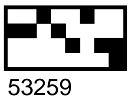
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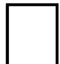

Request

VITAL R 6M

R ___

Your birth date: __ / __ / __ (month / day / year) → Last 4 digits of your social security # (for identification purposes ONLY) XXX-XX-____

WE MAILED YOU YOUR FIRST SUPPLY OF STUDY CAPSULES IN:
USING THIS DATE AS YOUR STARTING POINT, PLEASE ANSWER THE FOLLOWING QUESTIONS (#1-3):

1. For each study capsule, please describe your compliance during a typical month:

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

O Traveling and forgot calendar pack O Surgery O Illness O Other (Specify: ______________________)

d. Are you currently taking the large study capsule? O No O Yes

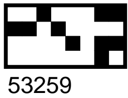
e. Are you currently taking the small study capsule? O No O Yes

2. SINCE YOU FIRST STARTED YOUR STUDY CAPSULES, have you been NEWLY DIAGNOSED with any of the following? Please answer NO/YES on each line. IF YES, please provide the month / year of the diagnosis in the boxes provided for this purpose.

			MO / YR of diagnosis:
a. Skin cancer	O No	O Yes →	__ / __
IF YES, which type of skin cancer: O not sure O melanoma O squamous or basal cell			
b. Other cancer (Specify: ______________________)	O No	O Yes →	__ / __
c. Heart attack or myocardial infarction	O No	O Yes →	__ / __
d. Coronary bypass surgery	O No	O Yes →	__ / __
e. Coronary angioplasty or stent (balloon used to unblock an artery)	O No	O Yes →	__ / __
f. Stroke	O No	O Yes →	__ / __
g. Mini-stroke (TIA)	O No	O Yes →	__ / __
h. High levels of calcium in your blood (hypercalcemia)	O No	O Yes →	__ / __
i. Any thyroid condition	O No	O Yes →	__ / __
j. Any PARAthyroid condition	O No	O Yes →	__ / __
IF YES, was your parathyroid gland surgically removed? O No O Yes **(Note: This is NOT thyroid disease - answer the previous question (i) to report a thyroid condition)**			
k. Kidney stones	O No	O Yes →	__ / __

OFFICE USE ONLY: ● 1 ● 2 ● 3 ● 4

Over →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VITAL
R 6M

R ___

3. SINCE YOU FIRST STARTED YOUR STUDY CAPSULES, have you experienced any of the following? Please answer NO/YES for each item in both left and right columns.

Item		
a. Stomach upset or pain	O No	O Yes
b. Nausea	O No	O Yes
c. Constipation	O No	O Yes
d. Diarrhea	O No	O Yes
e. Skin rash	O No	O Yes
f. Colds or upper respiratory infections	O No	O Yes
g. Flu-like symptoms	O No	O Yes

Item		
h. Frequent nosebleeds	O No	O Yes
i. Easy bruising	O No	O Yes
j. Blood in urine	O No	O Yes
k. Gastrointestinal bleeding	O No	O Yes
IF YES: Did you have a transfusion?	O No	O Yes
Were you hospitalized?	O No	O Yes
l. Bad taste in mouth	O No	O Yes
m. Increased burping	O No	O Yes

PLEASE ANSWER ALL ITEMS IN BOTH COLUMNS

THE FOLLOWING QUESTIONS (#4-7) ASK ABOUT YOUR CURRENT USE OF SUPPLEMENTS.

4. NOT INCLUDING YOUR STUDY CAPSULES and NOT including your diet, how much TOTAL vitamin D do you CURRENTLY take each day from nutritional supplements 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-study, non-diet sources of vitamin D.

O None O TOTAL of 800 IU or less/day O TOTAL of 801-1000 IU/day O TOTAL greater than 1000 IU/day

5. NOT INCLUDING YOUR STUDY CAPSULES, are you regularly taking individual supplements of fish oil? O No O Yes

6. Are you regularly taking any other multi-nutrient supplement that contains omega-3's? O No O Yes

IF YES: Brand name of supplement: ______________ AND, amount of omega-3's: ______________

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

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

O TOTAL of 1200 mg or less/day O TOTAL of 1201-1500 mg/day O TOTAL greater than 1500 mg/day

Please provide your phone numbers in the event that we need to contact you to clarify any of your responses. Thanks.

HOME PHONE ( ) -

CELL PHONE ( ) -

WORK PHONE ( ) -

What is your preferred contact:

O Home phone O Cell phone

O Work phone O No difference

If you would like to receive information about the study by e-mail, please provide your e-mail address here: ______________

OFFICE USE ONLY: O 1 O 2 O 3 O 4