17842

Request

Use ball-point pen to complete the form.

VITAL R 4 YR

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.

		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. Parkinson's disease	O No O Yes	/
ee. Multiple sclerosis	O No O Yes	/
ff. Cataract surgery (extraction)	O No O Yes	/
gg. Macular degeneration	O No O Yes	/
hh. Gastric bypass surgery	O No O Yes	/
ii. 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	
jj. Periodontal disease	O No O Yes	/

kk. 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.

_____

PLEASE ANSWER ALL ITEMS IN BOTH COLUMNS

OFFICE USE: O

2. Please provide your birthdate and last 4 digits of your social security number. We use this information for identification purposes -- to authenticate that the person providing the data is the person assigned to the study identification number.

A. Birth date: ☐☐ / ☐☐ / ☐☐ → **B. Last 4 digits of social security number:** XXX-XX-☐☐☐☐

month day year

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

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VITAL R 4 YR

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

4. In the PAST YEAR, has your memory changed? ○ No ○ Yes

IF YES: Which best describes the change? ○ My memory is BETTER ○ My memory is WORSE

5. 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

6. 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

7. <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

8. <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

9. 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

10. Are you CURRENTLY taking medications for high blood pressure? ○ No ○ Yes

Please indicate if you are CURRENTLY taking any of the medications listed below, and the reason for use.	**For high blood pressure**	**For other reasons or not sure**
a. Beta-blockers (Ex: atenolol, metoprolol)	○	○
b. Calcium-blockers (Ex: amlodipine, diltiazem)	○	○
c. Diuretics (Ex: hydrochlorothiazide, furosemide)	○	○
d. ACE-inhibitors (Ex: lisinopril, enalapril)	○	○
e. Angiotensin receptor blockers (Ex: valsartan, irbesartan)	○	○
f. Aldosterone receptor blockers (Ex: spironolactone, eplerenone)	○	○
g. Alpha-blockers (Ex: terazosin, doxazosin)	○	○

PLEASE CONTINUE ON THE NEXT PAGE

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 Boniva
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. Antiplatelet medication (Ex: clopidogrel, Plavix, prasugrel, Effient, ticagrelor, Brilinta, Zontivity) O No O Yes

c. Anti-coagulant/blood thinner (either group)
1. warfarin / Coumadin / heparin O No O Yes
OR
2. Pradaxa / dabigatran / Xarelto / rivaroxaban / Savaysa / Eliquis 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, Praluent, Repatha) 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)

n. Thyroid medication (Ex: Synthroid, Levoxyl, Levothroid, levothyroxine) O No O Yes

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 contact information of 2 individuals (not living in your household) whom we have permission to contact in the event that we are not able to reach you directly:

CONTACT 1

Name:_____
Phone number:_____
Address:_____
_____
Relationship (circle): Family Friend Neighbor Other

CONTACT 2

Name:_____
Phone number:_____
Address:_____
_____
Relationship (circle): Family Friend Neighbor Other

This is the E-MAIL that we have on file for you to receive study info:

If you would like to receive information about the study by e-mail, please update your e-mail address below, if applicable:

_____ O

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13. 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 2 questions deal with mood. If you have concerns about your answers to questions #14-15, 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***

14. 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	○	○	○	○

15. In the PAST YEAR, have you had a diagnosis (Dx) of depression? ○ No ○ Yes → What was the MO/YR of Dx? ☐☐ / ☐☐

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

16. IN THE PAST 4 YEARS, have you been NEWLY DIAGNOSED with any of the following? IF YES, please provide the month/year of the NEW diagnosis. Please answer items in both columns and NO/YES on each line.

			MO/YR
a. Peptic ulcer	○ No	○ Yes	☐☐ / ☐☐
b. Prostatic hyperplasia **(MEN ONLY)**	○ No	○ Yes	☐☐ / ☐☐
c. Prostatitis **(MEN ONLY)**	○ No	○ Yes	☐☐ / ☐☐
d. Chronic headaches	○ No	○ Yes	☐☐ / ☐☐
e. Restless legs syndrome (diagnosed by a clinician)	○ No	○ Yes	☐☐ / ☐☐
f. Colon or rectal polyp	○ No	○ Yes	☐☐ / ☐☐

IF YES: Did your doctor ask you to come back for a repeat colonoscopy or sigmoidoscopy in 5 years or less?
○ No ○ Yes ○ Don't remember

17. 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?	○	○	○

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18. These questions are about a typical day's activities. Does your health now limit you in these activities, and, if so, how much? Please answer for each item.

	NO, not limited at all	YES, limited a little	YES, limited a lot
a. Vigorous activities such as running, lifting heavy objects, or strenuous sports	O	O	O
b. Moderate activiies such as moving a table, vacuuming, bowling, or golf	O	O	O
c. Lifting or carrying groceries	O	O	O
d. Climbing several flights of stairs	O	O	O
e. Climbing one flight of stairs	O	O	O
f. Bending, kneeling, stooping	O	O	O
g. Walking more than a mile	O	O	O
h. Walking several blocks	O	O	O
i. Walking one block	O	O	O
j. Bathing or dressing yourself	O	O	O

19. IN THE PAST 2 YEARS, have you had any of the following exams, tests, procedures? Answer ALL ITEMS / BOTH COLUMNS.

a. Rectal exam	O No	O Yes
b. Test for blood in your stool (hemoccult, guaiac)	O No	O Yes
c. Colonoscopy	O No	O Yes
d. Sigmoidoscopy	O No	O Yes
e. Barium enema x-ray	O No	O Yes
f. Blood pressure measured	O No	O Yes
g. Eye exam	O No	O Yes

h. Fasting blood sugar	O No	O Yes
i. PSA test(s) **(men only)**	O No	O Yes
j. Mammogram(s) **(women only)**	O No	O Yes
k. Breast biopsy **(women only)**	O No	O Yes

IF YES: Estimated date (mo/yr) of biopsy: ☐☐ / ☐☐

20. What is your CURRENT weight? ☐☐☐ pounds

21. Please fill in your AVERAGE total use during the PAST YEAR.

	Never, or less than once per month	1-3 per month	1 per week	2-4 per week	5-6 per week	1 per day	2-3 per day	4-5 per day	6+ per day
Beer, including regular and light (1 glass, bottle, can)	O	O	O	O	O	O	O	O	O
Wine, including red, white and rose (5 oz. glass)	O	O	O	O	O	O	O	O	O
Liquor, e.g., vodka, gin, etc. (1 drink or shot)	O	O	O	O	O	O	O	O	O

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

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1 ☐☐☐☐☐☐☐ – ☐☐☐☐

2 ☐☐☐☐☐☐☐ – ☐☐☐☐

3 ☐☐☐☐☐☐☐ – ☐☐☐☐

4 ☐☐☐☐☐☐☐ – ☐☐☐☐

5 ☐☐☐☐☐☐☐ – ☐☐☐☐

6 ☐☐☐☐☐☐☐ – ☐☐☐☐

23. 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: ☐☐ / ☐☐

24. 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

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

26. How often are your eyes dry (not wet enough)? O Constantly O Often O Sometimes O Never

27. How often are your eyes irritated? O Constantly O Often O Sometimes O Never

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

29. 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

30. 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

31. 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) O None O 1-2 colds O 3-5 colds O 6-10 colds O 11+ colds

32. In the PAST FEW DAYS, have you had a cough, cold, or other acute illness? O No O Yes

33. Do you USUALLY have a cough? O No O Yes

34. Do you USUALLY bring up phlegm from your chest, not from the back of your nose? O No O Yes

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

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

37. 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? O No O Yes

38. Which best describes your hearing? O Excellent O Good O A little hearing trouble O Moderate hearing trouble O Deaf

39. Have you noticed a change in your hearing in the PAST 2 YEARS? O No O Yes

IF YES: → Has it: O Improved O Worsened a little O Worsened a lot

40. In the PAST 12 MONTHS, have you had ringing, roaring, or buzzing in your ears?

O Never O Once/month or less O 2-3 times/month O About once/wk. O Several times/wk. O Almost every day