



Please complete all 16 questions and return this form in the prepaid envelope provided

1. OVER THE PAST TWELVE MONTHS, how many of the approximately 180 white pills did you NOT take? (Please do not count as missed those pills you made up or extra pills missed in a short month.)

<input type="checkbox"/> TOOK ALL THE WHITE PILLS	<input type="checkbox"/> 31-90 not taken (18-50%)
<input type="checkbox"/> 1-9 not taken (5%)	<input type="checkbox"/> 91-162 not taken (51-90%)
<input type="checkbox"/> 10-30 not taken (6-17%)	<input type="checkbox"/> Took NONE or hardly any (91-100%)

 Reason for not taking white pills: _____

2. OVER THE PAST TWELVE MONTHS, how many of the approximately 180 red capsules did you NOT take? (Please do not count as missed those pills you made up or extra pills missed in a short month.)

<input type="checkbox"/> TOOK ALL THE RED CAPSULES	<input type="checkbox"/> 31-90 not taken (18-50%)
<input type="checkbox"/> 1-9 not taken (5%)	<input type="checkbox"/> 91-162 not taken (51-90%)
<input type="checkbox"/> 10-30 not taken (6-17%)	<input type="checkbox"/> Took NONE or hardly any (91-100%)

 Reason for not taking red capsules: _____

3. 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 Advil, Clinoril, Feldene, Indocin, Motrin, Naprosyn, Nuprin, Persantine, etc.?
 0 Days 1-6 Days 7-13 Days 14+ Days

4. OVER THE PAST YEAR, (including 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 Advil, Clinoril, Feldene, Indocin, Motrin, Naprosyn, Nuprin, Persantine, etc.?
 0 Days 1-13 Days 14-30 Days 31-60 Days 61-90 Days 91-120 Days 121-180 Days 180+ Days

5. Are you currently taking any of the following drugs (fish oil, Coumadin or Heparin) which interfere with blood clotting?
 No Fish oil: Brand _____ Coumadin Heparin

6. Are you currently taking multiple vitamins regularly? Yes No
 IF YES: Number per week: 1-3 4-7 8-14 15+

7. OVER THE PAST TWELVE MONTHS, other than study capsules, 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: 1-3 4-7 8-14 15+

8. 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 and PROVIDE DATE FOR EACH DIAGNOSIS.)

	Yes	No	Date of DX Month/Year		Yes	No	Date of DX Month/Year
Myocardial infarction	<input type="checkbox"/>	<input type="checkbox"/>	_____	Bleeding hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pulmonary embolism	<input type="checkbox"/>	<input type="checkbox"/>	_____	Non-bleeding hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	_____
Deep vein thrombosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Melena	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hematemesis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other GI bleeding: Site _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin cancer:				Gallstones	<input type="checkbox"/>	<input type="checkbox"/>	_____
Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Gallbladder removal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Basal cell	<input type="checkbox"/>	<input type="checkbox"/>	_____	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	_____
Squamous invasive	<input type="checkbox"/>	<input type="checkbox"/>	_____	Appendix removal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Squamous in situ	<input type="checkbox"/>	<input type="checkbox"/>	_____	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other skin: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer (non-skin): Site _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	Gout	<input type="checkbox"/>	<input type="checkbox"/>	_____
Coronary bypass (CABG)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Carotid artery surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Coronary angioplasty (PTCA)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Intermittent claudication	<input type="checkbox"/>	<input type="checkbox"/>	_____
Angina Pectoris	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other peripheral artery surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Transient cerebral ischemia (TIA)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Site _____			
Peptic ulcer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Subconjunctival hemorrhage	<input type="checkbox"/>	<input type="checkbox"/>	_____
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Renal disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Periodontal disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tooth loss in past year	<input type="checkbox"/>	<input type="checkbox"/>	_____ #

Other conditions requiring medical treatment _____

IF YES to ANY items in #8: Please provide details on back— especially for diagnosis, progression of disease and treatment.

→ PLEASE CONTINUE ON REVER:

9. Date of birth: ____/____/19____ (Necessary for verification)
Month Day Year

10. SINCE YOU FILLED OUT THE LAST QUESTIONNAIRE (ABOUT TWELVE MONTHS AGO):

	Yes	No	Date
			Month/Year
Have you had a cataract diagnosed in your RIGHT eye?	<input type="checkbox"/>	<input type="checkbox"/>	Diagnosis _____
Have you had a cataract extraction in your RIGHT eye?	<input type="checkbox"/>	<input type="checkbox"/>	Surgery _____
Have you had a cataract diagnosed in your LEFT eye?	<input type="checkbox"/>	<input type="checkbox"/>	Diagnosis _____
Have you had a cataract extraction in your LEFT eye?	<input type="checkbox"/>	<input type="checkbox"/>	Surgery _____

11. If you have any of the conditions listed in question 8 or 10, please complete and sign the following consent form. 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:

Diagnosis: _____
Name of hospital/physician _____
Address _____
City _____ State _____ Zip _____
Dates of hospitalization/treatment _____
Signed _____ Date _____

12. 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	<input type="checkbox"/>	<input type="checkbox"/>	Hematuria	<input type="checkbox"/>	<input type="checkbox"/>
Symptoms suggestive of peptic ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Epistaxis	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Other bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>
Skin discoloration	<input type="checkbox"/>	<input type="checkbox"/>	Migraine	<input type="checkbox"/>	<input type="checkbox"/>
Other symptoms _____					

Note: An enteric-coated preparation of the white pill is available upon request.

13. Have you ever had a vasectomy? Yes No Date ____/____/19____
Month Year

14. Have you ever smoked cigarettes regularly?

No

Yes: Please answer each of the following:

Age started smoking _____

When you smoke (or smoked), on average how many cigarettes per day do (did) you smoke?

Less than pack/day 1 pack/day 1-2 packs/day 2+ packs/day

Usual brand of cigarettes _____ Filter: Yes No

Age stopped smoking _____

OR if currently smoking, check here

We would appreciate the following OPTIONAL information which helps us to maintain high follow-up rates:

15. The name and address of someone who could give us your new address should you move:

Name _____ Address _____
City _____ State _____ Zip _____

16. Your current telephone numbers should we need to reach you:

Telephone: Home () _____ Office () _____