



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

1. Date of birth: ____/____/19 ____

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

2. How many of the 90 white pills did you not take? [] I took all the white pills [] I did not take ____ white pills
Reason: _____

3. How many of the 90 red pills did you not take? [] I took all the red pills [] I did not take ____ red pills
Reason: _____

4. Other than study pills, did you take additional tablets containing aspirin or other platelet active, nonsteroidal, 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. Other than study pills, did you take additional capsules containing beta-carotene or individual vitamin A supplements (other than multivitamins)? YES [] NO []
IF YES: Size ____ units #/Week ____

6. 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)

Table with 4 columns: Symptom, YES, NO, YES, NO. Symptoms include gastritis, peptic ulcer, nausea, constipation, diarrhea, melena, skin discoloration, easy bruising, spontaneous bleeding, epistaxis, hematemesis, hematuria, headache, and migraine.

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

Table with 4 columns: Condition, YES, NO, DATE MONTH/YEAR. Conditions include myocardial infarction, angina pectoris, diabetes mellitus, gout, cancer, arthritis, pulmonary embolism, deep vein thrombosis, stroke, transient cerebral ischemia, liver disease, renal disease, gallstones, peptic ulcer, hemorrhoids, varicose veins, peripheral vascular disease, glaucoma, bronchitis, laryngitis, periodontal disease, and teeth lost in past year.

Other conditions requiring medical treatment _____

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



8. If you have any of the conditions listed in question 7, we would appreciate your signing the following consent form. Obtaining hospital records or information from a treating physician 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 _____

9. Please indicate how often, on average, you have eaten each of the following foods during the past year. Rarely/ Never

	2+ /day	daily	5-6/wk	2-4/wk	1/wk	1-3/mth	Rarely/ Never
(1) Chicken or turkey (6-8 oz.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(2) Hot dogs (1)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(3) Beef, pork or lamb as a sandwich or mixed dish (hamburger, stew, casserole, lasagne, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(4) Beef, pork or lamb as a main dish (steak, roast, ham, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(5) Canned tuna fish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(6) Dark meat fish — e.g. mackerel, salmon, sardines, bluefish, swordfish (4-6oz.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(7) Other fish (4-6 Oz.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(8) Shrimp, lobster, scallops as a main dish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(9) Hard cheese (e.g. American, cheddar) (1 slice or 1 oz.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(10) Ice cream (1 cup)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(11) Cookies (1)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(12) Potato chips, corn chips (1 oz. or small bag)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(13) Peanut butter (1 tbl.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(14) Nuts (small packet or 1 oz.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(15) French fried potatoes (4 oz.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(16) Fried food of any type	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. How many pats or tsps. of margarine do you use daily? _____

11. How many pats or tsps. of real butter do you use daily? _____

12. How many tsps. of cream, e.g. coffee, whipped, sour, do you use daily? _____

13. Has your mother ever had a documented MI? NO YES DON'T KNOW
 IF YES, at what age? _____

14. Has your father ever had a documented MI? NO YES DON'T KNOW
 IF YES, at what age? _____

15. Have you ever had a coronary artery bypass or angioplasty? NO YES _____ / _____
 month year

16. Have you ever had any of the following?

	YES	NO	DATE MONTH/YEAR		YES	NO	DATE MONTH/YEAR
a) Diagnosis of cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____	d) Trauma directly to the eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
b) Cataract surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	e) Chronic eye inflammation	<input type="checkbox"/>	<input type="checkbox"/>	_____
c) Other ocular surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____				