47088

Request

VITAL JAN '18

Use ball-point pen to complete the form.

O K

DATE OF BIRTH: ☐☐ / ☐☐ / ☐☐ **We use DATE OF BIRTH (DOB) to verify the identity of the person providing information.**

Is the DOB above correct? O Yes O 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) 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:
O melanoma O squamous or basal cell O not sure

e. Heart attack or myocardial infarction O No O Yes ☐☐/☐☐

f. Coronary bypass surgery O No O Yes ☐☐/☐☐

g. Coronary angioplasty or stent (balloon used to unblock an artery) O No O Yes ☐☐/☐☐

h. Chest pain (angina) O No O Yes ☐☐/☐☐
IF YES, were you hospitalized? O No O Yes

i. Stroke O No O Yes ☐☐/☐☐

j. Mini-stroke (TIA) O No O Yes ☐☐/☐☐

k. Atrial fibrillation O No O Yes ☐☐/☐☐

l. Other irregular heart rhythm O No O Yes ☐☐/☐☐

m. Heart failure or congestive heart failure O No O Yes ☐☐/☐☐
IF YES, were you hospitalized? O No O Yes

n. Kidney stones O No O Yes ☐☐/☐☐

o. High levels of calcium in the blood (hypercalcemia) O No O Yes ☐☐/☐☐

p. Pneumonia O No O Yes ☐☐/☐☐
IF YES, were you hospitalized? O No O Yes

q. Sarcoid or Wegener's (granulomatosis) O No O Yes ☐☐/☐☐

r. Intermittent claudication (pain in legs while walking due to blocked arteries) O No O Yes ☐☐/☐☐

s. Peripheral artery surgery / stenting (procedure to unblock arteries in legs) O No O Yes ☐☐/☐☐

t. Carotid stenosis (blocked arteries in neck) O No O Yes ☐☐/☐☐

u. Carotid artery surgery / stenting (procedure to unblock arteries in neck) O No O Yes ☐☐/☐☐

v. Deep vein thrombosis (blood clot in legs) O No O Yes ☐☐/☐☐

w. Pulmonary embolism (blood clot in lungs) O No O Yes ☐☐/☐☐

x. Parkinson's disease O No O Yes ☐☐/☐☐

y. Multiple sclerosis O No O Yes ☐☐/☐☐

z. Macular degeneration O No O Yes ☐☐/☐☐

aa. Periodontal disease (gum disease) O No O Yes ☐☐/☐☐

bb. Colon or rectal polyp O No O Yes ☐☐/☐☐

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 Not sure

cc. For women: In the PAST YEAR have you:
(Men skip to question #2 below)

1. Had a mammogram? O No O Yes
2. Had a breast biopsy? O No O Yes
   IF YES, date of biopsy: ☐☐/☐☐
3. Been diagnosed with fibrocystic or other benign breast disease? O No O Yes
   IF YES, date of diagnosis: ☐☐/☐☐
   Was it confirmed by breast biopsy? O No O Yes
   Was it confirmed by aspiration? O No O Yes

2. IF YOU HAVE EVER BEEN DIAGNOSED WITH HEART FAILURE OR CONGESTIVE HEART FAILURE, ANSWER THE FOLLOWING. IF NEVER, PLEASE SKIP TO QUESTION #3 ON THE NEXT PAGE.

a. In the PAST YEAR, were you 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

b. 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

OFFICE: O ep O not ep O bl | O 1 O 2 O 3 O 4 O 5

PLEASE CONTINUE ON THE NEXT PAGE

3. 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	☐☐ / ☐☐

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

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

6. Do you CURRENTLY take Calcitriol? (Ex: Rocaltrol, Calcijex, Vectical, Paricalcitol, Zemplar) ○ No ○ Yes

7. In the PAST YEAR, have you had an unintentional fall (coming to rest on the ground, floor or lower surface)? ○ No ○ Yes

IF YES: →
a. Number of falls in the past year: ○ 1 ○ 2 ○ 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?
○ None ○ 1 ○ 2 ○ 3 or more
c. Were you evaluated by a health care provider or admitted to the hospital following any of the injuries? ○ No ○ Yes

8. In the PAST YEAR, has a doctor or other health care provider told you that you had broken a bone? ○ No ○ Yes

IF YES: →
a. Which bone (Mark ALL that apply)? ○ Hip ○ Spine ○ Forearm / shoulder ○ Other
b. Please provide the date (month/year) when the break occurred: ☐☐ / ☐☐

9. a. In the PAST YEAR, how often have you typically leaked urine, even a small amount?

○ Never: skip to question #10 below ○ Less than monthly ○ Monthly (once or more each month)
○ Weekly (once or more each week) ○ Daily (once or more each day)

b. If you have leaked urine, under what circumstances does your leakage most often occur? Please choose only one.

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

c. In the PAST YEAR, how many times per night did you most typically get up to urinate, from the time you went to bed at night until the time you got up in the morning? ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 or more

d. How often do you urinate during the day (and evening)? Please choose only one.

○ Hourly ○ Every 2 hours ○ Every 3 hours ○ Every 4 hours or more

e. How often do you have a sudden need to rush to the toilet to urinate? Please choose only one.

○ Never ○ Occasionally ○ Frequently ○ All of the time

10. 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

PLEASE CONTINUE ON THE NEXT PAGE

11. 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

12. a. PRIOR TO THE START OF THE TRIAL (about 5 years ago), did you have a painful health condition? ○ No ○ Yes

IF YES, how would you describe your symptoms since the start of the trial? ○ Not changed ○ Worsened ○ Improved

b. SINCE THE START OF THE TRIAL (about 5 years ago), have you been newly diagnosed with a painful health condition? ○ No ○ Yes

c. In the LAST 3 MONTHS, how often have you had pain? ○ Never ○ Some days ○ Most days ○ Every day

d. Thinking about the last time you had pain, how much pain did you have? ○ A little ○ Between a little and a lot ○ A lot

13. SINCE THE START OF THE TRIAL (about 5 years ago), have you experienced any change in your hair, nails, or skin?

(Please answer on each line)	Significantly increased	Slightly increased	NO CHANGE	Slightly decreased	Significantly decreased
a. Overall hair volume	○	○	○	○	○
b. Hair shine	○	○	○	○	○
c. Nail strength	○	○	○	○	○
d. Nail growth rate	○	○	○	○	○
e. Overall skin health	○	○	○	○	○
f. Skin smoothness	○	○	○	○	○

14. SINCE THE START OF THE TRIAL (about 5 years ago), have you noticed a change in the frequency of your bowel movements?

○ Significantly increased ○ Slightly increased ○ No change ○ Slightly decreased ○ Significantly decreased

15. SINCE THE START OF THE TRIAL (about 5 years ago), have you noticed a change in your energy level? ○ No ○ Yes

IF YES, has it: ○ Improved a lot ○ Improved a little ○ Worsened a little ○ Worsened a lot

16. a. Which best describes your hearing? ○ Excellent ○ Good ○ A little hearing trouble ○ Moderate hearing trouble ○ A lot of hearing trouble ○ Deaf

b. SINCE THE START OF THE TRIAL (about 5 years ago), have you noticed a change in your hearing? ○ No ○ Yes

IF YES, has it: ○ Improved ○ Worsened a little ○ Worsened a lot

c. SINCE THE START OF THE TRIAL (about 5 years ago), have you had ringing, roaring, or buzzing in your ears or head?

○ Never ○ Less than once/week ○ About once/week ○ Several times/week ○ Almost every day ○ Every day

Have these sounds changed in the PAST 2 YEARS? ○ Not applicable ○ No ○ Yes

IF YES, have they: ○ Improved ○ Worsened a little ○ Worsened a lot

17. a. Have you EVER experienced recurring (repeated) headaches ? ○ No → **If NO, skip to question #18.**

○ Yes ↓

b. SINCE THE START OF THE TRIAL (about 5 years ago), have your recurring headaches changed with respect to frequency or severity?

FREQUENCY: ○ No change in frequency ○ More headache days per month now ○ Fewer headache days per month now

SEVERITY: ○ No change in severity ○ Headaches are more severe now ○ Headaches are less severe now

PLEASE CONTINUE ON THE NEXT PAGE

18. SINCE THE START OF THE TRIAL (about 5 years ago), have you been diagnosed with gallbladder disease? ○ No ○ Yes

19. SINCE THE START OF THE TRIAL (about 5 years ago), have you had surgery to remove your gallbladder? ○ No ○ Yes

20. 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?	○	○	○

21. 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	○	○	○
b. Moderate activities such as moving a table, vacuuming, bowling, or golf	○	○	○
c. Lifting or carrying groceries	○	○	○
d. Climbing several flights of stairs	○	○	○
e. Climbing one flight of stairs	○	○	○
f. Bending, kneeling, stooping	○	○	○
g. Walking more than a mile	○	○	○
h. Walking several blocks	○	○	○
i. Walking one block	○	○	○
j. Bathing or dressing yourself	○	○	○

22. At the beginning of the trial, you were randomly assigned (like a flip of a coin) to either active or placebo for each study pill. If you had to guess, for each, what do you think you were assigned to?

a. Small capsule (vitamin D agent): ○ Active ○ Placebo ○ No idea

b. Large capsule (fish oil agent): ○ Active ○ Placebo ○ No idea

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

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:

○ **Home phone** ○ **Cell phone**

○ **Work phone** ○ **No difference**

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

If you would like to continue to receive information, including the most timely updates on the study results, and your address has changed, please provide your NEW E-MAIL below:

_____ ○

Office space - do not write below.

1 _____ – _____ 4 _____ – _____ 2