



HARVARD MEDICAL SCHOOL

PHYSICIANS' HEALTH STUDY

Please complete this questionnaire regardless of whether you are willing to participate so that we may determine if participants differ from non-participants in any systematic way. All information will be regarded as strictly confidential and will be used only for medical statistical purposes. PLEASE BE SURE TO COMPLETE ALL ITEMS.

1. Date of birth: _____ / _____ / 19____ 2. Sex: M F 3. Height: _____ 4. Weight _____ lbs.
(27) mo., (29) day (31) year (33) (34) in inches (36)

5. Do you have a personal history of any of the following? (Please check either "yes" or "no" to all items)

	YES	NO		YES	NO
(39) Myocardial infarction	<input type="checkbox"/>	<input type="checkbox"/>	(55) Angina pectoris	<input type="checkbox"/>	<input type="checkbox"/>
(40) Stroke	<input type="checkbox"/>	<input type="checkbox"/>	(56) Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
(41) Transient cerebral ischemia (TIA)	<input type="checkbox"/>	<input type="checkbox"/>	(57) Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
(42) Current liver disease	<input type="checkbox"/>	<input type="checkbox"/>	(58) Periodontal disease	<input type="checkbox"/>	<input type="checkbox"/>
(43) Current renal disease	<input type="checkbox"/>	<input type="checkbox"/>	(59) Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
(44) Peptic ulcer	<input type="checkbox"/>	<input type="checkbox"/>	(60) Gallstones	<input type="checkbox"/>	<input type="checkbox"/>
(45) Gout	<input type="checkbox"/>	<input type="checkbox"/>	(61) Pulmonary embolism	<input type="checkbox"/>	<input type="checkbox"/>
(46) Cancer: Site (47) _____ (48)	<input type="checkbox"/>	<input type="checkbox"/>	(62) Deep vein thrombosis	<input type="checkbox"/>	<input type="checkbox"/>

6. Do you have any personal history of adverse effects to aspirin or any other medical contraindication to its use?
(63) No Yes

7. On average, are you currently taking aspirin or aspirin-containing compounds as frequently as once per week?
(64) No Yes

8. Have you ever taken multiple vitamins regularly? (85) Never Past only Current
IF CURRENT: Brand (66) _____ Years (69) _____ #/week (71) _____

9. Have you ever taken regularly a capsule containing only vitamin A? (73) Never Past only Current
IF CURRENT: Years (74) _____ #/week (76) _____ Size (78) _____ units

10. Have you ever taken regularly a tablet containing only vitamin C? (80) Never Past only Current
IF CURRENT: Years (12) _____ #/week (14) _____ Size (16) _____ mgm

11. Have you ever taken regularly a capsule containing only vitamin E? (20) Never Past only Current
IF CURRENT: Years (21) _____ #/week (23) _____ Size (25) _____ units

12. Other than aspirin-containing compounds or vitamins, are you currently taking any medications at least once per week?
(20) No Yes

IF YES: Please specify: (30) _____ (36) _____
(Please print) (42) _____ (48) _____

13. a) CURRENT blood pressure level (54) _____ / _____ mm HG or Don't know
b) Have you ever received drug treatment for hypertension? (60) Never Past only Current

14. a) CURRENT level of blood cholesterol (61) _____ mg/100 ml or Don't know
b) Have you ever received drug treatment for high cholesterol? (64) Never Past only Current

15. Have you ever smoked cigarettes regularly? (65) Never Past only Current
IF CURRENT: On average how many cigarettes do you currently smoke daily (1 pack = 20 cigs)? (66) _____ cigs

16. Have you ever smoked cigars regularly? (68) Never Past only Current

17. Have you ever smoked a pipe regularly? (69) Never Past only Current

18. How often do you exercise vigorously enough to work up a sweat?
(70) Daily 5-6 times/wk 2-4 times/wk once/wk 1-3 times/month rarely/never

19. How often do you usually consume the following? (Check the most appropriate box)

	21/day	daily	5-6/wk	2-4/wk	1/wk	1-3/mth	Rarely/ Never
(71) Broccoli or Brussel sprouts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(72) Carrots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(73) Spinach or other dark greens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(74) Yellow (winter) squash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(75) Tomatoes or tomato juice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(76) Alcoholic beverages (beer, wine or liquor)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(77) Cold breakfast cereal Usual brand (78) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(80) Liver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE CONTINUE ON REVERSE

INFORMED CONSENT

I hereby consent to participate in the Physicians' Health Study. My collaboration will include:

- a) Taking one tablet or capsule daily from the monthly calendar packs I am sent;
- b) Completing, every six months, a brief questionnaire asking about my compliance and my recent health;
- c) Giving Charles H. Hennekens, MD permission to validate, from medical records, any relevant illnesses I report.

I understand that participants *will not be able to choose* their treatment group and that *I will not know* my treatment group, though the daily pills will contain alternate day aspirin (Bufferin, 325 mg), alternate day beta-carotene (Solatene, 30 mg), both or neither.

I further understand that:

- a) In a minority of takers, Bufferin can cause hypersensitivity, dyspepsia or other stomach upset, and it increases the tendency to **bleed**, particularly in the gastrointestinal tract, although generally at much higher doses than used in this study. If I should experience discomfort and wish to continue taking study medication, I may request a coated preparation.
- b) In doses higher than that given in this trial, Solatene produces yellow pigmentation of the skin and/or occasional looser stools in some individuals, though both effects are completely reversible.

I understand that all information will be kept strictly confidential, that I can contact study personnel if I have any questions, and that I may request other reference material on the possible role of aspirin in cardiovascular disease and beta-carotene in cancer. I further understand that I can withdraw from the study at any time.

I am willing to participate in the Physicians' Health Study to evaluate the possible (but unproven) benefits of aspirin and beta-carotene in healthy people.

Yes

No

Signed _____

Date _____

WHETHER OR NOT YOU CONSENT TO PARTICIPATE, we shall be grateful if you would complete the questionnaire on the reverse and return it in the reply-paid envelope.

THANK YOU!