72 mth (B)

HARVARD MEDICAL SCHOOL **PHYSICIANS' HEALTH STUDY**

Please complete all 13 questions and return this form in the prepaid envelope provided

1. Date of birth: ____/ ____/ 19____ (Necessary for verification)
   Month Day Year

2. 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%)

3. OVER THE PAST TWELVE MONTHS, on how many DAYS did you take multiple vitamins?
   ☐ 0 Days ☐ 1-13 Days ☐ 14-30 Days ☐ 31-60 Days ☐ 61-90 Days ☐ 91-120 Days ☐ 121-180 Days ☐ 180+ Days

4. OVER THE PAST TWELVE MONTHS, other than study capsules, on how many DAYS did you take additional BETA-CAROTENE or VITAMIN A (other than multivitamins)?
   ☐ 0 Days ☐ 1-13 Days ☐ 14-30 Days ☐ 31-60 Days ☐ 61-90 Days ☐ 91-120 Days ☐ 121-180 Days ☐ 180+ Days

5. 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

6. 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 _____

7. OVER THE PAST TWELVE MONTHS, were you diagnosed as having a cataract:

	No	Yes		Month/Year
In your RIGHT eye?	☐	☐	Date of RIGHT eye diagnosis	_____
In your LEFT eye?	☐	☐	Date of LEFT eye diagnosis	_____

8. OVER THE PAST TWELVE MONTHS, did you have a cataract extraction:

	No	Yes		Month/Year
In your RIGHT eye?	☐	☐	Date of extraction in RIGHT eye	_____
In your LEFT eye?	☐	☐	Date of extraction in LEFT eye	_____

9. OVER THE PAST TWELVE MONTHS, have you been 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	☐	☐	_____	Gallstones	☐	☐	_____
Pulmonary embolism	☐	☐	_____	Gallbladder removal	☐	☐	_____
Skin cancer, type _____	☐	☐	_____	Appendix removal	☐	☐	_____
Deep vein thrombosis	☐	☐	_____	Renal disease	☐	☐	_____
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	☐	☐	_____	Arthritis	☐	☐	_____
Non-bleeding hemorrhoids	☐	☐	_____	Gout	☐	☐	_____
Melena	☐	☐	_____	Diabetes mellitus	☐	☐	_____
Hematemesis	☐	☐	_____	Bronchitis	☐	☐	_____
Other GI bleeding	☐	☐	_____	Varicose veins	☐	☐	_____
Site _____				Vasectomy	☐	☐	_____
Transient cerebral ischemia (TIA)	☐	☐	_____	Glaucoma	☐	☐	_____
Peptic ulcer	☐	☐	_____	Periodontal disease	☐	☐	_____
Liver disease	☐	☐	_____	Teeth lost in past year	☐	☐	_____
Osteoporosis	☐	☐	_____	If YES, how many _____			

Other conditions requiring medical treatment _____

IF YES to ANY items in #9: Please provide details on back — especially for diagnosis, progression of disease and treatment.

→ PLEASE CONTINUE ON REVERSE

10. If you have any of the conditions listed in questions 7, 8 or 9, 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, 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:

Diagnosis: _____

Name of hospital/physician _____

Address _____

City _____ State _____ Zip _____

Dates of hospitalization/treatment _____

Signed _____ Date _____

11. OVER THE PAST TWELVE MONTHS, on how many DAYS have you taken aspirin (including from your calendar packs) 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 ☐ 180+ Days

12. OVER THE PAST TWELVE MONTHS, on how many DAYS have you taken platelet active or nonsteroidal 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 ☐ 180+ Days

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.)	☐	☐	☐	☐	☐	☐	☐
(2) Brussels sprouts (1/2 c.)	☐	☐	☐	☐	☐	☐	☐
(3) Carrots (whole or 1/2 c.)	☐	☐	☐	☐	☐	☐	☐
(4) Spinach, cooked (1/2 c.)	☐	☐	☐	☐	☐	☐	☐
(5) Spinach/Dark green lettuce salad	☐	☐	☐	☐	☐	☐	☐
(6) Yellow squash	☐	☐	☐	☐	☐	☐	☐
(7) Yams or sweet potatoes (1/2 c.)	☐	☐	☐	☐	☐	☐	☐
(8) Tomato Juice (small glass)	☐	☐	☐	☐	☐	☐	☐
(9) Tomatoes (1)	☐	☐	☐	☐	☐	☐	☐
(10) Orange juice (small glass)	☐	☐	☐	☐	☐	☐	☐
(11) Cantaloupe (1/4 melon)	☐	☐	☐	☐	☐	☐	☐
(12) Peaches, apricots or nectarines (fresh, frozen or canned)	☐	☐	☐	☐	☐	☐	☐
(13) Dried apricots (1/2 c.)	☐	☐	☐	☐	☐	☐	☐
(14) Liver (3-4 oz.)	☐	☐	☐	☐	☐	☐	☐
(15) Cold breakfast cereal (1 c.)	☐	☐	☐	☐	☐	☐	☐
(16) Eggs (1)	☐	☐	☐	☐	☐	☐	☐
(17) Whole milk (8 oz. glasses)	☐	☐	☐	☐	☐	☐	☐
(18) Skim or low fat milk (8 oz. glasses)	☐	☐	☐	☐	☐	☐	☐
(19) Red chili sauce (1 tbsp)	☐	☐	☐	☐	☐	☐	☐