Use ball-point pen to complete the form.

<table>
<thead>
<tr>
<th>DATE OF BIRTH:</th>
<th>We use DATE OF BIRTH (DOB) to verify the identity of the person providing information.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the DOB above correct?</td>
<td>O Yes  O No  (\rightarrow) IF NO, what is your correct date of birth?</td>
</tr>
</tbody>
</table>

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 N/Y for each item)

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>MO/yr</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Hypertension (high blood pressure)</td>
<td>O No  O Yes</td>
</tr>
<tr>
<td>b. Diabetes</td>
<td>O No  O Yes</td>
</tr>
<tr>
<td>c. Cancer (NOT including skin cancer)</td>
<td>O No  O Yes</td>
</tr>
<tr>
<td>d. Skin cancer</td>
<td>O No  O Yes</td>
</tr>
<tr>
<td>e. melanoma  squamous or basal cell</td>
<td>O not sure</td>
</tr>
<tr>
<td>f. Heart attack or myocardial infarction</td>
<td>O No  O Yes</td>
</tr>
<tr>
<td>g. Coronary bypass surgery</td>
<td>O No  O Yes</td>
</tr>
<tr>
<td>h. Coronary angioplasty or stent</td>
<td>O No  O Yes</td>
</tr>
<tr>
<td>i. Chest pain (angina)</td>
<td>O No  O Yes</td>
</tr>
<tr>
<td>j. Stroke</td>
<td>O No  O Yes</td>
</tr>
<tr>
<td>k. Mini-stroke (TIA)</td>
<td>O No  O Yes</td>
</tr>
<tr>
<td>l. Atrial fibrillation</td>
<td>O No  O Yes</td>
</tr>
<tr>
<td>m. Other irregular heart rhythm</td>
<td>O No  O Yes</td>
</tr>
<tr>
<td>n. Heart failure or congestive heart failure</td>
<td>O No  O Yes</td>
</tr>
<tr>
<td>o. Kidney failure or dialysis</td>
<td>O No  O Yes</td>
</tr>
<tr>
<td>p. Any thyroid condition</td>
<td>O No  O Yes</td>
</tr>
<tr>
<td>q. Pneumonia</td>
<td>O No  O Yes</td>
</tr>
<tr>
<td>r. Intermittent claudication (pain in legs while walking due to blocked arteries)</td>
<td>O No  O Yes</td>
</tr>
<tr>
<td>s. Peripheral artery surgery / stenting (procedure to unblock arteries in legs)</td>
<td>O No  O Yes</td>
</tr>
<tr>
<td>t. Carotid stenosis (blocked arteries in neck)</td>
<td>O No  O Yes</td>
</tr>
<tr>
<td>u. Carotid artery surgery / stenting (procedure to unblock arteries in neck)</td>
<td>O No  O Yes</td>
</tr>
<tr>
<td>v. Deep vein thrombosis (blood clot in legs)</td>
<td>O No  O Yes</td>
</tr>
<tr>
<td>w. Pulmonary embolism (blood clot in lungs)</td>
<td>O No  O Yes</td>
</tr>
<tr>
<td>x. Parkinson's disease</td>
<td>O No  O Yes</td>
</tr>
<tr>
<td>y. Multiple sclerosis</td>
<td>O No  O Yes</td>
</tr>
<tr>
<td>z. Cataract surgery (extraction)</td>
<td>O No  O Yes</td>
</tr>
<tr>
<td>aa. Macular degeneration</td>
<td>O No  O Yes</td>
</tr>
<tr>
<td>bb. Dry eye syndrome or dry eye disease</td>
<td>O No  O Yes</td>
</tr>
<tr>
<td>cc. Periodontal disease (gum disease)</td>
<td>O No  O Yes</td>
</tr>
<tr>
<td>dd. Colon or rectal polyp</td>
<td>O No  O Yes</td>
</tr>
<tr>
<td>ee. Have you had any OTHER MAJOR ILLNESS in the past year?</td>
<td>O No  O Yes  (\rightarrow) IF YES, please specify below and provide MO/yr of diagnosis.</td>
</tr>
</tbody>
</table>

ff. For women only: In the PAST YEAR have you:
(Men skip to question #2 on the NEXT page)

1. Had a mammogram? O No  O Yes
2. Had a breast biopsy? O No  O Yes

\(\rightarrow\) IF YES: date of biopsy: \[\ \]/\[\ \]

3. Been diagnosed with fibrocystic or other benign breast disease? O No  O Yes

\(\rightarrow\) 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. NOT including your diet, how much TOTAL vitamin D do you take each day from nutritional supplements 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 I or less/day
- 401-800 I/day
- 801-1000 I/day
- 1001-2000 I/day
- 2001-3000 I/day
- 3001-4000 I/day
- greater than 4000 I/day

3. Do you regularly take individual supplements of fish oil (including prescription fish oil, cod liver oil, krill oil, other fish oil)?

- No
- Yes

4. 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.

- 500 mg or less/day
- 501-1200 mg/day
- 1201-1500 mg/day
- greater than 1500 mg/day

5. 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.

<table>
<thead>
<tr>
<th>For high blood pressure</th>
<th>For other reasons or not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Beta-blockers (Ex: atenolol, metoprolol)</td>
<td></td>
</tr>
<tr>
<td>b. Calcium-blockers (Ex: amlodipine, diltiazem)</td>
<td></td>
</tr>
<tr>
<td>c. Diuretics (Ex: hydrochlorothiazide, furosemide)</td>
<td></td>
</tr>
<tr>
<td>d. ACE-inhibitors (Ex: lisinopril, enalapril)</td>
<td></td>
</tr>
<tr>
<td>e. Angiotensin receptor blockers (Ex: valsartan, irbesartan, Entresto)</td>
<td></td>
</tr>
<tr>
<td>f. Aldosterone receptor blockers (Ex: spironolactone, eplerenone)</td>
<td></td>
</tr>
<tr>
<td>g. Alpha-blockers (Ex: terazosin, doxazosin)</td>
<td></td>
</tr>
</tbody>
</table>

6. 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)
- Boniva
- Forteo (teriparatide injection)
- Micalcin or Fortical (calcitonin-salmon)
- Tymlos (abapetaparatide) injection
- Other osteoporosis medication, not listed above
- I do NOT take any medications for bone loss treatment/prevention

7. Are you CURRENTLY taking any of the following drugs regularly? Please answer ALL ITEMS in BOTH COLUMNS.

   a. Aspirin (Ex: Bayer, Bufferin, Anacin, Excedrin)  
      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
   
   b. Other non-steroidal anti-inflammatory agent (Ex: ibuprofen, Motrin, Advil, Nuprin, naproxen, Naprosyn, Aleve)  
   
   c. Antiplatelet medication (Ex: clopidogrel, Plavix, prasugrel, Effient, ticagrelor, Brilinta)  
   
   d. Anticoagulant / blood thinner  
      1. warfarin / Coumadin / heparin  
      2. Pradaxa / dabigatran / Xarelto / rivaroxaban / Savaysa / Eliquis  
      3. Insulin injection  
      4. Non-insulin injection (Ex: Exenatide, Byetta)  
      5. Glucophage (metformin)  
      6. Jardiance  
      7. Victoza  
      8. Other oral drugs (Ex: Avandia, Glucotrol, Prandin, Januvia, Starlix, Actos)  
   
   e. Statin drug to lower cholesterol (Ex: Lipitor, Zocor, Mevacor, Pravachol, Crestor)  
   
   f. Non-statin drug to lower cholesterol  
      1. Niacin / Lopid / Questran / Colestid / Zetia  
      2. Praluent / Repatha  
   
   g. Lithium  
   
   h. Estrogen, alone or with progestin (do NOT include vaginal estrogen)  
   
   i. Tamoxifen (Ex: Nolvadex)  
   
   j. Serotonin reuptake inhibitor (Ex: Celexa, Lexapro, Cipralex, Esertia, Prozac, Zoloft)  
   
   k. Aromatase inhibitor (Ex: Arimidex, Aromasin, Femara)  
   
   l. Corticosteroid or prednisone  
   
   m. Diabetes medication(s)  
   
   n. Thyroid medication (Ex: Synthroid, Levoxyl, Levothyroid, levothyroxine)  
   
   o. Calcitriol (Ex: Rocaltrol, Calcijex, Vectical, Paricalcitol, Zemplar)  
   
   If YES, mark ALL that apply:
8. Have you EVER taken any of the following drugs?

- a. Proton pump inhibitors (Ex: Omeprazole, Prilosec, Prevacid, Protonix, Nexium, Aciphex)  
  - No  
  - Yes  
  - IF YES, are you taking CURRENTLY?  
    - No  
    - Yes

- b. H2 antagonists (Ex: Ranitidine, Zantac, Famotidine, Pepcid, Tagamet)  
  - No  
  - Yes  
  - IF YES, are you taking CURRENTLY?  
    - No  
    - Yes

- c. Loop diuretics (Ex: Furosemide, Lasix, Bumex, Torsemide, Ethacrynic acid)  
  - No  
  - Yes  
  - IF YES, are you taking CURRENTLY?  
    - No  
    - Yes

- d. Thiazide diuretics (Ex: Hydrochlorothiazide, Moduretic, Dyazide, Chlorthalidone, Indapamide)  
  - No  
  - Yes  
  - IF YES, are you taking CURRENTLY?  
    - No  
    - Yes

9. 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

10. 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  
      - Pelvis  
      - Spine  
      - Wrist / Forearm  
      - Upper arm / Shoulder  
      - Other
   b. Please provide the date (month/year) when the break occurred:

   These are a few questions that pertain to some stresses and day-to-day hassles in life that people might experience. If you prefer not to answer the questions, please feel free to skip through this section and move on to question #12.

11. In your day-to-day life how often have any of the following things happened to you?  

   a. You are treated with less courtesy or respect than other people.  
      - Almost every day  
      - At least once a week  
      - A few times a month  
      - A few times a year  
      - Less than once a year  
      - Never

   b. You receive poorer service than other people at restaurants or stores.  
      - Almost every day  
      - At least once a week  
      - A few times a month  
      - A few times a year  
      - Less than once a year  
      - Never

   c. People act as if they think you are not smart.  
      - Almost every day  
      - At least once a week  
      - A few times a month  
      - A few times a year  
      - Less than once a year  
      - Never

   d. People act as if they are afraid of you.  
      - Almost every day  
      - At least once a week  
      - A few times a month  
      - A few times a year  
      - Less than once a year  
      - Never

   e. You are threatened or harassed.  
      - Almost every day  
      - At least once a week  
      - A few times a month  
      - A few times a year  
      - Less than once a year  
      - Never

The following 2 questions deal with mood. If you have concerns about your answers to questions #12-13, please share with your health care provider. Also, refer to information at the following web site:  

12. Over the PAST 2 WEEKS, how often have you been bothered by any of the following?  

   - a. Little interest or pleasure in doing things  
      - Not at all  
      - Several days  
      - More than half the days  
      - Nearly every day

   - b. Feeling down, depressed, or hopeless  
      - Not at all  
      - Several days  
      - More than half the days  
      - Nearly every day

13. 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

14. 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

15. In the PAST YEAR, have you been hospitalized for heart failure or congestive heart failure?  
    - No  
    - Yes

   IF YES, how many times in the past year?  
    - 1  
    - 2  
    - 3 or more

16. In the PAST YEAR, have you been treated in the emergency room (but not hospitalized) for heart failure or congestive heart failure?  
    - No  
    - Yes

   IF YES, how many times in the past year?  
    - 1  
    - 2  
    - 3 or more
17. 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.

<table>
<thead>
<tr>
<th>Disease</th>
<th>Diagnosis MO/Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Autoimmune thyroid disease (includes Graves’ disease, Hashimoto’s thyroiditis, underactive or overactive thyroid, but NOT thyroid nodule or cancer)</td>
<td>No/Yes</td>
</tr>
<tr>
<td>b. Inflammatory bowel disease (Crohn’s disease or ulcerative colitis, but NOT irritable bowel syndrome)</td>
<td>No/Yes</td>
</tr>
<tr>
<td>c. Polymyalgia rheumatica (PMR), temporal arteritis or giant cell arteritis</td>
<td>No/Yes</td>
</tr>
<tr>
<td>d. Rheumatoid arthritis (NOT osteoarthritis, degenerative arthritis or gout)</td>
<td>No/Yes</td>
</tr>
<tr>
<td>e. Psoriasis or psoriatic arthritis</td>
<td>No/Yes</td>
</tr>
<tr>
<td>f. Sarcoidosis or Granulomatosis with polyangiitis (Wegener’s)</td>
<td>No/Yes</td>
</tr>
<tr>
<td>g. Other autoimmune disease (Please specify:___________________________)</td>
<td>No/Yes</td>
</tr>
</tbody>
</table>

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

19. 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

20. What is your CURRENT marital status?  
- Married  
- Divorced  
- Widowed  
- Separated  
- Never married

21. What is your CURRENT weight? ___________ pounds

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

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

24. Are you the primary caregiver of another person (e.g., friend, spouse, relative, or other loved one)?  
- No  
- Yes

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

25. Do you have Hispanic or Latino heritage?  
- No  
- Yes

**IF YES, mark all that apply.**  
- Dominican or Dominican descent  
- Central American or Central American descent  
- Cuban or Cuban descent  
- Mexican or Mexican descent  
- Puerto Rican or Puerto Rican descent  
- South American or South American descent  
- Other

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

- If the phone numbers to the left are not correct or have changed, please provide UPDATED phone numbers below.

- 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:

<table>
<thead>
<tr>
<th>CONTACT 1</th>
<th>CONTACT 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Name:</td>
</tr>
<tr>
<td>Phone number:</td>
<td>Phone number:</td>
</tr>
</tbody>
</table>

- 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, and your address has changed, please provide NEW E-MAIL below: