14093

VITAL OBS 4

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 N/Y 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 hospitalized?**	○ No ○ No	○ Yes ○ 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 hospitalized?**	○ No ○ No	○ Yes ○ Yes	☐☐ / ☐☐
o. Kidney failure or dialysis	○ No	○ Yes	☐☐ / ☐☐
p. Any thyroid condition	○ No	○ Yes	☐☐ / ☐☐
q. Pneumonia **IF YES, were you hospitalized?**	○ No ○ No	○ Yes ○ 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	☐☐ / ☐☐
x. Parkinson's disease	○ No	○ Yes	☐☐ / ☐☐
y. Multiple sclerosis	○ No	○ Yes	☐☐ / ☐☐
z. Cataract surgery (extraction)	○ No	○ Yes	☐☐ / ☐☐
aa. Macular degeneration	○ No	○ Yes	☐☐ / ☐☐
bb. Dry eye syndrome or dry eye disease	○ No	○ Yes	☐☐ / ☐☐
cc. Periodontal disease (gum disease)	○ No	○ Yes	☐☐ / ☐☐
dd. Colon or rectal polyp	○ No	○ Yes	☐☐ / ☐☐

IF YES: Did your doctor ask you to come back for a repeat colonoscopy or sigmoidoscopy in 5 years or less?
○ No ○ Yes ○ Not sure

ee. Have you had any OTHER MAJOR ILLNESS in the past year?
○ No ○ Yes → IF YES, please specify below and provide MO/YR of diagnosis.

_____

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

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

OFFICE USE ONLY: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

PLEASE CONTINUE ON THE NEXT PAGE

2. Have you EVER been diagnosed by a doctor or healthcare professional as having had or probably having had the coronavirus (COVID-19)? O No O Yes

IF YES: a. Please provide date (MO/YR) of diagnosis: ☐☐ / ☐☐

b. Have you EVER been hospitalized due to COVID-19? O No O Yes

IF YES: i. When were you hospitalized? (MO/YR) ☐☐ / ☐☐

ii. Did you require treatment in an Intensive Care Unit (ICU)? O No O Yes

3. Have you EVER been tested for the coronavirus (COVID-19, SARS-CoV-2) and/or its antibodies? O No O Yes

IF YES: a. Have you had at least one test with a POSITIVE result? O No O Yes

b. Please provide the date (MO/YR) of your FIRST POSITIVE test: ☐☐ / ☐☐

4. Have you received at least one dose of a COVID-19 vaccine? O No O Yes

IF YES: a. When did you FIRST get the vaccine? (MO/YR) ☐☐ / ☐☐ → Date of SECOND dose, if applicable: ☐☐ / ☐☐

b. Which vaccine did you receive? O Moderna O Pfizer-BioNTech O Johnson & Johnson

c. Have you received a booster shot? O No O Yes

IF YES: Which booster did you receive? O Moderna O Pfizer-BioNTech O Johnson & Johnson

5. Since January 2020 (PAST 2 YEARS), 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

6. 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 (Example: 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

PLEASE CONTINUE ON THE NEXT PAGE

7. Do you regularly take individual supplements of fish oil or omega-3 (EPA and/or DHA)? ○ No ○ Yes
Please include prescription fish oil, cod liver oil, krill oil, other fish oil (over-the-counter).

IF YES: →

a. Indicate which type(s): ○ Lovaza ○ Vascepa (icosapent ethyl) ○ Other prescription fish oil ○ Cod liver oil ○ Krill oil ○ Eye supplements containing omega-3 ○ Other fish oil (over-the-counter)

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

8. 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 multivitamins. 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. Are you CURRENTLY taking any drugs for high blood pressure? ○ No ○ Yes

IF YES: Which **TYPES** of drugs are you taking? **(Mark ALL that apply)**

○ Beta-blockers (atenolol) ○ Calcium-blockers (amlodipine) ○ ACE-inhibitors (lisinopril) ○ Angiotensin receptor blockers (valsartan)
○ Loop diuretics (furosemide) ○ Thiazide diuretics (hydrochlorothiazide) ○ Aldosterone receptor blockers (spironolactone)
○ Alpha-blockers (terazosin) ○ Other high blood pressure medication, not listed

10. 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)
○ Boniva ○ Forteo (teriparatide injection) ○ Miacalcin or Fortical (calcitonin-salmon) ○ Tymlos (abaloparatide) injection
○ Evenity (romosozumab) ○ Prolia (denosumab) ○ Other osteoporosis medication, not listed
○ I do NOT take any medications for bone loss treatment/prevention

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

a. Aspirin (Ex: Bayer, Bufferin, Anacin, Excedrin) ○ 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

b. Other non-steroidal anti-inflammatory agent ○ No ○ Yes
(Ex: ibuprofen, Motrin, Advil, Nuprin, naproxen, Naprosyn, Aleve)

c. Antiplatelet medication ○ No ○ Yes
(Ex: clopidogrel, Plavix, prasugrel, Effient, ticagrelor, Brilinta)

d. Anticoagulant / blood thinner
1. warfarin / Coumadin / heparin ○ No ○ Yes
2. Pradaxa / dabigatran / Xarelto / rivaroxaban / Savaysa / Eliquis ○ No ○ Yes

e. Statin drug to lower cholesterol ○ No ○ Yes
(Ex: Lipitor, Zocor, Mevacor, Pravachol, Crestor)

f. **Non-statin** drug to lower cholesterol
1. Nexletol / Lopid / Questran / Colestid / Zetia ○ No ○ Yes
2. Praluent / Repatha ○ No ○ Yes

g. Lithium ○ No ○ Yes

h. Estrogen, alone or with progestin (do NOT include vaginal estrogen) ○ No ○ Yes

i. Tamoxifen (Ex: Nolvadex) ○ No ○ Yes

j. Serotonin reuptake inhibitor ○ No ○ Yes
(Ex: Celexa, Lexapro, Cipralex, Esertia, Prozac, Zoloft)

k. Aromatase inhibitor ○ No ○ Yes
(Ex: Arimidex, Aromasin, Femara)

l. Corticosteroid or prednisone ○ No ○ Yes

m. Diabetes medication(s) ○ No ○ Yes
IF YES, mark ALL that apply:
○ Insulin injection ○ Glucophage (metformin)
○ SGLT2 inhibitors (Ex:Jardiance, Farxiga, Invokana)
○ Non-insulin injection (Ex: exenatide, Byetta, Trulicity, Victoza, Ozempic)
○ Other oral drugs (Ex: Avandia, Glucotrol, Prandin, Januvia, Starlix, Actos)

n. Thyroid medication ○ No ○ Yes
(Ex: Synthroid, Levoxyl, Levothroid, levothyroxine)

o. Calcitriol ○ No ○ Yes
(Ex: Rocaltrol, Calcijex, Vectical, Paricalcitol, Zemplar)

12. 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

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

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

15. Did you receive the <u>influenza (flu)</u> vaccine after August 2021? ○ No ○ Yes

PLEASE CONTINUE ON THE NEXT PAGE

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The following 2 questions deal with mood. If you have concerns about your answers to questions #16-17, 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***

16. 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

17. 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

18. 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

19. 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

20. 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

21. 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

22. 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: ☐☐ / ☐☐

23. 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. Other autoimmune disease (Please specify:_____)	O No	O Yes	☐☐ / ☐☐

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

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:

_____

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