



36 mlh

Please complete all 12 questions and return this form in the prepaid envelope provided

- Date of birth: \_\_\_\_\_/\_\_\_\_\_/19\_\_\_\_\_ (For identification purposes)
- OVER THE PAST TWELVE MONTHS, how many of the approximately 180 white pills did you NOT take? (Do not include extra pills in a short month or made-up pills as missed pills.)
 

<input type="checkbox"/> TOOK ALL THE WHITE PILLS	<input type="checkbox"/> 31-90 not taken (18-50%)
<input type="checkbox"/> 1-9 not taken (5%)	<input type="checkbox"/> 91-162 not taken (51-90%)
<input type="checkbox"/> 10-30 not taken (6-17%)	<input type="checkbox"/> Took NONE or hardly any (91-100%)

 Reason for not taking white pills: \_\_\_\_\_
- OVER THE PAST TWELVE MONTHS, how many of the approximately 180 red pills did you NOT take? (Do not include extra pills in a short month or made-up pills as missed pills.)
 

<input type="checkbox"/> TOOK ALL THE RED PILLS	<input type="checkbox"/> 31-90 not taken (18-50%)
<input type="checkbox"/> 1-9 not taken (5%)	<input type="checkbox"/> 91-162 not taken (51-90%)
<input type="checkbox"/> 10-30 not taken (6-17%)	<input type="checkbox"/> Took NONE or hardly any (91-100%)

 Reason for not taking red pills: \_\_\_\_\_
- OVER THE PAST MONTH, other than study pills, on how many days did you take additional aspirin, 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
- OVER THE PAST TWELVE MONTHS (including the past month), other than study pills, on how many DAYS did you take any of the following:
 

	0 Days	1-4 Days	5-8 Days	9-14 Days	15-30 Days	31-60 Days	61+ Days
a) Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Medication containing aspirin Name of agent(s): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Platelet active, nonsteroidal anti-inflammatory agents (eg, Motrin, Feldene, Naprosyn, etc.). Name of agent(s): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- OVER THE PAST TWELVE MONTHS, other than study pills, did you take additional BETA-CAROTENE or VITAMIN A (other than multivitamins)?    Yes    No  
 IF YES: Which type?    VITAMIN A    BETA-CAROTENE  
 Number per week:    0    1-3    4-7    8-14    15+
- 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"/>	_____
Pulmonary embolism	<input type="checkbox"/>	<input type="checkbox"/>	_____	Gout	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer: Site _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
If skin cancer, type _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	Renal disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Deep vein thrombosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Peptic ulcer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diagnosis of cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	_____
Date 1st dx _____				Peripheral vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Subconjunctival hemorrhage	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes mellitus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Angina pectoris	<input type="checkbox"/>	<input type="checkbox"/>	_____	Gallstones	<input type="checkbox"/>	<input type="checkbox"/>	_____
Coronary bypass/angioplasty	<input type="checkbox"/>	<input type="checkbox"/>	_____	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Transient cerebral ischemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Periodontal disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nature of evidence for diagnosis of stroke or TIA _____				Teeth lost in past year	<input type="checkbox"/>	<input type="checkbox"/>	_____
				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.

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. 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"/>	Melena	<input type="checkbox"/>	<input type="checkbox"/>
Symptoms suggestive of peptic ulcer*	<input type="checkbox"/>	<input type="checkbox"/>	Hematemesis	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Other GI bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Site _____		
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Hematuria	<input type="checkbox"/>	<input type="checkbox"/>
Skin discoloration	<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	Epistaxis	<input type="checkbox"/>	<input type="checkbox"/>
Migraine	<input type="checkbox"/>	<input type="checkbox"/>	Other bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Other symptoms _____					

\*An enteric-coated preparation is available upon request.

10. Have you *EVER* had any of the following?

	Yes	No	Date Month/Year		Yes	No	Date Month/Year
Dx of osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Intermittent claudication	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gallbladder removal	<input type="checkbox"/>	<input type="checkbox"/>	_____	Carotid artery surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Appendix removal	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other peripheral artery surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
				IF YES, Site _____			

11. SINCE AGE 40, have you had a fracture resulting from a fall from a standing or walking position (exclude trauma from an auto accident, skiing, etc.)  Yes  No

IF YES: Circumstances \_\_\_\_\_  
 \_\_\_\_\_

12. Do you engage in a regular program of exercise vigorous enough to work up a sweat?  Yes  No

IF YES: a) How many days per week?  less than 1 day per week  1-2 days  3-4 days  5-7 days

b) How long have you had this pattern of exercise?  less than one year  1-2 years  3-5 years  6+ years

c) What types of vigorous exercise do you engage in?

racquet sports  swimming  jogging/running  cycling (include indoor)  other

d) How long is each average exercise session?  10 mins or less  11-24 mins  25-40 mins  41+ mins

e) If you jog/run, how long is your usual distance?

1 mile or less  1.1-2 miles  2.1-3 miles  3.1-4 miles  more than 4 miles