



(original yellow) 6 mths

Please complete ALL 7 questions and return this form in the prepaid envelope provided.

1. Date of birth: ____ / ____ / 19 ____
Mo Day Year

FOR THE FOLLOWING QUESTIONS, PLEASE CONSIDER YOUR EXPERIENCE OVER THE PAST SIX MONTHS:

2. Did you MISS any of your pills? NO I missed no days YES I missed ____ days
IF YES: Were they mostly: capsules tablets both equally

3. Have you taken any individual vitamin A supplements (other than multivitamins) YES NO
IF YES: Size ____ units #/week ____

4. Other than study pills, did you take additional tablets containing aspirin or other platelet active, non-steroidal, anti-inflammatory agents such as Motrin, Clinoril, Indocin, Feldene, Meclomen, Tolectin, Naprosyn, etc. YES NO
IF YES: On about how many of the past 180 days? ____ days
How many additional tablets did you take? ____ tablets
If non-aspirin, name of agent: _____

5. Since you filled out the last questionnaire (about six 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"/>	Spontaneous bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Symptoms suggestive of peptic ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Epistaxis	<input type="checkbox"/>	<input type="checkbox"/>
Nausea (without vomiting)	<input type="checkbox"/>	<input type="checkbox"/>	Hematemesis	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Hematuria	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>
Melena	<input type="checkbox"/>	<input type="checkbox"/>	Migraine	<input type="checkbox"/>	<input type="checkbox"/>
Skin discoloration	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>
Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>			

IF YES: Please provide details on the back, especially as to whether the condition is new or recurrent, the severity, treatment etc.

6. Since you filled out the last questionnaire (about six months ago) have you been diagnosed as having any of the following conditions? (Please check YES or NO for ALL items)

	YES	NO	DATE MONTH/YEAR		YES	NO	DATE MONTH/YEAR
Myocardial infarction	<input type="checkbox"/>	<input type="checkbox"/>	_____	Angina pectoris	<input type="checkbox"/>	<input type="checkbox"/>	_____
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Renal disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Peptic ulcer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Periodontal disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gout	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer-Site _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	Gallstones	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____	Pulmonary embolism	<input type="checkbox"/>	<input type="checkbox"/>	_____
Transient cerebral ischemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Deep vein thrombosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nature of evidence for diagnosis of stroke or TIA _____				Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	_____
				Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	_____
				Other:	<input type="checkbox"/>	<input type="checkbox"/>	_____

IF YES: Please provide details on back—especially evidence for diagnosis, progression of disease and treatment.

PLEASE CONTINUE ON REVERSE

7. If you have any of the conditions listed in question 6, we would appreciate your signing the following consent form. Obtaining hospital records is important in order that we may apply uniform criteria to the evaluation of 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 _____

THANK YOU!

Please return to: Physicians' Health Study
55 Pond Avenue
Brookline, MA 02146