44946

Request

VITAL 3 REV

1. Birth date: ☐☐ / ☐☐ / ☐☐ (month / day / year) → **Your social security number (for identification purposes ONLY)** ☐☐☐ - ☐☐ - ☐☐☐☐

2. During the PAST MONTH, on how many DAYS did you MISS taking your study pills?

○ Missed 0 days (took all) ○ Missed 1-5 days ○ Missed 6-10 days
○ Missed 11-15 days ○ Missed 16-29 days ○ Missed all (took none)

3. Are you willing to continue taking the study pills? ○ No ○ Yes

If you are not willing to continue, what is the reason or reasons?

○ Too inconvenient ○ Poor health ○ Side effects
○ Lost interest ○ Study is too demanding ○ No reason
○ Have difficulty taking pills ○ Other

4. Have you EVER had any of the following? Answer NO/YES on each line.

a.Skin cancer	○ No	○ Yes
IF YES, specify type: b. ○ melanoma ○ squamous or basal cell ○ not sure		
c. Other cancer (Specify: _____)	○ No	○ Yes
d. Heart attack or myocardial infarction	○ No	○ Yes
e. Coronary bypass surgery	○ No	○ Yes
f. Coronary angioplasty or stent (balloon used to unblock an artery)	○ No	○ Yes
g. **Hospitalization** for angina (chest pain)	○ No	○ Yes
h. Stroke	○ No	○ Yes
i. Mini-stroke (transient ischemic attack)	○ No	○ Yes
j. Atrial fibrillation	○ No	○ Yes
k. Other irregular heart rhythm	○ No	○ Yes
l. Heart failure (congestive heart failure)	○ No	○ Yes
m. Diabetes	○ No	○ Yes
n. Kidney stones	○ No	○ Yes
o. Kidney failure or dialysis	○ No	○ Yes
p. High levels of calcium in the blood (hypercalcemia)	○ No	○ Yes
q. Any thyroid condition	○ No	○ Yes
r. Any **para**thyroid condition	○ No	○ Yes
(Note: This is **NOT** thyroid disease -- answer the **previous** question (q) to report a thyroid condition)		

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4. (Continued) Have you EVER had any of the following? Answer NO/YES on each line.

s. Peptic ulcer	○ No	○ Yes
t. Cirrhosis of the liver or other severe liver disease	○ No	○ Yes
u. Tuberculosis (active)	○ No	○ Yes
v. Sarcoid or Wegener's (granulomatosis)	○ No	○ Yes
w. Intermittent claudication (pain in legs while walking due to blocked arteries)	○ No	○ Yes
x. Peripheral artery surgery / stenting (procedure to unblock arteries in legs)	○ No	○ Yes
y. Carotid stenosis (blocked arteries in neck)	○ No	○ Yes
z. Carotid artery surgery / stenting (procedure to unblock arteries in neck)	○ No	○ Yes
aa. Deep vein thrombosis (blood clot in legs)	○ No	○ Yes
bb. Pulmonary embolism (blood clot in lungs)	○ No	○ Yes
cc. Colon or rectal polyps	○ No	○ Yes
dd. Parkinson's disease	○ No	○ Yes
ee. Multiple sclerosis	○ No	○ Yes
ff. Cataract	○ No	○ Yes
gg. Cataract surgery (extraction)	○ No	○ Yes
hh. Gastric bypass surgery	○ No	○ Yes
ii. Prostatic hyperplasia **(men only)**	○ No	○ Yes
jj. Prostatitis **(men only)**	○ No	○ Yes
kk. Uterine fibroids **(women only)**	○ No	○ Yes
ll. Fibrocystic or other benign breast disease **(women only)**	○ No	○ Yes
IF YES: Confirmed by breast biopsy?	○ No	○ Yes
Confirmed by aspiration?	○ No	○ Yes
Atypical hyperplasia?	○ No	○ Yes
mm. Periodontal disease	○ No	○ Yes
Have you had dental x-rays in past 2 yrs?	○ No	○ Yes
IF you have periodontal disease, # teeth lost: ☐☐		

5. In general, would you say your health is:

○ Excellent ○ Very good ○ Good ○ Fair ○ Poor

OFFICE USE: 4c Other Ca: ○ el ○ nel ○ bl

(OVER)

6. SINCE YOU STARTED TAKING YOUR STUDY PILLS, have you experienced any of the following? Please answer NO/YES for each item in both left and right columns.

a. Stomach upset or pain	O No	O Yes	h. Frequent nosebleeds	O No	O Yes
b. Nausea	O No	O Yes	i. Easy bruising	O No	O Yes
c. Constipation	O No	O Yes	j. Blood in urine	O No	O Yes
d. Diarrhea	O No	O Yes	k. Gastro-intestinal bleeding	O No	O Yes
e. Skin rash	O No	O Yes	IF YES: Did you have a blood transfusion?	O No	O Yes
f. Colds or upper respiratory infections	O No	O Yes	Were you hospitalized?	O No	O Yes
g. Flu-like symptoms	O No	O Yes	l. Bad taste in mouth	O No	O Yes

PLEASE ANSWER ALL ITEMS IN BOTH COLUMNS

7. NOT including your study pills and NOT including your diet, how much TOTAL vitamin D do you take each day from nutritional supplements such as single tablets of vitamin D, multi-vitamins, calcium supplements (Calcium+D) or drugs that may include vitamin D (Example: Fosamax+D)? Referring to package labels, please add up ALL your non-diet sources of vitamin D.

O None O TOTAL of 800 IU or less/day O TOTAL of 801-1000 IU/day O TOTAL greater than 1000 IU/day

8. NOT including your study capsules, do you regularly take individual supplements of fish oil? O No O Yes

9. Do you take a calcium supplement daily such as Os-Cal, Caltrate, Citracal, Calcium+D? O No O Yes

IF YES: How much TOTAL calcium do you take each day from nutritional supplements such as single tablets of calcium and multi-vitamins. Referring to package labels, please add up ALL your non-diet sources of calcium.

O TOTAL of 1200 mg or less/day O TOTAL of 1201-1500 mg/day O TOTAL greater than 1500 mg/day

10. Are you CURRENTLY taking any of the following drugs regularly? Answer NO/YES on each line in both left and right columns.

a. Aspirin (Ex: Bayer, Bufferin, Anacin, Excedrin)	O No	O Yes	e .**Non-statin** drugs to lower cholesterol (Ex: Niacin, Lopid, Questran, Colestid, Zetia)	O No	O Yes
IF YES: In the past month, on how many DAYS did you take it? O 1-3 days O 4-10 days O 11-20 days O 21+ days			f. Tamoxifen (Ex: Nolvadex)	O No	O Yes
b. Anti-coagulant drugs (Ex: warfarin, Coumadin, clopidogrel, Plavix, heparin)	O No	O Yes	g. Serotonin reuptake inhibitor (Ex: Celexa, Lexapro, Cipralex, Esertia, Prozac, Zoloft, Zelmid)	O No	O Yes
c. Corticosteroids or prednisone	O No	O Yes	h. Aromatase inhibitor: (Ex: Arimidex, Aromasin, Femara)	O No	O Yes
d.Statin drugs to lower cholesterol (Ex: Lipitor, Zocor, Mevacor, Pravachol, Crestor)	O No	O Yes	i. Calcitriol (Rocaltrol, Calcijex, Vectical) or Paricalcitol (Zemplar)	O No	O Yes

PLEASE ANSWER ALL ITEMS IN BOTH COLUMNS

11. Are you CURRENTLY taking any of the following drugs for prevention or treatment of bone loss? (Mark ALL that apply}

O Fosamax (alendronate) O Evista (raloxifene) O Actonel (risedronate) O Reclast (zoledronic acid)
O Prolia (denosumab) O Forteo (teriparatide injection) O Miacalcin or Fortical (calcitonin-salmon)
O other osteoporosis medication, not listed above O NONE OF THESE MEDICATIONS

12. IN YOUR LIFETIME, have you smoked 100 cigarettes or more?

O No O Yes → **IF YES:**

a. How many TOTAL years have you smoked? → ☐☐ TOTAL years

b. On average, of the entire time you smoked, how many cigarettes did you smoke per day (1pack = 20 cigs)? → ☐☐ entire time, avg. cigs/day

c. Do you CURRENTLY smoke? O No O Yes

d. IF A CURRENT SMOKER, on average, how many cigarettes/day do you smoke (1 pack = 20 cigs.)? ☐☐ currently, avg. cigs/day

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13. DURING THE PAST YEAR, what was your approximate AVERAGE TIME PER WEEK spent at each of the following recreational activities? Please answer on each line.

	AVERAGE TIME PER WEEK							
	zero	1-19 min.	20-59 min.	1 hour	1.5 hours	2-3 hours	4-6 hours	7+ hours
a. Walking or hiking (include walking to work)	○	○	○	○	○	○	○	○
b. Jogging (slower than 10 minute miles)	○	○	○	○	○	○	○	○
c. Running (10 minute miles or faster)	○	○	○	○	○	○	○	○
d. Bicycling (include stationary bike)	○	○	○	○	○	○	○	○
e. Aerobic exercise / aerobic dance / exercise machines	○	○	○	○	○	○	○	○
f. Lower intensity exercise / yoga / stretching / toning	○	○	○	○	○	○	○	○
g. Tennis, squash, or raquetball	○	○	○	○	○	○	○	○
h. Lap swimming	○	○	○	○	○	○	○	○
i. Weight lifting / strength training	○	○	○	○	○	○	○	○
j. Other: Please specify activity: _____	○	○	○	○	○	○	○	○

14. ON AVERAGE, how many FLIGHTS of stairs (not individual steps) do you climb daily?

○ None ○ 1-2 flights ○ 3-4 flights ○ 5-9 flights ○ 10-14 flights ○ 15 or more flights

15. What is your usual walking pace outdoors?

○ Don't walk regularly ○ Easy, casual (less than 2 mph) ○ Normal, average (2-2.9mph)
○ Brisk pace (3-3.9 mph) ○ Very brisk/striding (4 mph or faster)

16. Other than a major accident such as a car accident or falling from a high ladder, have you ever broken any of these bones at age 50 or older? ○ Hip ○ Spine ○ Forearm / shoulder ○ Other ○ None

If you have any concerns about your answers to the following mood questions (#17-20), please share them with your health provider. Also, please refer to information at the following web site: **http://www.nimh.nih.gov/health/publications/depression/complete-index.shtml**

17. Over the PAST 2 WEEKS, how often have you been bothered by any of the following?

	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	○	○	○	○
b. Feeling down, depressed, or hopeless	○	○	○	○
c. Trouble falling or staying asleep, or sleeping too much	○	○	○	○
d. Feeling tired or having little energy	○	○	○	○
e. Poor appetite or overeating	○	○	○	○
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	○	○	○	○
g. Trouble concentrating on things like reading the paper or watching T.V.	○	○	○	○
h. Moving or speaking so slowly that others could have noticed? Or the opposite -- being fidgety, restless, or moving a lot more than usual	○	○	○	○

18. Have you EVER had a diagnosis of depression, or regularly taken medicine or had counseling for depression? ○ No ○ Yes

IF YES: Have you taken an antidepressant or had counseling in the past 2 years? ○ No ○ Yes

19. In the PAST 2 YEARS, have you had 2 weeks or more during which you felt sad, blue, or depressed or lost pleasure in things that you usually cared about or enjoyed? ○ No ○ Yes

20. Have you had 2 or more consecutive years of feeling depressed or sad most days, even if you felt OK sometimes? ○ No ○ Yes

IF YES: Have you felt depressed or sad much of the time in the past year? ○ No ○ Yes

21. IN THE PAST 10 YEARS, have you had any of the following?

a. Rectal exam(s)	○ No	○ Yes →	Number of exams:	○ 1	○ 2	○ 3	○ 4	○ 5 or more
b. Test(s) for blood in your stool (hemoccult, guaiac)	○ No	○ Yes →	Number of exams:	○ 1	○ 2	○ 3	○ 4	○ 5 or more
c. Colonoscopy	○ No	○ Yes →	Number of exams:	○ 1	○ 2	○ 3	○ 4	○ 5 or more
d. Sigmoidoscopy	○ No	○ Yes →	Number of exams:	○ 1	○ 2	○ 3	○ 4	○ 5 or more
e. Barium enema x-ray(s)	○ No	○ Yes →	Number of exams:	○ 1	○ 2	○ 3	○ 4	○ 5 or more
f. PSA test(s) **(men only)**	○ No	○ Yes →	Number of exams:	○ 1	○ 2	○ 3	○ 4	○ 5 or more
g. Mammogram(s) **(women only)**	○ No	○ Yes →	Number of exams:	○ 1	○ 2	○ 3	○ 4	○ 5 or more
h. Breast biopsy **(women only)**	○ No	○ Yes →	Number of exams:	○ 1	○ 2	○ 3	○ 4	○ 5 or more

22. This question applies only to females. (If male, please skip this question and go on to question #23.)

a. At what age did your menstrual periods begin? ○ 9 or younger ○ 10-12 ○ 13-15 ○ 16 and older

b. At what age did your natural periods stop? ○ before 45 ○ 45-49 ○ 50-54 ○ 55 and older

c. Have you ever used post-menopausal female hormones? ○ No ○ Yes, currently ○ Yes, in the past only

d. Have you had a hysterectomy? ○ No ○ Yes

e. Have your ovaries been surgically removed? ○ No ○ Yes, only 1 ovary ○ Yes, both ovaries

f. What was your age at the time of your first live birth of a child? ○ No children ○ under 20 ○ 20-24 ○ 25-29 ○ 30 or older

23. The following information assists us in classifying our study population and is considered OPTIONAL.
Which of these income groups represents your TOTAL household income in the past year?

○ Under $15,000 ○ $15,000 to 29,999 ○ $30,000 to 49,999 ○ $50,000 to 69,999
○ $70,000 to 89,999 ○ $90,000 to 120,000 ○ over $120,000

PLEASE COMPLETE THE IMPORTANT CONTACT INFORMATION BELOW. IT WILL NOT BE SHARED AND WILL BE USED BY STUDY STAFF ONLY.

Please provide us with your phone numbers in the event that we need to reach you to clarify any of your responses.

HOME PHONE ( ) -
CELL PHONE ( ) -
WORK PHONE ( ) -

What is your preferred method of contact:
○ **Home phone** ○ **Cell phone**
○ **Work phone** ○ **No difference**

Please provide us with the names and phone numbers of 2 individuals (not living in your household) whom we have permission to contact in the event that we are not able to contact you directly:

CONTACT 1
Name:_____
Phone number:_____
Relationship (circle): Family Friend Neighbor Other

CONTACT 2
Name:_____
Phone number:_____
Relationship (circle): Family Friend Neighbor Other

If you would like to receive information about the study by e-mail, please provide your e-mail address on the line below:

_____ ○

Thank you for completing the form. Please return it in the enclosed pre-paid envelope.

OFFICE USE ONLY:
○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 CTSC No Contact