28227

Request

Use ball-point pen to complete the form.

VITAL R 1YR

1. Birth date: ☐☐ / ☐☐ / ☐☐ (month / day / year) → **Last 4 digits of social security number (for identification purposes ONLY)** XXX-XX-☐☐☐☐

2. 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 (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. Colon or rectal polyps	O No	O Yes	☐☐/☐☐
ee. Parkinson's disease	O No	O Yes	☐☐/☐☐
ff. Multiple sclerosis	O No	O Yes	☐☐/☐☐
gg. Cataract surgery (extraction)	O No	O Yes	☐☐/☐☐
hh. Macular degeneration	O No	O Yes	☐☐/☐☐
ii. Gastric bypass surgery	O No	O Yes	☐☐/☐☐
jj. 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	
kk. Periodontal disease	O No	O Yes	☐☐/☐☐

ll. 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.

_____

_____

OFFICE USE: O

PLEASE ANSWER ALL ITEMS IN BOTH COLUMNS

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

PLEASE CONTINUE ON THE NEXT PAGE

28227

Use ball-point pen to complete the form.

VITAL R 1YR

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

4. IN THE PAST YEAR, have you experienced any of the following? Please answer NO/YES for each item.

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

PLEASE ANSWER ALL ITEMS IN BOTH COLUMNS

5. 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. Are you currently taking the large study capsule? ○ No ○ Yes

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

6. <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 ○ greater than 1000 IU/day

7. <u>NOT including your study capsules</u>, do you regularly take individual supplements of fish oil? ○ No ○ Yes

8. 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

9. Do you CURRENTLY smoke cigarettes? ○ No ○ Yes

IF YES, what is the average number of cigarettes that you smoke per day? ○ less than 15 ○ 15-25 ○ greater than 25

PLEASE CONTINUE ON THE NEXT PAGE

28227

Use ball-point pen to complete the form.

VITAL R 1YR

10. Are you CURRENTLY taking any of the following drugs regularly? Please answer NO/YES for each item.

a. Aspirin (Ex: Bayer, Bufferin, Anacin, Excedrin)	○ No	○ Yes	g. Tamoxifen (Ex: Nolvadex)	○ No	○ Yes
IF YES: In the past month, on how many DAYS did you take it? ○ 1-3 days ○ 4-10 days ○ 11-20 days ○ 21+ days			h. Serotonin reuptake inhibitor (Ex: Celexa, Lexapro, Cipralex, Esertia, Prozac, Zoloft, Zelmid)	○ No	○ Yes
b. Anti-coagulant/blood thinner (Ex: warfarin, Coumadin, clopidogrel, Plavix, heparin, Pradaxa, dabigatran, Xarelto, rivaroxaban)	○ No	○ Yes	i. Aromatase inhibitor (Ex: Arimidex, Aromasin, Femara)	○ No	○ Yes
c. Calcitriol (Rocaltrol, Calcijex, Vectical) or Paricalcitol (Zemplar)	○ No	○ Yes	j. Lithium	○ No	○ Yes
d.Statin drugs to lower cholesterol (Ex: Lipitor, Zocor, Mevacor, Pravachol, Crestor)	○ No	○ Yes	k. Corticosteroids or prednisone	○ No	○ Yes
e. **Non-statin** drugs to lower cholesterol (Ex: Niacin, Lopid, Questran, Colestid, Zetia)	○ No	○ Yes	l. Diabetes medication(s) - Mark ALL that apply: ○ NONE ○ Insulin injection ○ Non-insulin injection (EX: Exenatide, Byetta) ○ Glucophage (metformin) ○ Other oral drugs (EX: Avandia, Glucotrol, Prandin, Januvia, Starlix, Actos)		
f. Estrogen, alone or with progestin (do NOT include vaginal estrogen)	○ No	○ Yes			

PLEASE ANSWER ALL ITEMS IN BOTH COLUMNS

11. Are you CURRENTLY taking any of the following drugs for prevention or treatment of bone loss? (Mark ALL that apply)

○ Fosamax (alendronate) ○ Evista (raloxifene) ○ Actonel (risedronate) ○ Reclast (zoledronic acid)

○ Prolia (denosumab) ○ Forteo (teriparatide injection) ○ Miacalcin or Fortical (calcitonin-salmon)

○ other osteoporosis medication, not listed above ○ I do NOT take any medications for bone loss treatment/prevention

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:

○ **Home phone** ○ **Cell phone**

○ **Work phone** ○ **No difference**

Please provide us with the names and phone numbers of 2 individuals (not living in your household) whom we have permission to contact in the event that we are not able to contact you directly:

CONTACT 1	CONTACT 2
Name:_____	**Name:**_____
Phone number:_____	**Phone number:**_____
Relationship (circle): Family Friend Neighbor Other	**Relationship (circle): Family Friend Neighbor Other**

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

_____

PLEASE CONTINUE ON THE NEXT PAGE

12. In the PAST YEAR, have you been NEWLY DIAGNOSED with any of the following auto-immune 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. Other autoimmune disease (Please specify:_____) Office use only: O	O No	O Yes	/

13. Have you EVER been diagnosed with celiac disease? O No O Yes

IF YES: Was it FIRST DIAGNOSED during the past year? O No O Yes

The following questions have to do with mood. If you have any concerns about your answers to questions #14-17, please share them with your health care provider. Also, please 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	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
d. Feeling tired or having little energy	O	O	O	O
e. Poor appetite or overeating	O	O	O	O
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	O	O	O	O
g. Trouble concentrating on things like reading the paper or watching TV	O	O	O	O
h. Moving or speaking so slowly that others could have noticed. Or the opposite -- being fidgety, restless, or moving a lot more than usual	O	O	O	O

15. 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

16. In the PAST YEAR, have you had 2 weeks or more during which you felt sad, blue, or depressed or lost pleasure in things that you usually cared about or enjoyed? O No O Yes

17. Have you had 2 or more consecutive years of feeling depressed or sad most days, even if you felt OK sometimes? O No O Yes

PLEASE CONTINUE ON THE NEXT PAGE

28227

Use ball-point pen to complete the form.

VITAL R 1YR

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

19. When was your most recent blood pressure measured?

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

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

If YES, which medications do you take? (Mark all that apply)

○ 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)

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

IF YES, which bone? (Mark ALL that apply) ○ Hip ○ Spine ○ Forearm / shoulder ○ Other

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

IF YES, please answer the following:

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

23. In the PAST YEAR, have you had a NEW DIAGNOSIS of anemia (low red blood cell count)? ○ No ○ Yes

IF YES: a. What was the date (month/year) of this new diagnosis? ☐☐/☐☐

b. Did you have a blood transfusion for your anemia? ○ No ○ Yes

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

DO NOT WRITE IN THE SPACE BELOW. PLEASE CONTINUE ON THE LAST PAGE. →

OFFICE USE ONLY

1 ☐☐☐☐☐☐☐ – ☐☐☐☐
2 ☐☐☐☐☐☐☐ – ☐☐☐☐
3 ☐☐☐☐☐☐☐ – ☐☐☐☐
4 ☐☐☐☐☐☐☐ – ☐☐☐☐
5 ☐☐☐☐☐☐☐ – ☐☐☐☐
6 ☐☐☐☐☐☐☐ – ☐☐☐☐

25. In the PAST YEAR, have you had an eye exam? ○ No ○ Yes

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

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

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

IF YES, what was the month/year of the diagnosis? ☐☐ / ☐☐

29. In the PAST YEAR, have you been hospitalized for heart failure (congestive heart failure)? ○ No ○ Yes

IF YES, how many times? ○ 1 ○ 2 ○ 3 or more

30. In the PAST YEAR, have you been treated in the emergency room (but not hospitalized) for heart failure (congestive heart failure)? ○ No ○ Yes IF YES, how many times? ○ 1 ○ 2 ○ 3 or more

31. In the PAST YEAR have you experienced any of the following? If YES, please provide the month/year of the event/procedure.

			MO/YR
a. Been told by a physician that you have urinary tract or kidney infection	○ No	○ Yes	☐☐ / ☐☐
b. Been told by a physician that you have eczema, including atopic dermatitis	○ No	○ Yes	☐☐ / ☐☐
c. Been told by a physician that you have skin infection, including cellulitis	○ No	○ Yes	☐☐ / ☐☐
d. Received influenza vaccine (seasonal flu shot)	○ No	○ Yes	☐☐ / ☐☐
e. Received pneumococcus vaccine (Pneumovax)	○ No	○ Yes	☐☐ / ☐☐
f. Been treated with an antibiotic for an acute infection	○ No	○ Yes	☐☐ / ☐☐
g. Been hospitalized overnight for any type of acute infection	○ No	○ Yes	☐☐ / ☐☐

32. 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) ○ None ○ 1-2 colds ○ 3-5 colds ○ 6-10 colds ○ 11+ colds

33. In the past few days, have you had a cough, cold, or other acute illness? ○ No ○ Yes

34. Do you USUALLY have a cough? ○ No ○ Yes

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

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

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

38. 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? ○ No ○ Yes

39. If female, please answer the following questions.

a. In the PAST 2 YEARS, have you had a mammogram? ○ No ○ Yes

b. In the PAST 2 YEARS, have you had a breast biopsy? ○ No ○ Yes

Thank you for completing the form. Please return it in the enclosed pre-paid envelope.
If you have questions about the form or the study, call our toll-free number, 1-800-388-3963.

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6

OFFICE USE ONLY