

18 ml

021 _____
(4) (10) (11) (14)



(15) (20)

HARVARD MEDICAL SCHOOL

PHYSICIANS' HEALTH STUDY

Please complete ALL 10 questions and return this form in the prepaid envelope provided.

- Date of birth: ____/____/19____
(21) Mo (23) Day (25) Year
- Are you willing to continue to collaborate in this study? (27) Yes No
IF NO: Please specify your reason: (28) _____
- In the past 30 days, did you MISS any of your pills? (30) No I missed no days Yes I missed (31) _____ days
IF YES: Were they mostly: (33) capsules tablets both equally
- Did you start taking any new medications or vitamin prescriptions on a regular basis during the past four months? (34) Yes No
IF YES: Please specify: (35) _____ (41) _____
(47) _____ (53) _____
- Other than study pills, did you take additional tablets containing aspirin (*Include use of platelet active, non-steroidal, anti-inflammatory agents such as Motrin, Clinoril, etc.*)? (59) Yes No
IF YES: On how many of the past 30 days? (60) _____ days
How many additional tablets did you take? (62) _____ tablets
For what reason? (65) _____
Is/was this condition temporary? (67) Yes No
If *non-aspirin*, name of agent: (68) _____

6. Since we sent your calendar packs (about 4 months ago), have you experienced any of the following? (Please check Yes or No for ALL items)

	Yes	No		Yes	No
(69) Symptoms suggestive of gastritis	<input type="checkbox"/>	<input type="checkbox"/>	(74) Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
(70) Symptoms suggestive of peptic ulcer	<input type="checkbox"/>	<input type="checkbox"/>	(75) Melena	<input type="checkbox"/>	<input type="checkbox"/>
(71) Nausea (without vomiting)	<input type="checkbox"/>	<input type="checkbox"/>	(76) Skin discoloration	<input type="checkbox"/>	<input type="checkbox"/>
(72) Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	(77) Other:	<input type="checkbox"/>	<input type="checkbox"/>
(73) Constipation	<input type="checkbox"/>	<input type="checkbox"/>	(78) _____		

022 7. 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
(13) Broccoli (1/2 c.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(14) Brussels sprouts (1/2 c.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(15) Carrots (whole or 1/2 c. cooked)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(16) Spinach, cooked (1/2 c.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(17) Spinach/dark green lettuce salad (exclude iceberg)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(18) Yellow squash (1/2 c.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(19) Yams or sweet potatoes (1/2 c.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(20) Tomato juice (small glass)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(21) Tomatoes (1)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(22) Orange juice (small glass)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(23) Cantaloupe (1/4 melon)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(24) Peaches, apricots or nectarines (fresh, frozen or canned)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(25) Dried apricots (1/2 c.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(26) Liver (3-4 oz.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(27) Cold breakfast cereal (1 c.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(28) Eggs (1)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(29) Whole milk (8 oz. glasses)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(30) Skim or low fat milk (8 oz. glasses)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(31) Red chili sauce (1 tablespoon)	<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

8. Since we sent your calendar packs (about 4 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
(32) Myocardial infarction	<input type="checkbox"/>	<input type="checkbox"/>	(33) _____	023	(13) Angina pectoris	<input type="checkbox"/>	(14) _____
(37) Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	(38) _____		(18) Diabetes	<input type="checkbox"/>	(19) _____
(42) Renal disease	<input type="checkbox"/>	<input type="checkbox"/>	(43) _____		(23) Arthritis	<input type="checkbox"/>	(24) _____
(47) Peptic ulcer	<input type="checkbox"/>	<input type="checkbox"/>	(48) _____		(28) Periodontal disease	<input type="checkbox"/>	(29) _____
(52) Gout	<input type="checkbox"/>	<input type="checkbox"/>	(53) _____		(33) Cataracts	<input type="checkbox"/>	(34) _____
(57) Cancer	<input type="checkbox"/>	<input type="checkbox"/>	(58) _____		(38) Gallstones	<input type="checkbox"/>	(39) _____
Site (62) _____					(43) Pulmonary embolism	<input type="checkbox"/>	(44) _____
(66) Stroke	<input type="checkbox"/>	<input type="checkbox"/>	(67) _____		(48) Deep vein thrombosis	<input type="checkbox"/>	(49) _____
Clinical Evidence (71) _____					(53) Hemorrhoids	<input type="checkbox"/>	(54) _____
Lab Evidence (72) _____					(58) Varicose veins	<input type="checkbox"/>	(59) _____
(73) Transient cerebral ischemia (TIA)	<input type="checkbox"/>	<input type="checkbox"/>	(74) _____		(63) Other:	<input type="checkbox"/>	(64) _____
Clinical Evidence (78) _____					(68) _____		
Lab Evidence (79) _____					(72) _____		

(76) 9. If you have any of the conditions listed in question 8, 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 _____

(77) 10. The following question is OPTIONAL.

Because of our possible need to contact you if our mail does not reach you in the future, we would appreciate having telephone numbers at which we could reach you during the day and in the evening, as well as the names and addresses of one or two people who could give us your new address should you move. Please note that this information will be used *only* if we cannot reach you through regular postal channels.

Telephone: Home () _____ Office () _____

Contacts

Name _____ Address _____

City _____ State _____ Zip _____

Name _____ Address _____

City _____ State _____ Zip _____

I am unwilling to provide this optional information

THANK YOU!

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