



Please complete all 14 questions and return this form in the prepaid envelope provided

1. Over the past twelve months, how many of the 180 white pills did you NOT take?
- 0 (took all the white pills) 31-90 not taken (18-50%)
 1-9 not taken (5%) 91-162 not taken (51-90%)
 10-30 not taken (6-17%) Did not take any or hardly any (91-100%)

Reason for not taking white pills: _____

2. Over the past twelve months, how many of the 180 red pills did you NOT take?
- 0 (took all the red pills) 31-90 not taken (18-50%)
 1-9 not taken (5%) 91-162 not taken (51-90%)
 10-30 not taken (6-17%) Did not take any or hardly any (91-100%)

Reason for not taking red pills: _____

3. Over the past twelve months, other than study pills, did you take any additional medication containing aspirin and/or other platelet-active, nonsteroidal anti-inflammatory agents such as Motrin, Clinoril, Indocin, Feldene, Meclomen, Tolectin, Naprosyn, etc? NO YES

Total Number
of Days Taken

IF YES: Was this ASPIRIN? NO YES _____

and/or
OTHER PLATELET ACTIVE DRUGS? NO YES _____ Name of agent (s): _____
(such as those listed above)

4. Please consider only the last 30 days: On how many of the past 30 days did you take additional medication containing aspirin and/or other platelet active, nonsteroidal anti-inflammatory agents such as Motrin, Clinoril, Indocin, Feldene, Meclomen, Tolectin, Naprosyn, etc? 0 days 1 day 2-3 days 4-6 days 7-10 days 11-20 days 21-30 days

If taken on more than one day, was the use: All on consecutive days Mostly consecutive days Sporadic

5. Over the past twelve months, other than study pills, did you take additional capsules containing beta-carotene or individual vitamin A supplements (other than multivitamins)? NO YES which type? VITAMIN A BETA-CAROTENE

IF YES: Size _____units #/Week: 1-3 4-10 11-14 15+

6. SINCE YOU FILLED OUT THE LAST QUESTIONNAIRE (ABOUT TWELVE 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"/>	Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>
Symptoms suggestive of peptic ulcer*	<input type="checkbox"/>	<input type="checkbox"/>	Spontaneous bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Epistaxis	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Hematemesis	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Hematuria	<input type="checkbox"/>	<input type="checkbox"/>
Melena	<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>
Skin discoloration	<input type="checkbox"/>	<input type="checkbox"/>	Migraine	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>			

*An enteric coated preparation is available upon request.

7. SINCE YOU FILLED OUT THE LAST QUESTIONNAIRE (ABOUT TWELVE MONTHS AGO), have you been NEWLY DIAGNOSED as having any of the following conditions? (Please check YES or NO for ALL items)

	YES	NO	DATE OF DX MONTH/YEAR		YES	NO	DATE OF DX MONTH/YEAR
Myocardial infarction	<input type="checkbox"/>	<input type="checkbox"/>	_____	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Deep vein thrombosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Gout	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pulmonary embolism	<input type="checkbox"/>	<input type="checkbox"/>	_____	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer: Site _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	Renal disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
If skin cancer, type _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	Gallstones	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diagnosis of cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____	Peptic ulcer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	_____
Subconjunctival hemorrhage	<input type="checkbox"/>	<input type="checkbox"/>	_____	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	_____
Angina pectoris	<input type="checkbox"/>	<input type="checkbox"/>	_____	Peripheral vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Coronary artery bypass or angioplasty	<input type="checkbox"/>	<input type="checkbox"/>	_____	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes mellitus	<input type="checkbox"/>	<input type="checkbox"/>	_____	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____	Periodontal disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Transient cerebral ischemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Teeth lost in past year	<input type="checkbox"/>	<input type="checkbox"/>	_____
				If YES, how many _____			

Nature of evidence for diagnosis of stroke or TIA _____

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, please complete and sign the following consent form. Obtaining hospital records or information from a treating physician is important in order that we may apply uniform criteria to evaluation of the 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. We have the following date recorded as your birthdate:

Is this information correct? YES NO, my correct birthdate is _____

10. a) CURRENT blood pressure level ____/____ mm/Hg or Don't Know
 b) Since you initially enrolled in our study, (approx. 2 yrs) have you received drug treatment for hypertension? YES NO
11. a) Current level of blood cholesterol ____mg/100 ml or Don't Know
 b) Since you initially enrolled in our study, (approx. 2 yrs.) have you received drug treatment for high cholesterol? YES NO
12. a) Since you initially enrolled in our study, (approx. 2 yrs.) did you smoke cigarettes regularly? YES NO
 If YES: On average over the past twelve months, how many cigarettes did you smoke daily?
 (1 pack = 20 cigs.) 0-4 5-14 15-24 25-34 35-44 45 +
13. 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.

	2+ /day	daily	5-6/wk	2-4/wk	1/wk	1-3/mth	Rarely/ Never
(1) Broccoli (1/2 c.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(2) Brussels sprouts (1/2 c.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(3) Carrots (whole or 1/2 c. cooked)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(4) Spinach, cooked (1/2 c.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(5) Spinach/dark green lettuce salad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(6) Yellow squash (1/2 c.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(7) Yams or sweet potatoes (1/2 c.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(8) Tomato juice (small glass)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(9) Tomatoes (1)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(10) Orange juice (small glass)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(11) Cantaloupe (1/4 melon)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(12) Peaches, apricots or nectarines (fresh, frozen or canned)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(13) Dried apricots (1/2 c.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(14) Liver (3-4 oz.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(15) Cold breakfast cereal (1 c.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(16) Eggs (1)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(17) Whole milk (8 oz. glasses)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(18) Skim or low fat milk (8 oz. glasses)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(19) Red chili sauce (1 tbsp)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. The following is OPTIONAL.

Because of our possible need to contact you if our mail does not reach you in the future, we would appreciate having your current telephone numbers at which we could reach you during the day and in the evening. Please note that this information will be used ONLY if we cannot reach you through regular postal channels.

Telephone: Home () _____ Office () _____