72 MONTH

1a. Are you CURRENTLY taking the WHITE PILLS? ☐ No ☐ Yes

Are you CURRENTLY taking the AMBER CAPS? ☐ No ☐ Yes

b. For EACH of the TWO study agents (white pill; amber capsule), please indicate below the percentage of pills you have TAKEN over the PAST YEAR.

	WHITE PILL	AMBER CAPS
Took 100%, or missed none	☐	☐
Took 93-99%, or missed only a few	☐	☐
Took 75-92%, or missed between 1-3 months	☐	☐
Took 67-74%, or missed between 3-4 months	☐	☐
Took 50-66%, or missed between 4-6 months	☐	☐
Took 33-49%, or missed between 6-8 months	☐	☐
Took less than 33%, or missed more than 8 months	☐	☐
Took none, or missed all	☐	☐

If you missed taking your pills, what was the main reason?

_____

2. IN THE PAST YEAR, were you NEWLY DIAGNOSED with any of the following? Please check NO or YES for EACH item. If YES, please provide the month and year of diagnosis and complete the consent form on the next page.

	NO	YES	Dx MO/YR	
a. Myocardial infarction (heart attack)	☐	☐	➡ _____	(a)
b. Angina pectoris	☐	☐	➡ _____	(b)
IF YES, confirmed by:	NO	YES		
angiogram/cardiac cath?	☐	☐		
stress test?	☐	☐		
c. Coronary angioplasty (PTCA)	☐	☐	➡ _____	(c)
IF YES, # of vessels: _____				
d. Coronary bypass surgery (CABG)	☐	☐	➡ _____	(d)
IF YES, # of vessels: _____				
e. Congestive heart failure	☐	☐	➡ _____	(e)
f. Ventricular tachycardia	☐	☐	➡ _____	(f)
g. Atrial fibrillation	☐	☐	➡ _____	(g)
h. Intermittent claudication	☐	☐	➡ _____	(h)
i. Pulmonary embolism (PE)	☐	☐	➡ _____	(i)
j. Deep vein thrombosis (DVT)	☐	☐	➡ _____	(j)
k. Stroke	☐	☐	➡ _____	(k)
l. TIA (transient ischemic attack)	☐	☐	➡ _____	(l)
m. Carotid artery surgery (endarterectomy)	☐	☐	➡ _____	(m)
n. Peripheral artery surgery (not varicose veins)	☐	☐	➡ _____	(n)
o. Asthma	☐	☐	➡ _____	(o)
p. Other chronic lung disease (e.g., emphysema, chronic bronchitis, bronchiectasis)	☐	☐	➡ _____	(p)

PLEASE GO TO THE TOP OF THE NEXT COLUMN

NEWLY DIAGNOSED IN PAST YEAR?	NO	YES	Dx MO/YR	
q. Elevated cholesterol (dx by clinician)	☐	☐	➡ _____	(q)
r. Hypertension (dx by clinician)	☐	☐	➡ _____	(r)
s. Melanoma	☐	☐	➡ _____	(s)
t. Non-melanoma skin cancer	☐	☐	➡ _____	(t)
IF YES, type: ☐ **basal cell** ☐ **squamous cell** ☐ **unknown**				
u. Breast cancer	☐	☐	➡ _____	(u)
v. Lung cancer	☐	☐	➡ _____	(v)
w. Colon cancer	☐	☐	➡ _____	(w)
x. Other cancer (non-skin)	☐	☐	➡ _____	(x)
IF YES, SPECIFY SITE: _____				
y. Colon polyp	☐	☐	➡ _____	(y)
z. Fibrocystic or other benign breast disease	☐	☐	➡ _____	(z)
IF YES, confirmed by:	NO	YES		
breast biopsy?	☐	☐		
aspiration?	☐	☐		
aa. Diabetes mellitus	☐	☐	➡ _____	(aa)
bb. Gout	☐	☐	➡ _____	(bb)
cc. Peptic ulcer	☐	☐	➡ _____	(cc)
dd. Gallstones	☐	☐	➡ _____	(dd)
IF YES, how diagnosed? ☐ **x-ray, ultrasound** ☐ **other**				
ee. Gallbladder removal	☐	☐	➡ _____	(ee)
ff. Active or chronic liver disease or cirrhosis	☐	☐	➡ _____	(ff)
gg. Kidney disease (NOT kidney stones)	☐	☐	➡ _____	(gg)
IF YES, specify type: _____				
hh. Chronic kidney failure	☐	☐	➡ _____	(hh)
ii. Migraine headaches	☐	☐	➡ _____	(ii)
jj. Bleeding hemorrhoids	☐	☐	➡ _____	(jj)
kk. Any other gastrointestinal bleeding	☐	☐	➡ _____	(kk)
ll. Coagulation disorder	☐	☐	➡ _____	(ll)
mm. Periodontal disease	☐	☐	➡ _____	(mm)
IF YES, # teeth lost: _____				
nn. Macular degeneration RIGHT eye	☐	☐	➡ _____	(nn)
oo. Macular degeneration LEFT eye	☐	☐	➡ _____	(oo)
pp. Cataract RIGHT eye	☐	☐	➡ _____	(pp)
qq. Cataract LEFT eye	☐	☐	➡ _____	(qq)
rr. Cataract extraction RIGHT eye	☐	☐	➡ _____	(rr)
ss. Cataract extraction LEFT eye	☐	☐	➡ _____	(ss)
tt. Other major illness	☐	☐	➡ _____	(tt)
IF YES, SPECIFY: _____				

IF "YES" IN QUESTION # 2, PLEASE COMPLETE THE CONSENT FORM ON PAGE 2.

CONSENT FORM **If you responded YES to any of the items in question # 2, please COMPLETE and SIGN the consent form below. The information we request will be used solely for medical statistical purposes and maintained in the strictest confidence.**

I hereby grant permission to Drs. Julie Buring and Charles H. Hennekens, Professors, Harvard Medical School, 900 Commonwealth Avenue East, Boston, MA 02215, to review a copy of the records of my hospitalization or treatment for:

DIAGNOSIS: _____ **DATES OF HOSPITALIZATION/TREATMENT:** _____

Name of hospital/physician: _____ **Phone # :** _____

Address of hospital/physician: _____

City: _____ **State:** _____ **Zip:** _____

YOUR FULL NAME AT TIME OF DIAGNOSIS: _____

YOUR SIGNATURE: _____
Signed Date

COPY VALID AS ORIGINAL

3. IN THE PAST YEAR, have you experienced any of the following? Please check NO or YES for EACH item.

	NO	YES
a. Symptoms suggestive of gastric upset	☐	☐
b. Symptoms suggestive of peptic ulcer	☐	☐
c. Nausea	☐	☐
d. Constipation	☐	☐
e. Diarrhea	☐	☐
f. Skin discoloration	☐	☐
g. Blood in urine (hematuria)	☐	☐

NEXT COLUMN

	NO	YES
h. Easy bruising	☐	☐
i. Nose bleed (epistaxis)	☐	☐
j. Skin rash	☐	☐
k. Fatigue	☐	☐
l. Drowsiness	☐	☐
m. Headache	☐	☐

4. DURING THE PAST MONTH, on approximately how many DAYS did you take any of the following? Do NOT include your study pills. Please respond for each item.

	DAYS IN THE PAST MONTH				
	0	1-3	4-10	11-20	21 +
a. Acetaminophen (e.g., Tylenol, Excedrin P.M.)	☐	☐	☐	☐	☐
b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin)	☐	☐	☐	☐	☐
c. Medications containing aspirin (e.g., Alka-Seltzer, Doan's Pills, Fiorinal)	☐	☐	☐	☐	☐
d. Nonsteroidal, anti-inflammatory agents (e.g., Motrin, Advil, Nuprin, Naprosyn, Feldene, Aleve)	☐	☐	☐	☐	☐
e. Multivitamins: Specify brand name: _____ Specify: Does multivitamin contain vitamin E? ☐ No ☐ Yes ➡ content _____ IU Contain vitamin A (including beta-carotene)? ☐ No ☐ Yes ➡ content _____ IU	☐	☐	☐	☐	☐
f. Individual supplements of vitamin C (not including multivitamins)	☐	☐	☐	☐	☐
g. Individual supplements of beta-carotene (not including multivitamins)	☐	☐	☐	☐	☐
h. Individual supplements of vitamin E (not including multivitamins)	☐	☐	☐	☐	☐
i. Individual supplements of vitamin A (not including multivitamins)	☐	☐	☐	☐	☐
j. Other vitamin preparations containing beta-carotene, vitamin E or vitamin A (not including multivitamins) Specify EXACT BRAND and TYPE: _____	☐	☐	☐	☐	☐

5. Do you CURRENTLY smoke cigarettes?
☐ No ☐ Yes ➡ IF YES: On average, how many cigarettes do you smoke EACH DAY?
☐ 1-4 cigs. ☐ 5-14 cigs. ☐ 15-24 cigs. ☐ 25-35 cigs. ☐ 36-44 cigs. ☐ 45 + cigs.

6. Have you EVER been diagnosed **by a physician** as having rheumatoid arthritis?
☐ No ☐ Yes ➡ IF YES: a. When were you diagnosed (month/year)? _____ / _____
b. Rheumatoid factor: ☐ negative / unknown ☐ positive

7. Have you EVER had shingles (Varicella-zoster virus)? ☐ No ☐ Yes ➡ IF YES: What YEAR were you initially diagnosed with shingles? _____

8. What is your CURRENT weight and height? Weight: _____ pounds AND Height: _____ ft. _____ in.

PLEASE CONTINUE ON BACK ⟹

9. Using the instructions found on the cover letter, please record the following measurements to the nearest quarter inch:

	inches	fraction		inches	fraction
WAIST:	_____	_____ /4	HIPS:	_____	_____ /4

10. During the PAST 6 YEARS (since the study began), what is the difference between your highest and lowest weight (excluding illness)?

☐ No change ☐ 2-4 lbs ☐ 5-9 lbs ☐ 10-14 lbs ☐ 15-29 lbs ☐ 30-49 lbs ☐ 50 + lbs

11. During the PAST 6 YEARS (since the study began), have you had unintentional weight loss (e.g., due to illness, unusual stress, depression)?

☐ No ☐ Yes ➡ IF YES: How many lbs.? ☐ 2-4 lbs ☐ 5-9 lbs ☐ 10-14 lbs ☐ 15-29 lbs ☐ 30-49 lbs ☐ 50 + lbs

12. During the PAST 6 YEARS (since the study began), what primary methods have you used to control your weight? PLEASE CHECK ALL THAT APPLY.

☐ None ☐ Diet pills/over-the-counter ☐ Crash diet/fasting
☐ Exercise ☐ Diet pills/prescription ☐ Cigarette smoking
☐ Calorie restriction ☐ Commercial diet program (e.g., Weight Watchers) ☐ Gastric surgery
☐ Low-fat diet ☐ Commercial diet supplement (e.g., Slim-Fast) ☐ Other

13. DURING THE PAST YEAR, what was your approximate average time per week spent at each of the following recreational activities?

	TIME PER WEEK							
	Zero	1-19 Min.	20-59 Min.	One Hr.	1½ Hr.	2-3 Hr.	4-6 Hr.	7 + Hr.
a. Walking for exercise (including walking to work, hiking, treadmill)	☐	☐	☐	☐	☐	☐	☐	☐
b. Jogging (slower than 10 minute miles)	☐	☐	☐	☐	☐	☐	☐	☐
c. Running (10 minute miles or faster)	☐	☐	☐	☐	☐	☐	☐	☐
d. Bicycling (include stationary machine)	☐	☐	☐	☐	☐	☐	☐	☐
e. Aerobic exercise/aerobic dance/exercise machines	☐	☐	☐	☐	☐	☐	☐	☐
f. Lower intensity exercise/yoga/stretching/toning	☐	☐	☐	☐	☐	☐	☐	☐
g. Tennis, squash, or racquetball	☐	☐	☐	☐	☐	☐	☐	☐
h. Lap swimming	☐	☐	☐	☐	☐	☐	☐	☐
i. Other: Please specify activity:	☐	☐	☐	☐	☐	☐	☐	☐

14.

THE INFORMATION BELOW IS IMPORTANT FOR VERIFICATION PURPOSES AND ASSISTS US IN MAINTAINING HIGH RATES OF FOLLOW-UP.

A. Please provide us with your phone number(s) so we may contact you if we are unable to reach you through the mail:

HOME: ( ) _____ WORK: ( ) _____

B. Please indicate the name, address and phone number of *SOMEONE AT A DIFFERENT PERMANENT ADDRESS* whom we might contact if we are unable to contact you. Please indicate if: ☐ friend ☐ neighbor ☐ relative

NAME: _____ PHONE NO.: ( ) _____

ADDRESS: _____ STATE/ZIP: _____

C. Your birthdate: ☐☐ ☐☐ ☐☐ AND ➡ D. LAST 6-digits of Social Security Number: XXX-☐☐-☐☐☐☐
MO DAY YR (OPTIONAL)

E. Your Maiden Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
(LAST NAME ONLY)

THANK YOU!

IF YOU HAVE ANY QUESTIONS, PLEASE CALL OUR TOLL-FREE NUMBER

1-800-633-6911