15992

VITAL OBS 5

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. Any thyroid condition	○ No ○ Yes →	☐☐ / ☐☐
q. Pneumonia **IF YES, were you <u>hospitalized?</u>** ○ No ○ Yes	○ No ○ Yes →	☐☐ / ☐☐
r. Intermittent claudication (pain in legs while walking due to blocked arteries)	○ No ○ Yes →	☐☐ / ☐☐
s. Peripheral artery surgery / stenting (procedure to unblock arteries in legs)	○ No ○ Yes →	☐☐ / ☐☐
t. Carotid stenosis (blocked arteries in neck)	○ No ○ Yes →	☐☐ / ☐☐
u. Carotid artery surgery / stenting (procedure to unblock arteries in neck)	○ No ○ Yes →	☐☐ / ☐☐
v. Deep vein thrombosis (blood clot in legs)	○ No ○ Yes →	☐☐ / ☐☐
w. 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
x. Parkinson's disease	O No O Yes →	☐☐/☐☐
y. Cataract surgery (extraction)	O No O Yes →	☐☐/☐☐
z. Macular degeneration	O No O Yes →	☐☐/☐☐
aa. Dry eye syndrome or dry eye disease	O No O Yes →	☐☐/☐☐
bb. Periodontal disease (gum disease)	O No O Yes →	☐☐/☐☐
cc. Colon or rectal polyp **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 No O Yes O Not sure	☐☐/☐☐
dd. Have you had any OTHER MAJOR ILLNESS in the past year? **IF YES, please specify:**_____	O No O Yes →	☐☐/☐☐
ee. Coronavirus (COVID-19) **IF YES:** a. Was this confirmed by a positive COVID-19 test? b. Were you hospitalized? c. Did you require treatment in an Intensive Care Unit (ICU)?	O No O Yes → O No O Yes O No O Yes → O No O Yes	☐☐/☐☐ ☐☐/☐☐

2. IN THE PAST YEAR, have you experienced any of these symptoms that may occur with conditions such as allergies, colds and flu, COVID-19 or when taking certain medications?

		Duration of symptom				Is this symptom CURRENTLY present?
	Did not have this symptom	Less than 2 weeks	2 weeks to less than 8 weeks	8 weeks to less than 6 months	6 months or more	
a. Fever	O	O	O	O	O	O Yes
b. Persistent cough	O	O	O	O	O	O Yes
c. Chills or sweats	O	O	O	O	O	O Yes
d. Headache	O	O	O	O	O	O Yes
e. Sore throat	O	O	O	O	O	O Yes
f. Hoarseness	O	O	O	O	O	O Yes
g. Loss of smell or taste	O	O	O	O	O	O Yes
h. Shortness of breath/ difficulty breathing	O	O	O	O	O	O Yes
i. Chest pain/tightness	O	O	O	O	O	O Yes
j. Muscle aches	O	O	O	O	O	O Yes
k. Abdominal pain	O	O	O	O	O	O Yes
l. Diarrhea	O	O	O	O	O	O Yes
m. Confusion or “brain fog”	O	O	O	O	O	O Yes
n. Malaise- a general feeling of illness, discomfort, uneasiness	O	O	O	O	O	O Yes
o. Sleep disturbance	O	O	O	O	O	O Yes
p. Unusual fatigue	O	O	O	O	O	O Yes

PLEASE CONTINUE ON THE NEXT PAGE

3. Have you received at least one dose of a COVID-19 vaccine? O No O Yes
IF YES, please indicate the date you received the shot and which vaccines you received:

	Date: MO/YR	Vaccine Received
a. FIRST vaccine	☐☐ / ☐☐	O Moderna O Pfizer-BioNTech O Johnson & Johnson
b. SECOND vaccine	☐☐ / ☐☐	O Moderna O Pfizer-BioNTech O Johnson & Johnson
c. FIRST booster shot	☐☐ / ☐☐	O Moderna O Pfizer-BioNTech
d. SECOND booster shot	☐☐ / ☐☐	O Moderna O Pfizer-BioNTech
e. THIRD booster shot	☐☐ / ☐☐	O Moderna O Pfizer-BioNTech

4. 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

5. 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 Cod liver oil O Krill oil O Other fish oil (over-the-counter)
O Eye supplements containing omega-3

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

6. Do you take a calcium supplement daily? O No O Yes
(Ex: Os-Cal, Caltrate, Citracal, Calcium+D, Viactiv, Tums)
IF YES: How much TOTAL calcium do you take each day from nutritional supplements such as single tablets of calcium and multivitamins. Referring to package labels, please add up ALL your non-diet sources of calcium.
O 500 mg or less/day O 501-1200 mg/day O 1201-1500 mg/day O greater than 1500 mg/day

7. Are you CURRENTLY taking any drugs for high blood pressure? O No O Yes
IF YES: Which **TYPES** of drugs are you taking? **(Mark ALL that apply)**
O Beta-blockers (atenolol) O Calcium-blockers (amlodipine) O Alpha-blockers (terazosin)
O Thiazide diuretics (hydrochlorothiazide) O Angiotensin receptor blockers (valsartan)
O Aldosterone receptor blockers (spironolactone) O Loop diuretics (furosemide) O ACE-inhibitors (lisinopril)
O Other high blood pressure medication, not listed

8. 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 Tymlos (abaloparatide) injection
O Forteo (teriparatide injection) O Miacalcin or Fortical (calcitonin-salmon) O Reclast (zoledronic acid)
O Evenity (romosozumab) O Prolia (denosumab) O Boniva O Other osteoporosis medication, not listed
O I do NOT take any medications for bone loss treatment/prevention

PLEASE CONTINUE ON THE NEXT PAGE

9. 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) **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	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. Tamoxifen (Ex: Nolvadex)	O No	O Yes
j. Serotonin reuptake inhibitor (Ex: Celexa, Lexapro, Cipralex, Esertia, Prozac, Zoloft)	O No	O Yes
k. Aromatase inhibitor (Ex: Arimidex, Aromasin, Femara)	O No	O Yes
l. Corticosteroid or prednisone	O No	O Yes
m. Diabetes medication(s) **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, Byetta, Bydureon, Trulicity, Ozempic, Victoza, Saxenda, Adlyxin) 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	O No	O Yes
n. Thyroid medication (Ex: Synthroid, Levoxyl, Levothroid, levothyroxine)	O No	O Yes
o. Calcitriol (Ex: Rocaltrol, Calcijex, Vectical, Paricalcitol, Zemplar)	O No	O Yes

10. IN THE PAST 3 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 **(women only)**	O No	O Yes

11. Do you CURRENTLY smoke cigarettes? O No O Yes
IF YES, what is the average number of cigarettes that you smoke per day?
O less than 15 O 15-25 O greater than 25

PLEASE CONTINUE ON THE NEXT PAGE

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

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

14. Did you receive the influenza (flu) vaccine after August 2022? O No O Yes

15. What is your CURRENT marital status? O Married O Divorced O Widowed O Separated O Never married

16. Where do you live? O Independent housing in the general community O Nursing home or skilled nursing facility
O Senior/retirement housing or community for people age 55+ O Assisted living facility

17. With whom do you live? (Mark ALL that apply) O Alone O With spouse or partner
O With other family O With non-relatives

18. Are you the primary caregiver of another person (Ex: friend, spouse, relative, or other loved one)? O No O Yes

IF YES: Overall, how burdened do you feel in providing this care?
O Not at all O A little O Moderately O Quite a bit O Extremely

The following 2 questions deal with mood. If you have concerns about your answers to questions #19-20, 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

19. 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
c. Trouble falling or staying asleep, or sleeping too much	O	O	O	O

20. 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

21. On average, how many hours of sleep do you get per night?
O Less than 4 hours O 4 hours O 5 hours O 6 hours O 7 hours O 8 hours O 9 hours O 10 hours or more

22. 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

23. 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

24. 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

PLEASE CONTINUE ON THE NEXT PAGE

25. 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

26. 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: ☐☐/☐☐

27. 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)	O No	O Yes	☐☐/☐☐
b. Inflammatory bowel disease (Crohn's disease or ulcerative colitis, but NOT irritable bowel syndrome)	O No	O Yes	☐☐/☐☐
c. Polymyalgia rheumatica (PMR), temporal arteritis or giant cell arteritis	O No	O Yes	☐☐/☐☐
d. Rheumatoid arthritis (NOT osteoarthritis, degenerative arthritis or gout)	O No	O Yes	☐☐/☐☐
e. Psoriasis or psoriatic arthritis	O No	O Yes	☐☐/☐☐
f. Sarcoidosis or granulomatosis with polyangiitis (Wegener's)	O No	O Yes	☐☐/☐☐
g. Multiple sclerosis	O No	O Yes	☐☐/☐☐
h. Other autoimmune disease (Please specify:_____)	O No	O Yes	☐☐/☐☐

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

YOUR HOME PHONE: (☐☐☐) ☐☐☐-☐☐☐☐ **YOUR 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:

_____

Name, address and phone of someone at a different address than you whom we may contact if we are unable to reach you:

NAME: _____ **STREET:** _____

CITY: _____ **STATE:** ☐☐ **ZIP:** ☐☐☐☐☐ **THIS CONTACT IS:** O Relative O Friend O Neighbor O Other

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