60188

# VITAL 2

1. **Birth date:** ☐☐ / ☐☐ / ☐☐ (month / day / year) → **Your social security number (for identification purposes ONLY)** ☐☐☐ - ☐☐ - ☐☐☐☐

2. **What is your CURRENT weight?** ☐☐☐ pounds → **Your CURRENT height?** ☐ feet AND ☐☐ inches

3. **In the PAST 2 YEARS, did you lose five (5) or more pounds NOT on purpose at any time?** ○ No ○ Yes

4. **What is your sex?** ○ Male ○ Female

***The next several questions ask about your use of nutritional supplements. A supplement is a product, often in the form of a pill, which provides vitamins, minerals, or fatty acids.***

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

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

6. **Do you have any allergies that prevent you from eating fish, shell fish or taking fish oil supplements?** ○ No ○ Yes

7. **Do you have any allergies to soy?** ○ No ○ Yes

8. **Do you regularly take individual supplements of fish oil?** ○ No ○ Yes

**IF YES: Are you willing to stop taking your fish oil supplements while you participate in VITAL?** ○ No ○ Yes

9. **Do you take any of the following anti-coagulant drugs: warfarin (Coumadin), clopidogrel (Plavix) or heparin?** ○ No ○ Yes

10. **The following questions will help us assess your natural skin pigmentation (color) which determines how much vitamin D can be made in the skin with sun exposure.**

a. **What is the color of your skin (non exposed areas)?** ○ White ○ Brown ○ Black

b. **When your skin is exposed to the summer sun for 45-60 minutes at noon for the first time in the season, which of the following best describes its reaction?**

○ Always burn, never tan
○ Sometimes mild burn, tan about average
○ Usually burn, tan less than average (with difficulty)
○ Rarely burn, tan more than average (with ease)

***Over the next pages, we ask you questions about your health history.***

11. **Have you EVER been screened for diabetes by having the level of glucose in your blood measured after fasting?** ○ No ○ Yes

12. **Have you EVER been diagnosed with diabetes?** ○ No ○ Yes

**IF YES:** a. Are you treated with (mark all that apply):

○ Diet and exercise only ○ Insulin injection ○ Non-insulin injections (EX: Exanatide, Byetta)
○ Oral drugs (EX: Glucophage, Avandia, Glucotrol, Prandin, Januvia, Starlix, Actos)

b. Were you diagnosed before age 30? ○ No ○ Yes

c. Have you ever been diagnosed with diabetic kidney disease? ○ No ○ Yes

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○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6



**(OVER)**

**13. The following questions have to do with KNEE PAIN:**

**a. During the LAST MONTH, how often did you have pain or discomfort in or around your knee or knees?**

○ Never ○ Less than 1 day/week ○ 1-2 days/week ○ 3-6 days/week ○ Daily

**b. In the LAST MONTH, did you have knee pain or discomfort when walking 2-3 blocks (1/4 mile)?** ○ No ○ Yes ○ Not applicable

**c. If you have knee pain with walking, for how long have you had this pain?** ○ Less than 1 year ○ 1-5 yrs ○ More than 5 yrs

**d. Have you had a knee replacement surgery?** ○ No ○ Yes → Which knee(s)? ○ Right knee ○ Left knee

**e. Has a doctor EVER told you that you have osteoarthritis (common degenerative arthritis, NOT inflammatory arthritis as gout or rheumatoid arthritis) in your knees?** ○ No ○ Yes

**14. Have you EVER had any of the following illnesses? Answer NO/YES for each item in <u>both left and right columns</u>.**

| | | | | | |
|---|---|---|---|---|---|
| a. Kidney stones | ○ No | ○ Yes | e. Hypo- or hyper**<u>para</u>**thyroidism (**para**thyroid disease is <u>NOT</u> the same as thyroid disease) | ○ No | ○ Yes |
| b. Kidney failure or dialysis | ○ No | ○ Yes | f. Tuberculosis | ○ No | ○ Yes |
| c. High levels of calcium in blood (hypercalcemia) | ○ No | ○ Yes | g. Sarcoid or Wegener's (granulomat.) | ○ No | ○ Yes |
| d. Cirrhosis of the liver or other severe liver disease | ○ No | ○ Yes | h. Mini-stroke (transient ischemic attack or TIA) | ○ No | ○ Yes |

**PLEASE ANSWER ALL ITEMS IN BOTH COLUMNS**

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○ el
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**15. Not including the illnesses listed in #14 above, do you have any other major illnesses that might prevent you from participating in the VITAL study?** ○ No ○ Yes

**<u>IF YES:</u> Please specify the illness:** _____

**16. Have you had recurring (repeated) headaches during the PAST YEAR?**

○ No ○ Yes →

**<u>IF YES:</u> Describe these recurring headaches:**

a. Pain is most severe on one side of the head? ○ No ○ Yes
b. Pain is of pulsating / throbbing / pounding quality? ○ No ○ Yes
c. Pain becomes worse during physical activity? ○ No ○ Yes
d. Pain is associated with nausea / vomiting? ○ No ○ Yes

**17. Do you have unpleasant leg sensations (crawling, paraesthesias, or pain) combined with leg restlessness and an urge to move?**

○ No ○ Yes →

**<u>IF YES:</u>**

a. Do these symptoms occur only at rest and does moving improve them? ○ No ○ Yes
b. Are these symptoms worse in the evening/night compared to the morning? ○ No ○ Yes
c. How often do these symptoms occur? ○ Daily ○ 3-6/week ○ 1-2/week ○ 1-3/month ○ less than 1/month ○ Not sure

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

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

**20. Has your chest EVER sounded wheezy or whistling?** ○ No ○ Yes

**21. Has a physician EVER told you that you have asthma?** ○ No ○ Yes

**22. Have you EVER been diagnosed with chronic bronchitis, emphysema, or chronic obstructive lung disease (COPD)?** ○ No ○ Yes

**23. Within the PAST YEAR, have you been diagnosed with pneumonia?** ○ No ○ Yes

**<u>IF YES:</u>** Related to your diagnosis of pneumonia, were you hospitalized? ○ No ○ Yes

**24. The following questions have to do with blood pressure:**

**a. Has a physician EVER told you that you have high blood pressure?** ○ No ○ Yes ○ Don't know

**b. Have you EVER been prescribed medication to treat high blood pressure?** ○ Never ○ Past only ○ Current

**IF CURRENT: Which type(s) of medication(s) do you CURRENTLY take? (mark all that apply)**
**After each type of medication are examples of some of the most common medication names of that type.**

- ○ 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)

**c. Blood pressure is represented as two numbers, an UPPER NUMBER (systolic) and a LOWER NUMBER (diastolic). The upper number is always larger than the lower one. For example, a blood pressure measurement of 110 over 70 is written as 110/70.**

**Do you know your CURRENT blood pressure measurement?** ○ No ○ Yes

**IF YES: Please mark the bubbles below that best match your CURRENT blood pressure measurement. Mark only one bubble for UPPER and one bubble for LOWER.**

**UPPER BLOOD PRESSURE NUMBER:**

| | | | |
|---|---|---|---|
| ○ less than 110 | ○ 130-139 | ○ 160-169 | ○ 190-199 |
| ○ 110-119 | ○ 140-149 | ○ 170-179 | ○ 200-209 |
| ○ 120-129 | ○ 150-159 | ○ 180-189 | ○ 209+ |

**LOWER BLOOD PRESSURE NUMBER:**

| | | | |
|---|---|---|---|
| ○ less than 65 | ○ 75-79 | ○ 90-94 | ○ 105-109 |
| ○ 65-69 | ○ 80-84 | ○ 95-99 | ○ 110-114 |
| ○ 70-74 | ○ 85-89 | ○ 100-104 | ○ 115+ |

**d. How many years ago was your most recent blood pressure measured?**

○ Within past year ○ 1-2 years ○ 3-5 years ○ More than 5 years ago ○ Don't know

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**25. Have you EVER had anemia (low red blood cell count)?** ○ No ○ Yes

**IF YES: Have you EVER had a blood transfusion for your anemia?** ○ No ○ Yes

**26. Have you EVER been evaluated by a hematologist (blood specialist)?** ○ No ○ Yes

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**27. When was your last eye exam?** ○ Within past year ○ 1-2 yrs. ago ○ 3-5 yrs. ago ○ More than 5 yrs. ago ○ Never had an exam

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

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

**30. Have you EVER been diagnosed (by a clinician) with dry eye syndrome or dry eye disease?** ○ No ○ Yes

**31. Have you EVER had macular degeneration?** ○ No ○ Yes

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**32. The level of total cholesterol in the blood is given as one number, usually 3-digits in length. Do you know your total cholesterol level?**

○ No ○ Yes →

**IF YES: Please mark the bubble below that best matches your CURRENT total cholesterol level. Mark only one bubble.**

| | | | | | |
|---|---|---|---|---|---|
| ○ less than 140 | ○ 140-159 | ○ 160-179 | ○ 180-199 | ○ 200-219 | ○ 220-239 |
| ○ 240-259 | ○ 260-279 | ○ 280-299 | ○ 300-319 | ○ greater than 320 | |

**33. The following question has to do with autoimmune disease. Please mark the appropriate bubble in the columns to the right whether you or any blood relative has EVER been told by a doctor that you (or relative) have one of the following diseases. A blood relative includes father, mother, sister (full or half), brother (full or half) and child and does not include relatives through marriage only. Please answer for each disease in both columns.**

| NAME OF AUTOIMMUNE DISEASE | ME | ANY BLOOD RELATIVE |
|---|---|---|
| a. Autoimmune thyroid disease (includes Graves' disease, Hashimoto's thyroiditis, underactive or overactive thyroid, but NOT thyroid nodule or cancer) | O No O Yes | O No O Yes O Don't know |
| b. Inflammatory bowel disease (Crohn's disease or ulcerative colitis, but NOT irritable bowel syndrome) | O No O Yes | O No O Yes O Don't know |
| c. Polymyalgia rheumatica (PMR), temporal arteritis or giant cell arteritis | O No O Yes | O No O Yes O Don't know |
| d. Rheumatoid arthritis (NOT osteoarthritis, degenerative arthritis or gout) | O No O Yes | O No O Yes O Don't know |
| e. Psoriasis or psoriatic arthritis | O No O Yes | O No O Yes O Don't know |
| f. Other autoimmune disease (Please specify:_____) Office use only: O | O No O Yes | O No O Yes O Don't know |

**As a participant in the VITAL study, there may be opportunities for you to also participate in other smaller studies, called sub-studies, that are related to the supplements that we are studying (vitamin D and fish oil). For example:**

**Would you be willing to learn about an additional study of memory, that would require only 3 phone interviews over the next five years?** O No O Yes O Not sure, please provide more information

**An important part of the VITAL study is to look at amounts of vitamin D, omega-3 fatty acids (found in fish oil) and other chemicals (biomarkers) in blood samples provided by study participants.**

**Would you be willing to provide a blood sample if we sent you a convenient collection kit containing everything you need? This would require you to go to your health provider to get assistance in drawing the blood. A pre-paid and pre-addressed mailer would be provided for return of the blood sample to our lab, at no cost to you. If you are not willing to provide a blood sample, it will NOT affect your eligibility to participate in the VITAL trial.**

O No O Yes O Not sure, please provide more information

**In the event that we need to reach you to clarify any of your responses, please provide your contact information here.**

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**

→ **E-MAIL ADDRESS:**_____

***Thank you for completing the form. Please return it along with the Informed Consent form in the enclosed pre-paid envelope.***

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