ☐☐/☐☐ |
| g. Been hospitalized overnight for any type of acute infection | ○ No | ○ Yes | ☐☐/☐☐ |

**32. In the PAST YEAR, how many colds have you had? (COLD = an illness that included at least 1 of the following: runny nose, nasal stuffiness, sore throat, cough)** ○ None ○ 1-2 colds ○ 3-5 colds ○ 6-10 colds ○ 11+ colds

**33. In the past few days, have you had a cough, cold, or other acute illness?** ○ No ○ Yes

**34. Do you USUALLY have a cough?** ○ No ○ Yes

**35. Do you USUALLY bring up phlegm from your chest, not from the back of your nose?** ○ No ○ Yes

**36. In the LAST 12 MONTHS, have you had wheezing or whistling in your chest at any time?** ○ No ○ Yes

**37. In the LAST 12 MONTHS, were you diagnosed with asthma by a doctor or other health professional?** ○ No ○ Yes

**38. In the LAST 12 MONTHS, were you diagnosed with chronic bronchitis, emphysema, or chronic obstructive lung disease (COPD) by a doctor or other health professional?** ○ No ○ Yes

**39. <u>WOMEN ONLY:</u> How many pregnancies lasting 6 months or more have you had?** ○ 0 ○ 1 ○ 2 ○ 3 or more

**Have you ever been diagnosed with any of the following disorders of pregnancy?**

a. Gestational diabetes ○ No ○ Yes → Year of FIRST diagnosis: ☐☐

b. Preeclampsia/hypertension of pregnancy ○ No ○ Yes → Year of FIRST diagnosis: ☐☐

***Thank you for completing the form. Please return it in the enclosed pre-paid envelope.***
***If you have questions about the form or the study, call our toll-free number, 1-800-388-3963.***



○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6
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