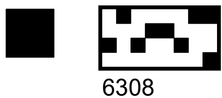
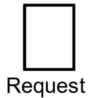



6308

Request

VITAL OBS 1

Use ball-point 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)	○ No	○ Yes	☐☐/☐☐
IF YES, were you hospitalized?	○ No	○ 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	○ No	○ Yes	☐☐/☐☐
IF YES, were you hospitalized?	○ No	○ Yes	
o. Kidney failure or dialysis	○ No	○ Yes	☐☐/☐☐
p. Any thyroid condition	○ No	○ Yes	☐☐/☐☐
q. Pneumonia	○ No	○ Yes	☐☐/☐☐
IF YES, were you hospitalized?	○ No	○ 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.

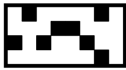
____

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


6308
Use ball-point pen to complete the form.

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.
   - O None
   - O 400 I or less/day
   - O 401-800 I/day
   - O 801-1000 I/day
   - O 1001-2000 I/day
   - O 2001-3000 I/day
   - O 3001-4000 I/day
   - O 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)?
   O No O Yes → Indicate which type(s): O Prescription fish oil O Cod liver oil O Krill oil O Other fish oil

4. Do you take a calcium supplement daily such as Os-Cal, Caltrate, Citracal, Calcium+D? O No O 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.
   O 500 mg or less/day O 501-1200 mg/day O 1201-1500 mg/day O greater than 1500 mg/day

5. Are you CURRENTLY taking medications for high blood pressure? O No O Yes

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
a. Beta-blockers (Ex: atenolol, metoprolol)	O	O
b. Calcium-blockers (Ex: amlodipine, diltiazem)	O	O
c. Diuretics (Ex: hydrochlorothiazide, furosemide)	O	O
d. ACE-inhibitors (Ex: lisinopril, enalapril)	O	O
e. Angiotensin receptor blockers (Ex: valsartan, irbesartan, Entresto)	O	O
f. Aldosterone receptor blockers (Ex: spironolactone, eplerenone)	O	O
g. Alpha-blockers (Ex: terazosin, doxazosin)	O	O

6. Are you CURRENTLY taking any of the following drugs for prevention or treatment of bone loss? (Mark ALL that apply)
   - O Fosamax (alendronate)
   - O Evista (raloxifene)
   - O Actonel (risedronate)
   - O Reclast (zoledronic acid)
   - O Prolia (denosumab)
   - O Boniva
   - O Forteo (teriparatide injection)
   - O Miacalcin or Fortical (calcitonin-salmon)
   - O Tymlos (abaloparatide) injection
   - O Other osteoporosis medication, not listed above
   - O 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) 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)

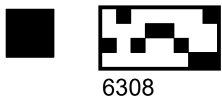
l. Corticosteroid or prednisone O No O Yes

m. Diabetes medication(s) O No O Yes
   IF YES, mark ALL that apply:
   - O Insulin injection
   - O Non-insulin injection (Ex: Exenatide, Byetta)
   - O Glucophage (metformin)
   - O Jardiance
   - O Victoza
   - 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



6308

Use ball-point pen to complete the form.

VITAL OBS 1

8. Have you EVER taken any of the following drugs?

a. Proton pump inhibitors (Ex: Omeprazole, Prilosec, Prevacid, Protonix, Nexium, Aciphex)	O No	O Yes →	**IF YES, are you taking CURRENTLY?**	O No	O Yes
b. H2 antagonists (Ex: Ranitidine, Zantac, Famotidine, Pepcid,Tagamet)	O No	O Yes →	**IF YES, are you taking CURRENTLY?**	O No	O Yes
c. Loop diuretics (Ex: Furosemide, Lasix, Bumex, Torsemide, Ethacrynic acid)	O No	O Yes →	**IF YES, are you taking CURRENTLY?**	O No	O Yes
d. Thiazide diuretics (Ex: Hydrochlorothiazide, Moduretic, Dyazide, Chlorthalidone, Indapamide)	O No	O Yes →	**IF YES, are you taking CURRENTLY?**	O No	O Yes

9. 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

10. 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: ☐☐ / ☐☐

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?	**Almost every day**	**At least once a week**	**A few times a month**	**A few times a year**	**Less than once a year**	**Never**
a. You are treated with less courtesy or respect than other people.	O	O	O	O	O	O
b. You receive poorer service than other people at restaurants or stores.	O	O	O	O	O	O
c. People act as if they think you are not smart.	O	O	O	O	O	O
d. People act as if they are afraid of you.	O	O	O	O	O	O
e. You are threatened or harassed.	O	O	O	O	O	O

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: ***http://www.nimh.nih.gov/health/publications/depression/complete-index.shtml***

12. 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

13. 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

14. 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

15. 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

16. 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

PLEASE CONTINUE ON THE NEXT PAGE

6308

Use ball-point pen to complete the form.

VITAL OBS 1

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.

			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	__ __ / __ __

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

19. 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

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

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

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

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

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

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

25. Do you have Hispanic or Latino heritage? O No O Yes → **IF YES, mark all that apply.**

O Dominican or Dominican descent
O Central American or Central American descent
O Cuban or Cuban descent
O Mexican or Mexican descent
O Puerto Rican or Puerto Rican descent
O South American or South American descent
O 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.

HOME PHONE (___) ___ - ____ → HOME PHONE (___) ___ - ____

CELL PHONE (___) ___ - ____ → CELL PHONE (___) ___ - ____

WORK PHONE (___) ___ - ____ → WORK PHONE (___) ___ - ____

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:

CONTACT 1

Name:______________________________

Phone number:______________________________

CONTACT 2

Name:______________________________

Phone number:______________________________

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:

____