031 _____ _____

(original yellow) 6 mth

HARVARD MEDICAL SCHOOL

PHYSICIANS' HEALTH STUDY

Please complete ALL 7 questions and return this form in the prepaid envelope provided.

1. Date of birth: ___ ___ / ___ ___ / 19 ___ ___
   Mo Day Year

FOR THE FOLLOWING QUESTIONS, PLEASE CONSIDER YOUR EXPERIENCE OVER THE PAST SIX MONTHS:

2. Did you MISS any of your pills? NO ☐ I missed no days YES ☐ I missed ____days
   IF YES: Were they mostly: capsules ☐ tablets ☐ both equally ☐

3. Have you taken any individual vitamin A supplements (other than multivitamins) YES ☐ NO ☐
   IF YES: Size ____units #/week ____

4. Other than study pills, did you take additional tablets containing aspirin or other platelet active, non-steroidal, anti-inflammatory agents such as Motrin, Clinoril, Indocin, Feldene, Meclomen, Tolectin, Naprosyn, etc. YES ☐ NO ☐
   IF YES: On about how many of the past 180 days? ____days
   How many additional tablets did you take? ____tablets
   If non-aspirin, name of agent: _____ _____

5. Since you filled out the last questionnaire (about six 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	☐	☐	Spontaneous bleeding	☐	☐
Symptoms suggestive of peptic ulcer	☐	☐	Epistaxis	☐	☐
Nausea (without vomiting)	☐	☐	Hematesis	☐	☐
Constipation	☐	☐	Hematuria	☐	☐
Diarrhea	☐	☐	Headache	☐	☐
Melena	☐	☐	Migraine	☐	☐
Skin discoloration	☐	☐	Other:	☐	☐
Easy bruising	☐	☐			

_____

IF YES: Please provide details on the back, especially as to whether the condition is new or recurrent, the severity, treatment etc.

6. Since you filled out the last questionnaire (about six months ago) have you been diagnosed as having any of the following conditions? (Please check YES or NO for ALL items)

	YES	NO	DATE MONTH/YEAR		YES	NO	DATE MONTH/YEAR
Myocardial infarction	☐	☐	_____	Angina pectoris	☐	☐	_____
Liver disease	☐	☐	_____	Diabetes	☐	☐	_____
Renal disease	☐	☐	_____	Arthritis	☐	☐	_____
Peptic ulcer	☐	☐	_____	Periodontal disease	☐	☐	_____
Gout	☐	☐	_____	Cataracts	☐	☐	_____
Cancer-Site _____	☐	☐	_____	Gallstones	☐	☐	_____
Stroke	☐	☐	_____	Pulmonary embolism	☐	☐	_____
Transient cerebral ischemia	☐	☐	_____	Deep vein thrombosis	☐	☐	_____
Nature of evidence for diagnosis of stroke or TIA _____				Hemorrhoids	☐	☐	_____
_____				Varicose veins	☐	☐	_____
				Other:	☐	☐	_____
				_____			
				_____			

IF YES: Please provide details on back—especially evidence for diagnosis, progression of disease and treatment.

PLEASE CONTINUE ON REVERSE

7. If you have any of the conditions listed in question 6, we would appreciate your signing the following consent form. Obtaining hospital records is important in order that we may apply uniform criteria to the evaluation of 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 _____

THANK YOU!

Please return to: Physicians' Health Study
55 Pond Avenue
Brookline, MA 02146