36 mth

HARVARD MEDICAL SCHOOL **PHYSICIANS' HEALTH STUDY**

Please complete all 12 questions and return this form in the prepaid envelope provided

1. Date of birth: _____/_____/19_____ (For identification purposes)

2. OVER THE PAST TWELVE MONTHS, how many of the approximately 180 white pills did you *NOT* take? (Do not include extra pills in a short month or made-up pills as missed pills.)
   - ☐ TOOK ALL THE WHITE PILLS
   - ☐ 1–9 not taken (5%)
   - ☐ 10–30 not taken (6–17%)
   - ☐ 31–90 not taken (18–50%)
   - ☐ 91–162 not taken (51–90%)
   - ☐ Took NONE or hardly any (91–100%)

   Reason for not taking white pills: _____

3. OVER THE PAST TWELVE MONTHS, how many of the approximately 180 red pills did you *NOT* take? (Do not include extra pills in a short month or made-up pills as missed pills.)
   - ☐ TOOK ALL THE RED PILLS
   - ☐ 1–9 not taken (5%)
   - ☐ 10–30 not taken (6–17%)
   - ☐ 31–90 not taken (18–50%)
   - ☐ 91–162 not taken (51–90%)
   - ☐ Took NONE or hardly any (91–100%)

   Reason for not taking red pills: _____

4. OVER THE **PAST MONTH**, *other than study pills,* on how many days did you take additional aspirin, medication containing aspirin and/or other platelet active, nonsteroidal anti-inflammatory agents such as Motrin, Clinoril, Indocin, Feldene, Meclomen, Tolectin, Naprosyn, etc?

   ☐ 0 Days ☐ 1 Day ☐ 2–3 Days ☐ 4–6 Days ☐ 7–10 Days ☐ 11–20 Days ☐ 21–30 Days

   If taken on more than one day, was the use: ☐ All on consecutive days ☐ Mostly consecutive days ☐ Sporadic

5. OVER THE PAST TWELVE MONTHS (including the past month), *other than study pills,* on how many DAYS did you take any of the following:

	0 Days	1–4 Days	5–8 Days	9–14 Days	15–30 Days	31–60 Days	61 + Days
a) Aspirin	☐	☐	☐	☐	☐	☐	☐
b) Medication containing aspirin Name of agent(s): _____	☐	☐	☐	☐	☐	☐	☐
c) Platelet active, nonsteroidal anti-inflammatory agents (eg, Motrin, Feldene, Naprosyn, etc.). Name of agent(s): _____	☐	☐	☐	☐	☐	☐	☐

6. OVER THE PAST TWELVE MONTHS, *other than study pills,* did you take additional BETA-CAROTENE or VITAMIN A (other than multivitamins)? ☐ Yes ☐ No

   IF YES: Which type? ☐ VITAMIN A ☐ BETA-CAROTENE

   Number per week: ☐ 0 ☐ 1–3 ☐ 4–7 ☐ 8–14 ☐ 15+

7. *SINCE YOU FILLED OUT THE LAST QUESTIONNAIRE (ABOUT TWELVE MONTHS AGO),* have you been NEWLY DIAGNOSED as having any of the following conditions? (Please check YES or NO for *ALL items.)*

	Yes	No	Date of DX Month/Year		Yes	No	Date of DX Month/Year
Myocardial infarction	☐	☐	_____	Arthritis	☐	☐	_____
Pulmonary embolism	☐	☐	_____	Gout	☐	☐	_____
Cancer: Site _____	☐	☐	_____	Liver disease	☐	☐	_____
If skin cancer, type _____	☐	☐	_____	Renal disease	☐	☐	_____
Deep vein thrombosis	☐	☐	_____	Peptic ulcer	☐	☐	_____
Diagnosis of cataracts	☐	☐	_____	Hemorrhoids	☐	☐	_____
Cataract surgery	☐	☐	_____	Varicose veins	☐	☐	_____
Date 1st dx _____				Peripheral vascular disease	☐	☐	_____
Subconjunctival hemorrhage	☐	☐	_____	Diabetes mellitus	☐	☐	_____
Angina pectoris	☐	☐	_____	Gallstones	☐	☐	_____
Coronary bypass/angioplasty	☐	☐	_____	Glaucoma	☐	☐	_____
Stroke	☐	☐	_____	Bronchitis	☐	☐	_____
Transient cerebral ischemia	☐	☐	_____	Periodontal disease	☐	☐	_____
Nature of evidence for diagnosis of stroke or TIA _____				Teeth lost in past year	☐	☐	_____
				IF YES, how many _____			

Other conditions requiring medical treatment _____

IF YES to ANY items in #7: Please provide details on back— especially for diagnosis, progression of disease and treatment.

PLEASE CONTINUE ON REVERSE

8. If you have any of the conditions listed in question 7, please complete and sign the following consent form. Obtaining hospital records or information from a treating physician is important in order that we may apply uniform criteria to evaluation of the medical endpoints. This information will be used solely for medical statistical purposes and maintained in the strictest professional confidence.

I hereby grant permission to Charles H. Hennekens, MD, Associate Professor of Medicine, Harvard Medical School, 55 Pond Avenue, Brookline, MA 02146, to review a copy of the records of my hospitalization or treatment for:

_____

Name of hospital/physician _____

Address _____

City _____ State _____ Zip _____

Dates of hospitalization/treatment _____

Signed _____ Date _____

9. SINCE YOU FILLED OUT THE LAST QUESTIONNAIRE (ABOUT TWELVE MONTHS AGO), have you experienced any of the following? (Please check YES or NO for *ALL items.)*

	Yes	No		Yes	No
Symptoms suggestive of gastritis*	☐	☐	Melena	☐	☐
Symptoms suggestive of peptic ulcer*	☐	☐	Hematemesis	☐	☐
Nausea	☐	☐	Other GI bleeding	☐	☐
Constipation	☐	☐	Site _____		
Diarrhea	☐	☐	Hematuria	☐	☐
Skin discoloration	☐	☐	Easy bruising	☐	☐
Headache	☐	☐	Epistaxis	☐	☐
Migraine	☐	☐	Other bleeding	☐	☐

Other symptoms _____

**An enteric-coated preparation is available upon request.*

10. Have you *EVER* had any of the following?

	Yes	No	Date Month/Year		Yes	No	Date Month/Year
Dx of osteoporosis	☐	☐	_____	Intermittent claudication	☐	☐	_____
Gallbladder removal	☐	☐	_____	Carotid artery surgery	☐	☐	_____
Appendix removal	☐	☐	_____	Other peripheral artery surgery	☐	☐	_____
				IF YES, Site _____			

11. *SINCE AGE 40,* have you had a fracture resulting from a fall from a standing or walking position (exclude trauma from an auto accident, skiing, etc.) ☐ Yes ☐ No

IF YES: Circumstances _____

_____

12. Do you engage in a regular program of exercise vigorous enough to work up a sweat? ☐ Yes ☐ No

IF YES: a) How many days per week? ☐ less than 1 day per week ☐ 1–2 days ☐ 3–4 days ☐ 5–7 days

b) How long have you had this pattern of exercise? ☐ less than one year ☐ 1–2 years ☐ 3–5 years ☐ 6+ years

c) What types of vigorous exercise do you engage in?
☐ racquet sports ☐ swimming ☐ jogging/running ☐ cycling (include indoor) ☐ other

d) How long is each average exercise session? ☐ 10 mins or less ☐ 11–24 mins ☐ 25–40 mins ☐ 41 + mins

e) If you jog/run, how long is your usual distance?
☐ 1 mile or less ☐ 1.1–2 miles ☐ 2.1–3 miles ☐ 3.1–4 miles ☐ more than 4 miles