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HARVARD MEDICAL SCHOOL | **PHYSICIANS' HEALTH STUDY**

Please complete all 19 questions and return this form in the prepaid envelope provided

1. Date of birth: ______/______/19______ (necessary for verification)
   Month Day Year

2. Current weight: ______________ lbs.

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. 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	______

6. 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	______

7. 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 #7: Please provide details on back — especially for diagnosis, progression of disease and treatment.

→ PLEASE CONTINUE ON REVERSE

8. If you have any of the conditions listed in questions 5, 6 or 7, 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 ______________

9. 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 #10–15 RELATE TO YOUR OWN PERSONAL MEDICATIONS (NOT THE STUDY PILLS)

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

10. 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

11. 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

12. Multivitamins?

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

13. 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

14. INDIVIDUAL SUPPLEMENTS of Vitamin E? (*NOT* Multivitamins)

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

    IF TAKEN on one or more days: Usual Daily Dose __________ mg or IU (circle one)

15. INDIVIDUAL SUPPLEMENTS of Vitamin C? (*NOT* Multivitamins)

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

    IF TAKEN on one or more days: Usual Daily Dose __________ mg

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

17. 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

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

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

    Name ____________________ Address ____________________

    City ____________________ State ____________________ Zip __________

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

    Home (   ) ____________________ Office (   ) ____________________