HARVARD MEDICAL SCHOOL **PHYSICIANS' HEALTH STUDY**

Please complete all 20 questions and return this form in the prepaid envelope provided

1. Date of birth: ____/____/19____ (necessary for verification) 2. Current weight: _____ lbs.
   Month Day Year

3. 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.)

   ❑ Took all the red capsules ❑ 10–30 not taken (6–17%) ❑ 91–162 not taken (51–90%)
   ❑ 1–9 not taken (5%) ❑ 31–90 not taken (18–50%) ❑ Took NONE or hardly any (91–100%)

   Reason for not taking red capsules: _____

4. OVER THE PAST TWELVE MONTHS, have you experienced any of the following? (Please check YES or NO for ALL items.)

	NO	YES		NO	YES		NO	YES
Symptoms suggestive of gastritis	❑	❑	Diarrhea	❑	❑	Epistaxis	❑	❑
Symptoms suggestive of peptic ulcer	❑	❑	Skin discoloration	❑	❑	Other bleeding	❑	❑
Nausea	❑	❑	Hematuria	❑	❑	Headache	❑	❑
Constipation	❑	❑	Easy bruising	❑	❑	Migraine	❑	❑

   Other symptoms _____

5. Have any of these relatives ever been diagnosed with diabetes? (Please check YES or NO for ALL items.)

	NO	YES		NO	YES
Mother	❑	❑	Father	❑	❑
Sister	❑	❑	Brother	❑	❑

6. SINCE YOU FILLED OUT THE LAST QUESTIONNAIRE (about twelve months ago), were you NEWLY DIAGNOSED as having any of the following IN YOUR RIGHT EYE? (Please check YES or NO for ALL items and provide date for each diagnosis.)

	NO	YES		MONTH/YEAR
Cataract	❑	❑	Date of cataract diagnosis	_____
Cataract extraction	❑	❑	Date of cataract extraction	_____
Macular degeneration	❑	❑	Date of macular degeneration diagnosis	_____

7. SINCE YOU FILLED OUT THE LAST QUESTIONNAIRE (about twelve months ago), were you NEWLY DIAGNOSED as having any of the following IN YOUR LEFT EYE? (Please check YES or NO for ALL items and provide date for each diagnosis.)

	NO	YES		MONTH/YEAR
Cataract	❑	❑	Date of cataract diagnosis	_____
Cataract extraction	❑	❑	Date of cataract extraction	_____
Macular degeneration	❑	❑	Date of macular degeneration diagnosis	_____

8. SINCE YOU FILLED OUT THE LAST QUESTIONNAIRE (about twelve months ago), were you NEWLY DIAGNOSED as having any of the following conditions? (Please check YES or NO for ALL items and provide date for each diagnosis.)

	NO	YES	DATE of DX MONTH/YEAR		NO	YES	DATE of DX MONTH/YEAR
Myocardial infarction	❑	❑	_____	Benign prostatic hyperplasia	❑	❑	_____
Pulmonary embolism	❑	❑	_____	Benign prostatic hyperplasia surgery	❑	❑	_____
Skin cancer, type _____	❑	❑	_____	Arthritis	❑	❑	_____
Deep vein thrombosis	❑	❑	_____	Bronchitis	❑	❑	_____
Stroke	❑	❑	_____	Subconjunctival hemorrhage	❑	❑	_____
Cancer (non-skin): Site _____	❑	❑	_____	Intermittent claudication	❑	❑	_____
Coronary angioplasty (PTCA)	❑	❑	_____	Carotid artery surgery	❑	❑	_____
Angina pectoris	❑	❑	_____	Other peripheral artery surgery	❑	❑	_____
Coronary bypass (CABG)	❑	❑	_____	Site _____			
Bleeding hemorrhoids	❑	❑	_____	Gallstones	❑	❑	_____
Non-bleeding hemorrhoids	❑	❑	_____	Gallbladder removal	❑	❑	_____
Gout	❑	❑	_____	Appendix removal	❑	❑	_____
Diabetes mellitus	❑	❑	_____	Abdominal aortic aneurysm	❑	❑	_____
Gastrointestinal bleeding	❑	❑	_____	Renal disease	❑	❑	_____
Site _____				Varicose veins	❑	❑	_____
Transient cerebral ischemia (TIA)	❑	❑	_____	Vasectomy	❑	❑	_____
Peptic ulcer	❑	❑	_____	Glaucoma	❑	❑	_____
Liver disease	❑	❑	_____	Periodontal disease	❑	❑	_____
Osteoporosis	❑	❑	_____	Teeth lost in past year	❑	❑	_____
				If YES, how many _____			

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 REVERSE

9. If you have any of the conditions listed in questions 6, 7 or 8, 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, Professor of Medicine and Ambulatory Care and Prevention, Harvard Medical School, 900 Commonwealth Avenue East, Boston, MA 02215, 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 _____

10. OVER THE PAST TWELVE MONTHS, on how many DAYS did you take the white pills from your calendar packs?

❑ 0 Days ❑ 1–13 Days ❑ 14–30 Days ❑ 31–60 Days ❑ 61–90 Days ❑ 91–120 Days ❑ 121–180 Days ❑ 181+ Days

PLEASE NOTE THAT QUESTIONS #11–16 RELATE TO YOUR OWN PERSONAL MEDICATIONS (NOT THE STUDY PILLS)

OVER THE PAST 12 MONTHS, on how many DAYS did you take:

11. Aspirin or medication containing aspirin (Alka Seltzer, etc.)?

❑ 0 Days ❑ 1–13 Days ❑ 14–30 Days ❑ 31–60 Days ❑ 61–90 Days ❑ 91–120 Days ❑ 121–180 Days ❑ 181+ Days

12. Platelet active or non-steroidal anti-inflammatory agents (Persantine, Anturane, Advil, Feldene, Naprosyn, etc.)?

❑ 0 Days ❑ 1–13 Days ❑ 14–30 Days ❑ 31–60 Days ❑ 61–90 Days ❑ 91–120 Days ❑ 121–180 Days ❑ 181+ Days

13. Multivitamins?

❑ 0 Days ❑ 1–13 Days ❑ 14–30 Days ❑ 31–60 Days ❑ 61–90 Days ❑ 91–120 Days ❑ 121–180 Days ❑ 181+ Days

14. INDIVIDUAL SUPPLEMENTS of Vitamin A or INDIVIDUAL Beta-carotene? (*NOT* Multivitamins)

❑ 0 Days ❑ 1–13 Days ❑ 14–30 Days ❑ 31–60 Days ❑ 61–90 Days ❑ 91–120 Days ❑ 121–180 Days ❑ 181+ Days

15. SINCE 1982, have you taken regularly an INDIVIDUAL SUPPLEMENT of Vitamin E? (*NOT* Multivitamins)

❑ NO ❑ YES TOTAL number of years taken _____

IF YES: In what calendar year did you most recently take Vitamin E regularly? 19 _____ year

For this most recent usage, please provide: Average Number/Week _____ Usual Size _____ mg or IU (circle one)

16. SINCE 1982, have you taken regularly an INDIVIDUAL SUPPLEMENT of Vitamin C? (*NOT* Multivitamins)

❑ NO ❑ YES TOTAL number of years taken _____

IF YES: In what calendar year did you most recently take Vitamin C regularly? 19 _____ year

For this most recent usage, please provide: Average Number/Week _____ Usual Size _____ mg

17. OVER THE PAST TWELVE MONTHS, have you STARTED taking medication for hypertension? ❑ NO ❑ YES

18. 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

19. Have you ever smoked cigarettes regularly?

❑ NO

❑ PAST ONLY TOTAL number of years smoked _____ Calendar Year last smoked: 19 _____

❑ CURRENTLY TOTAL number of years smoked _____ Current number of cigarettes smoked daily _____

20. What is your race: ❑ White/Non-Hispanic ❑ Hispanic ❑ African American/Black ❑ Asian or Pacific Islander

❑ American Indian or Alaskan native ❑ Other _____ ❑ Unknown