



48 mth

Please complete all 11 questions and return this form in the prepaid envelope provided

1. Date of birth: ____/____/19____ (For identification purposes)
 Month Day Year
2. OVER THE PAST TWELVE MONTHS, how many of the approximately 180 white pills did you NOT take? (Do not count as missed extra pills in a short month or made-up pills.)
- 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%) Took NONE or hardly any (91-100%)
- Reason for not taking white pills: _____

3. OVER THE PAST TWELVE MONTHS, how many of the approximately 180 red capsules did you NOT take? (Do not count as missed extra capsules in a short month or made-up capsules.)
- TOOK ALL THE RED CAPSULES 31-90 not taken (18-50%)
 1-9 not taken (5%) 91-162 not taken (51-90%)
 10-30 not taken (6-17%) Took NONE or hardly any (91-100%)
- Reason for not taking red capsules: _____

4. 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, Advil, Nuprin, 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 (including the past month), other than study pills, on how many DAYS did you take the following: (Please answer ALL items— a, b, and c.)
- | | 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 (e.g., 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"/> |

6. OVER THE PAST TWELVE MONTHS, other than study capsules, 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: 1-3 4-7 8-14 15+

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"/>	_____
Pulmonary embolism	<input type="checkbox"/>	<input type="checkbox"/>	_____	Gout	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin cancer, type _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	Gallstones	<input type="checkbox"/>	<input type="checkbox"/>	_____
Deep vein thrombosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Gallbladder removal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer: Site _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	_____
Coronary bypass/angioplasty	<input type="checkbox"/>	<input type="checkbox"/>	_____	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	_____
Angina pectoris	<input type="checkbox"/>	<input type="checkbox"/>	_____	Appendix removal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Melena	<input type="checkbox"/>	<input type="checkbox"/>	_____	Intermittent claudication	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hematemesis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Carotid artery surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other GI bleeding	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other peripheral artery surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Site _____				IF YES, Site _____			
Transient cerebral ischemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Subconjunctival hemorrhage	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes mellitus	<input type="checkbox"/>	<input type="checkbox"/>	_____	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Peptic ulcer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Periodontal disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Renal disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Teeth lost in past year	<input type="checkbox"/>	<input type="checkbox"/>	_____ # _____

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.

