48989 Request

Use ball-point pen to complete the form.

VITAL OBS 2

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

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2. 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

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

4. 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

5. What is your CURRENT weight? [ ][ ][ ] pounds

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, 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.

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

7. 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 Eye supplements containing omega-3 O Other fish oil (over-the-counter)

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

8. Do you take a calcium supplement daily such as Os-Cal, Caltrate, Citracal, Calcium+D? O No O 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.

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

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

a. Aspirin (Ex: Bayer, Bufferin, Anacin, Excedrin) O No O Yes
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

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

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

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 O No O Yes
(Ex: Lipitor, Zocor, Mevacor, Pravachol, Crestor)

f. **Non-statin** drug to lower cholesterol
1. Niacin / 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 O No O Yes
(Ex: Celexa, Lexapro, Cipralex, Esertia, Prozac, Zoloft)

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

l. Corticosteroid or prednisone O No O Yes

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

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

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

PLEASE CONTINUE ON THE NEXT PAGE

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

11. Please indicate if you are CURRENTLY taking any of the medications listed below, and the reason for use.	**For high blood pressure**	**For other reasons or not sure**	**Not taking**
a. Beta-blockers (Ex: atenolol, metoprolol)	○	○	○
b. Calcium-blockers (Ex: amlodipine, diltiazem)	○	○	○
c. Loop diuretics (Ex: furosemide, Lasix, Bumex, torsemide, ethacrynic acid)	○	○	○
d. Thiazide diuretics (Ex: hydrochlorothiazide, Moduretic, Dyazide, chlorthalidone, indapamide)	○	○	○
e. ACE-inhibitors (Ex: lisinopril, enalapril)	○	○	○
f. Angiotensin receptor blockers (Ex: valsartan, irbesartan, Entresto)	○	○	○
g. Aldosterone receptor blockers (Ex: spironolactone, eplerenone)	○	○	○
h. Alpha-blockers (Ex: terazosin, doxazosin)	○	○	○

12. 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 above
○ I do NOT take any medications for bone loss treatment/prevention

13. Are you CURRENTLY taking any of the following drugs?

a. Proton pump inhibitors (Ex: Omeprazole, Prilosec, Prevacid, Protonix, Nexium, Aciphex)	○ No	○ Yes
b. H2 antagonists (Ex: Ranitidine, Zantac, Famotidine, Pepcid,Tagamet)	○ No	○ Yes

The following 2 questions deal with mood. If you have concerns about your answers to questions #14-15, 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***

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	○	○	○	○
b. Feeling down, depressed, or hopeless	○	○	○	○
c. Trouble falling or staying asleep, or sleeping too much	○	○	○	○
d. Feeling tired or having little energy	○	○	○	○
e. Poor appetite or overeating	○	○	○	○
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	○	○	○	○
g. Trouble concentrating on things like reading the paper or watching T.V.	○	○	○	○
h. Moving or speaking so slowly that others have noticed? Or the opposite -- being fidgety, restless, or moving a lot more than usual	○	○	○	○

15. 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

16. 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

17. 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

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18. 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

19. 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: ☐☐ / ☐☐

20. 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	☐☐ / ☐☐

21. 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

22. Fill in the circle for each question that best fits your CURRENT ability level compared to 5 YEARS AGO.

	Better	No change	Minimally worse	Noticeably worse	Much worse
a. Recalling information when I really try	O	O	O	O	O
b. Remembering names and faces of new people I meet	O	O	O	O	O
c. Remembering things that have happened recently	O	O	O	O	O
d. Recalling conversations a few days later	O	O	O	O	O

23. PLEASE COMPLETE YOUR 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. ↴

HOME PHONE (☐☐☐) ☐☐☐ - ☐☐☐☐ → HOME PHONE (☐☐☐) ☐☐☐ - ☐☐☐☐

CELL PHONE (☐☐☐) ☐☐☐ - ☐☐☐☐ → CELL PHONE (☐☐☐) ☐☐☐ - ☐☐☐☐

WORK PHONE (☐☐☐) ☐☐☐ - ☐☐☐☐ → WORK PHONE (☐☐☐) ☐☐☐ - ☐☐☐☐

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

If you would like to continue to receive information, and your e-mail has changed, please provide NEW E-MAIL below:

_____