18 mth

021 _____ _____ _____
(4) (10) (11) (14) (15) (20)

HARVARD MEDICAL SCHOOL

PHYSICIANS' HEALTH STUDY

Please complete ALL 10 questions and return this form in the prepaid envelope provided.

1. Date of birth: ___ ___/___ ___/19___ ___
(21) Mo (23) Day (25) Year

2. Are you willing to continue to collaborate in this study? (27) Yes ☐ No ☐
IF NO: Please specify your reason: (28) _____

3. In the past 30 days, did you *MISS* any of your pills? (30) No ☐ I missed no days Yes ☐ I missed (31) _____ days
IF YES: Were they mostly: (33) capsules ☐ tablets ☐ both equally ☐

4. Did you start taking any new medications or vitamin prescriptions on a regular basis during the past four months? (34) Yes ☐ No ☐
IF YES: Please specify: (35) _____ (41) _____
(47) _____ (53) _____

5. Other than study pills, did you take additional tablets containing aspirin *(Include use of platelet active, non-steroidal, anti-inflammatory agents such as Motrin, Clinoril, etc.)*? (59) Yes ☐ No ☐
IF YES: On how many of the past 30 *days*? (60) _____ days
How many additional *tablets* did you take? (62) _____ tablets
For what reason? (65) _____
Is/was this condition temporary? (67) Yes ☐ No ☐
If *non-aspirin*, name of agent: (68) _____

6. Since we sent your calendar packs (about 4 months ago), have you experienced any of the following? (Please check Yes or No for ALL items)

		Yes	No			Yes	No
(69)	Symptoms suggestive of gastritis	☐	☐	(74)	Diarrhea	☐	☐
(70)	Symptoms suggestive of peptic ulcer	☐	☐	(75)	Melena	☐	☐
(71)	Nausea (without vomiting)	☐	☐	(76)	Skin discoloration	☐	☐
(72)	Vomiting	☐	☐	(77)	Other:	☐	☐
(73)	Constipation	☐	☐	(78)	_____		

___ 7. Please indicate how often, *on average*, you have eaten each of the following foods during the past year. For seasonal foods, average your use over the full 12 months.
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		2+/day	daily	5-6/wk	2-4/wk	1/wk	1-3/mth	Rarely/ Never
(13)	Broccoli (½ c.)	☐	☐	☐	☐	☐	☐	☐
(14)	Brussels sprouts (½ c.)	☐	☐	☐	☐	☐	☐	☐
(15)	Carrots (whole or ½ c. cooked)	☐	☐	☐	☐	☐	☐	☐
(16)	Spinach, cooked (½ c.)	☐	☐	☐	☐	☐	☐	☐
(17)	Spinach/dark green lettuce salad (exclude iceberg)	☐	☐	☐	☐	☐	☐	☐
(18)	Yellow squash (½ c.)	☐	☐	☐	☐	☐	☐	☐
(19)	Yams or sweet potatoes (½ c.)	☐	☐	☐	☐	☐	☐	☐
(20)	Tomato juice (small glass)	☐	☐	☐	☐	☐	☐	☐
(21)	Tomatoes (1)	☐	☐	☐	☐	☐	☐	☐
(22)	Orange juice (small glass)	☐	☐	☐	☐	☐	☐	☐
(23)	Cantaloupe (¼ melon)	☐	☐	☐	☐	☐	☐	☐
(24)	Peaches, apricots or nectarines (fresh, frozen or canned)	☐	☐	☐	☐	☐	☐	☐
(25)	Dried apricots (½ c.)	☐	☐	☐	☐	☐	☐	☐
(26)	Liver (3-4 oz.)	☐	☐	☐	☐	☐	☐	☐
(27)	Cold breakfast cereal (1 c.)	☐	☐	☐	☐	☐	☐	☐
(28)	Eggs (1)	☐	☐	☐	☐	☐	☐	☐
(29)	Whole milk (8 oz. glasses)	☐	☐	☐	☐	☐	☐	☐
(30)	Skim or low fat milk (8 oz. glasses)	☐	☐	☐	☐	☐	☐	☐
(31)	Red chili sauce (1 tablespoon)	☐	☐	☐	☐	☐	☐	☐

Please continue on reverse

8. Since we sent your calendar packs (about 4 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
(32)	Myocardial infarction	☐	☐	(33) ____
(37)	Liver disease	☐	☐	(38) ____
(42)	Renal disease	☐	☐	(43) ____
(47)	Peptic ulcer	☐	☐	(48) ____
(52)	Gout	☐	☐	(53) ____
(57)	Cancer	☐	☐	(58) ____
	Site (62) ____			
(66)	Stroke	☐	☐	(67) ____
	Clinical Evidence (71) ____			
	Lab Evidence (72) ____			
(73)	Transient cerebral ischemia (TIA)	☐	☐	(74) ____
	Clinical Evidence (78) ____			
	Lab Evidence (79) ____			

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		Yes	No	Da month
(13)	Angina pectoris	☐	☐	(14) ____
(18)	Diabetes	☐	☐	(19) ____
(23)	Arthritis	☐	☐	(24) ____
(28)	Periodontal disease	☐	☐	(29) ____
(33)	Cataracts	☐	☐	(34) ____
(38)	Gallstones	☐	☐	(39) ____
(43)	Pulmonary embolism	☐	☐	(44) ____
(48)	Deep vein thrombosis	☐	☐	(49) ____
(53)	Hemorrhoids	☐	☐	(54) ____
(58)	Varicose veins	☐	☐	(59) ____
(63)	Other:	☐	☐	(64) ____
	(68) ____			
	(72) ____			

(76) 9. If you have any of the conditions listed in question 8, we would appreciate your signing the following consent form. Obta hospital records is important in order that we may apply uniform criteria to the evaluation of medical endpoints. This infc tion 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 ____

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(77) 10. The following question is OPTIONAL.

Because of our possible need to contact you if our mail does not reach you in the future, we would appreciate having telephon numbers at which we could reach you during the day and in the evening, as well as the names and addresses of one or two peor who could give us your new address should you move. Please note that this information will be used *only* if we cannot reach you through regular postal channels.

Telephone: Home ( ) ____ Office ( ) ____

Contacts

Name ____ Address ____

City ____ State ____ Zip ____

Name ____ Address ____

City ____ State ____ Zip ____

I am unwilling to provide this optional information ☐

THANK YOU!

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