



Division of Preventive MedicineDepartment of Medicine

Please Reply to:

VITAL Study 900 Commonwealth Avenue Boston, Massachusetts 02215-1204 (800) 388-3963 (617) 731-3843 FAX vitalstudy@partners.org

Thank you very much for your participation in the VITamin D and OmegA-3 TriaL (VITAL). We are writing now, as we always do between your annual follow-up questionnaires, to check on your current health status and to ask whether your contact information has changed. As you know, VITAL is testing whether vitamin D and/or omega-3 supplements can reduce the risk for cancer, heart disease, stroke, and other health conditions. Thus, we follow these outcomes closely during the study. The enclosed questionnaire asks whether you have recently been diagnosed with these conditions.

However, you will notice that this interim questionnaire is longer than usual. There are two reasons for this. One reason is that the questionnaire contains a series of questions on your diet over the past year. You may recall that we asked similar questions about your diet at the beginning of the study. We now need to ask about your diet again, as this will provide information on your current diet and on changes in your diet over time that will be very helpful in interpreting the results of the study. We know that filling out the diet questions can be time consuming, but *please note that this is the last time that we will ask you detailed questions about your diet.* The other reason that this questionnaire is longer than usual is that it asks about two health issues that we have not previously assessed—(a) migraine or other recurring headaches and (b) leg pain when walking.

We request that you please complete the questionnaire and return it to us in the prepaid envelope at your earliest convenience.

We will mail your annual follow-up questionnaire to you in 5-6 months. In the meantime, if you have any questions about the study, please contact us at 1-800-388-3963 or witalstudy@partners.org.

Thank you again for your support and commitment.

Sincerely,

IdAnn E. Manson, MD

Professor of Medicine

Harvard Medical School

Julie E. Buring, ScD

Professor of Medicine

Harvard Medical School

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VITAL STUDY R 4.5

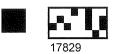
1. Have you had any of the following within the PAST YEAR? Please mark illness or procedure. If YES, provide the month/year of the event:	NO or YES next to the	Month / Year
A. Cancer - NOT including skin cancer (Specify type:) O No O Yes →	of event
B. Heart attack or myocardial infarction	\ T	11/11
C. Coronary bypass surgery		11/11
D. Coronary angioplasty or stent (balloon used to unblock artery)		11/11
E. Stroke		+1/-
F. Mini-stroke (TIA)		+1/+
2. If you are having difficulties taking your study capsules and have newly	y discontinued taking them,	please explain:
3. Below are the phone numbers that we have on file for you. IF THESE NUMBERS ARE NOT CORRECT OR HAVE CHANGED, write the updated information in the space provided to the right. If the numbers below are correct, please skip to item #4.	If the phone numbers to t correct or have changed, UPDATED telephone num	please provide
CURRENT HOME PHONE: $\left(\begin{array}{ c c c c c c c c c c c c c c c c c c c$) -	-
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4. The e-mail address we have on file for you is:		
If you would like to receive information from the study, indicate if your or provide an updated e-mail address on the line below:	e-mail address is the same	→ O Same
. We use DATE OF BIRTH as an identifier. Please verify		
CORRECT, please write your correct birthdate (month/day/year)	If the birth date to the left is correct, please provide COI date of birth information be	RRECTED
month day year	month day / year]
Please continue on the next pag	e. ————————————————————————————————————	
OFFICE USE ONLY. PLEASE DO NOT WRITE BELOW	THIS LINE.	
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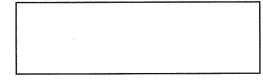




6. Have you EVER experienced recurring (repeated) headaches? O Yes O No If NO, skip to question #7 below. a. Did your recurring headaches have any of the following characteristics? Mark all that apply. O Duration 4-72 hours O Moderate or severe pain intensity O Pain pounding, pulsating, or throbbing O Nausea and/or vorniting O Aggravated by routine physical activity O Pain worse on one side of the head of Sensitivity to Suph O Nausea and/or vorniting O Aggravated by routine physical activity O Pain worse on one side of the head of Sensitivity to Suph O Nausea and/or vorniting O Aggravated by routine physical activity O Pain worse on one side of the head of Sensitivity to Suph O Nausea and/or vorniting of Sensitivity to Suph O Nausea and/or vorniting Politics, zigzagi lines, or "heat waves")? O Never O Sometimes O Always c. Since you first started experiencing recurring headaches, what was the highest frequency of these headaches? O At least 15 days per month O Weekly O Monthly O Every other month O Less than 6 times per year d. On average, have your recurring headaches changed in the past 5 years with respect to frequency or severity? Please answer both FREQUENCY O No change in frequency over past 5 years O I have more headache days per month now O I have flewer headache days per month now O I have flewer headache days per month now O I have flewer headache days per month now O I have flewer headache days per month now O I have flewer headache days per month now O I Pain includes the service of the service	
O Duration 4-72 hours O Nausea and/or vorniting O Sensitivity to sound O Limited your ability to do daily activities D Law according to the sense of the s	6. Have you EVER experienced recurring (repeated) headaches? O Yes O No -> If NO, skip to question #7 bel
O Nausea and/or vomiting O Aggravated by routine physical activity O Pain worse on one side of the head O Sensitivity to sound O Sensitivity to light b. How often have you experienced aura around the time of your recurring headaches (i.e., seen things like spots, stars, lines, flashing lights, zigzag lines, or "heat waves")? O Never O Sometimes O Always c. Since you first started experiencing recurring headaches, what was the highest frequency of these headaches? O At least 15 days per month O Weekly O Monthly O Every other month O Less than 6 times per year d. On average, have your recurring headaches changed in the past 5 years with respect to frequency or severity? Please answer both FREQUENCY and SEVERITY columns below. FREQUENCY O No change in frequency over past 5 years O I have more headache days per month now O I have fewer headache days per month now O I have fewer headache days per month now O I have fewer headache days per month now O 1 have fewer headache days per month now O 1 have fewer headache days per month now O 2 your still experience recurring headaches stopped approximately how many years ago? O 1-2 years O 3-4 years O 5 or more years 7. Do you get pain in either leg or buttock on walking? O yes O No O Uncertain b. In what part of the leg or buttock do you feel it? Mark all that apply. O Pain includes calf/calves O Pain includes thigh/thighs O Pain includes buttock/buttocks c. Do you get it when you walk uphill or hurry? O yes O No O Never walk uphill or hurry d. Do you get it when you walk at an ordinary pace on the level? O yes O No O Uncertain e. Does the pain ever disappear while you are walking? O yes O No O Uncertain f. What do you do if you get it when you are walking? O Yes O No O Uncertain f. What happens to the pain if you stand still? O Unchanged O Lessens or relieved h. If you answered "lessens or relieved" in the question above, how soon does the pain lessen/stop? O Not applicable O 10 minutes or less O More than 10 minutes	a. Did your recurring headaches have any of the following characteristics? Mark all that apply.
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O Not applicable O 10 minutes or less O More than 10 minutes	g. What happens to the pain if you stand still? O Unchanged O Lessens or relieved
	h. If you answered "lessens or relieved" in the question above, how soon does the pain lessen/stop?
i. On average, have you noticed a change in the pain in the past 5 years?	O Not applicable O 10 minutes or less O More than 10 minutes
	i. On average, have you noticed a change in the pain in the past 5 years?
O The pain is more severe/frequent now O The pain is less severe/frequent now O No change	O The pain is more severe/frequent now O The pain is less severe/frequent now O No change

(OVER)





VITAL STUDY DIET ASSESSMENT 2 R 4.5

DIET ASSESSMENT SECTION

Please fill in your AVERAGE total use, during the PAST YEAR, of each specified food. Please try to average your seasonal use of foods over the entire year. For example, if a food such as cantaloupe is eaten 4 times a week during 3 months that it is in season, then the AVERAGE total use would be once per week over the year.

AVERAGE USE LAST YEAR

	ever, or less than once per month	1-3 per month	1 per week	2-4 per week	5-6 per week	1 per day	2-3 per day	4-5 per day	6+ per day
Canned tuna fish (3-4 oz.)	0	0	0	0	0	0	0	0	0
Breaded fish cakes, pieces, or fish sticks (1 serving store bought)	0	0	0	0	0	0	0	0	0
Shrimp, lobster, scallops as a main dish	0	0	0	0	0	0	0	0	0
Dark meat fish, e.g., mackerel, salmon, sard bluefish, swordfish (3-5 oz.)	lines, O	0	0	0	0	0	0	0	0
Other fish, e.g., cod, haddock, halibut (3-5 o	z.) O	0	0	0	0	0	0	0	0

DAIR	Y FO	ODS Never, or once pe	less than r month	1-3 per month	1 per week	2-4 per week	5-6 per week	1 per day	2-3 per day	4-5 per day	6+ per day
		Skim milk	0	0	0	0	0	0	0	0	0
Mills /O am ad	lass)	1 or 2% milk	0	0	0	0	0	0	0	0	0
Milk (8 oz. gl	iass)	Whole milk	0	0	0	0	0	0	0	0	0
	The state of the s	Soy milk	0	0	0	0	0	0	0	0	0
ls your milk	fortifie	ed with omega-3? O No O	Yes O	Don't kno	w		,	,		· · · · · · · · · · · · · · · · · · ·	
Cream, e.g.,	, coffee	, whipped or sour cream (1 Tbs)	0	0	0	0	0	0	0	0	0
Non-dairy co	offee wl	nitener (1 Tbs)	0	0	0	0	0	0	0	0	0
Frozen yogu	ırt, shei	bet or low-fat ice cream (1 cup)	0	0	0	0	0	0	0	0	0
Regular ice	cream	(1 cup)	0	0	0	0	0	0	0	0	0
Yogurt Lo	w-carb	, artificially sweeetened or plain	0	0	0	0	0	0	0	0	0
/4	weetene	ed with fruit or other flavoring	0	0	0	0	0	0	0	0	0
Margarine (p		ded to food or bread; exclude	0	0	0	0	0	0	0	0	0
ls your butte	ery spi	read or margarine fortified with	omega-3	? O No	O Y	es Ol	Don't knov	v			
Is your butte	ery spi	read or margarine fortified with	flax oil?	O No	O Y	es Ol	Don't knov	N			
Butter (pat), use in cookir		to food or bread, exclude	0	0	0	0	0	0	0	0	0
Cottage or ri	icotta c	heese (1/2 cup)	0	0	0	0	0	0	0	0	0
Cream chee	ese (1 o	z.)	0	0	0	0	0	0	0	0	0
		American, cheddar, etc., plain (1 slice or 1 oz. serving)	0	0	0	0	0	0	0	0	0
What type o	of chee	se do you usually eat? O Reg	ular O	Low fat or	lite (O Nonfat	O No	ne	,		

(GO TO NEXT PAGE)







VITAL STUDY DIET ASSESSMENT 2 R 4.5

EGGS,	N/I - N/I	r less than er month	1-3 per month	1 per week	2-4 per week	5-6 per week	1 per day	2-3 per day	4-5 per day	6+ per day
Eggs	Omega-3 fortified including yolk	0	0	0	0	0	0	0	0	0
	Regular eggs including yolk	0	0	0	0	0	0	0	0	0
roast, har	b or pork as a main dish, e.g., steak, n, or chops (4-6 oz.) or as a sandwich dish, e.g., stew, casserole, lasagna, etc.	0	0	0	0	0	0	0	0	0
sausage	ork hot dogs (1), bacon (2 slices), (2 oz. or 2 small links), salami, or other processed meats	0	0	0	0	0	0	0	0	0
	er (1 patty)	0	0	0	0	0	0	0	0	0
Chicken/t	urkey sandwich or frozen dinner	0	0	0	0	0	0	0	0	0
Other chi	cken or turkey, with or without skin (3 oz.)	0	0	0	0	0	0	0	0	0
Chicken o	or turkey hot dogs (1)	0	0	0	0	0	0	0	0	0
BEVER	RAGES Never, or once pe		1-3 per month	1 per week	2-4 per week	5-6 per week	1 per day	2-3 per day	4-5 per day	6+ per day
Beer, reg	ular (1 glass, bottle, can)	0	0	0	0	0	0	0	0	0
Light Bee	r, e.g., Bud Light (1 glass, bottle, can)	0	0	0	0	0	0	0	0	0
Red wine	(5 oz. glass)	0	0	0	0	0	0	0	0	0
White wir	e (5 oz. glass)	0	0	0	0	0	0	0	0	0
Liquor, e.	g., vodka, gin, etc. (1 drink or shot)	0	0	0	0	0	0	0	0	0
Tea with	caffeine (8 oz. cup), including green tea	0	0	0	0	0	0	0	0	0
Decaffein	ated coffee (8 oz. cup)	0	0	0	0	0	0	0	0	0
Coffee wi	th caffeine (8 oz. cup)	0	0	0	0	0	0	0	0	0
MISCE	LLANEOUS Never, or once pe	less than r month	1-3 per month	1 per week	2-4 per week	5-6 per week	1 per day	2-3 per day	4-5 per day	6+ per day
Cold brea	kfast cereal (1 cup) fortified calcium/vit D	0	0	0	0	0	0	0	0	0
Cold brea	kfast cereal (1 cup) not fortified	0	0	0	0	0	0	0	0	0
	utter (1 Tbs.)	0	0	0	0	0	0	0	0	0
	peanut butter fortified with omega-3?	7		O Don't						
Oil used f	or food prep - soybean or canola (1 Tbs.)	0	0	0	0	0	0	0	0	0
Oil used f	or food prep - NOT soy or canola (1 Tbs.)	0	0	0	0	0	0	0	0	0
Pizza (2 s	slices)	0	0	0	0	0	0	0	0	0
Salad dre	ssing	0	0	0	0	0	0	0	0	0
Тур	e of salad dressing O Nonfat O Lov	v-fat O	Olive oil	O Ot	her veget	able oil	,			
Peanuts (s	mall packet or 1 oz.)	0	0	0	0	0	0	0	0	0
Walnuts (1	oz.)	0	0	0	0	0	0	0	0	0
	(small packet or 1 oz.)	0			0	0	0	0	0	0







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	FRUITS AN	II) VECELIARIES	less than er month	1-3 per month	1 per week	2-4 per week	5-6 per week	1 per day	2-3 per day	4-5 per day	6+ per day
	Orange juice	Calcium / vitamin D fortified	0	0	0	0	0	0	0	0	0
	(small glass)	Regular (not calcium / vit D fortified)	0	0	0	0	0	0	0	0	0
	ls your orange	juice fortified with omega-3?	No O	Yes C) Don't l	now					
Other fruit juices (small glass), e.g., apple, grape, grapefruit juices (not fruit flavored drinks)			0	0	0	0	0	0	0	0	0
	Fruit, fresh, froz	zen or canned (not juices or dry fruits)	0	0	0	0	0	0	0	0	0
	Tomato, V-8 or	other vegetable juice (small glass)	0	0	0	0	0	0	0	0	0
	Tomato sauce	(1/2 cup), e.g., spaghettii sauce	0	0	0	0	0	0	0	0	0
	Salsa, picante d	or taco sauce (1/4 cup)	0	0	0	0	0	0	0	0	0
		ith or without other vegetables, y or lettuce salad, spinach salad	0	0	0	0	0	0	0	0	0
	Beans, baked o	or dried (1/2 cup) (not green beans)	0	0	0	0	0	0	0	0	0
Other vegetables, raw, cooked, frozen or canned, e.g., tomatoes, green beans, green peas, broccoli, cabbage, carrots, corn, kale, peppers, celery, sweet potatoes (not other kind of potatoes)		0	0	0	0	0	0	0	0	0	
	Tofu, soy burge	er, soybeans, miso, other soy protein	0	0	0	0	0	0	0	0	0
L						· · · · · · · · · · · · · · · · · · ·					

USE OF SUPPLEMENTS:

1. Do you currently take multi-vitamins?		O No SKIP to question #2 below.			
	C	Yes $ ightarrow$ Please ans	swer 1a. and 1b. belov	v .	
a. How many do you take per week? O 2 or fewer O 3-5 O 6-9 O 10 or more					
b. What specific brand (or equivalency) do you usually use? (Please specify exact Brand and Type).					
O Centrum Silver	O Centrum O Other				O
O Theragran M	O One-A-Day Essential Ex: AARP Alphabet II Formula 643 Multivitamin & Minerals				
2. Please mark the appropriate bubble for any other supplements (below) that you take on a regular basis:					
O Vitamin A / retinol	O Folic acid	O Coenzyme Q10	O Flax seed	O Evening primrose	O Melatonin
O Beta-carotene	O Niacin	O Chromium	O Flax seed oil	O Ginko biloba	O Metamucil
O B-complex	O Vitamin C	O Magnesium	O Choline	O Iron	O Lycopene
O Vitamin B12	O Vitamin E	O DHEA	O Lecithin	O Glucosamine/Chon	droitin
Please return this form in the postage pre-paid envelope. Thank you!					
OFFICE USE ONLY. PLEASE DO NOT WRITE BELOW THIS LINE.					