HARVARD MEDICAL SCHOOL

6 month (A)

PHYSICIANS' HEALTH STUDY

Please complete all 16 questions and return this form in the prepaid envelope provided

1. OVER THE PAST TWELVE MONTHS, how many of the approximately 180 white pills did you *NOT* take? (Please do not count as missed those pills you made up or extra pills missed in a short month.)
   - ☐ TOOK ALL THE WHITE PILLS
   - ☐ 1–9 not taken (5%)
   - ☐ 10–30 not taken (6–17%)
   - ☐ 31–90 not taken (18–50%)
   - ☐ 91–162 not taken (51–90%)
   - ☐ Took NONE or hardly any (91–100%)

   Reason for not taking white pills: _____

2. OVER THE PAST TWELVE MONTHS, how many of the approximately 180 red capsules did you *NOT* take? (Please do not count as missed those pills you made up or extra pills missed in a short month.)
   - ☐ TOOK ALL THE RED CAPSULES
   - ☐ 1–9 not taken (5%)
   - ☐ 10–30 not taken (6–17%)
   - ☐ 31–90 not taken (18–50%)
   - ☐ 91–162 not taken (51–90%)
   - ☐ Took NONE or hardly any (91–100%)

   Reason for not taking red capsules: _____

3. OVER THE **PAST MONTH,** *other than study pills,* on how many DAYS did you take additional aspirin, medication containing aspirin and/or other platelet active, nonsteroidal anti-inflammatory agents such as Advil, Clinoril, Feldene, Indocin, Motrin, Naprosyn, Nuprin, Persantine, etc.? ☐ 0 Days ☐ 1–6 Days ☐ 7–13 Days ☐ 14+ Days

4. OVER THE **PAST YEAR,** (including the past month) *other than study pills,* on how many DAYS did you take additional aspirin, medication containing aspirin and/or other platelet active, nonsteroidal anti-inflammatory agents such as Advil, Clinoril, Feldene, Indocin, Motrin, Naprosyn, Nuprin, Persantine, etc.?
   ☐ 0 Days ☐ 1–13 Days ☐ 14–30 Days ☐ 31–60 Days ☐ 61–90 Days ☐ 91–120 Days ☐ 121–180 Days ☐ 180+ Days

5. Are you currently taking *any* of the following drugs (fish oil, Coumadin or Heparin) which interfere with *blood clotting*?
   ☐ No ☐ Fish oil: Brand _____ ☐ Coumadin ☐ Heparin

6. Are you currently taking multiple vitamins regularly? ☐ Yes ☐ No
   IF YES: Number per week: ☐ 1–3 ☐ 4–7 ☐ 8–14 ☐ 15+

7. OVER THE PAST TWELVE MONTHS, *other than study capsules,* did you take additional BETA-CAROTENE or VITAMIN A (other than multivitamins)? ☐ Yes ☐ No
   IF YES: Which type? ☐ VITAMIN A ☐ BETA-CAROTENE Number per week: ☐ 1–3 ☐ 4–7 ☐ 8–14 ☐ 15+

8. *SINCE YOU FILLED OUT THE LAST QUESTIONNAIRE (ABOUT TWELVE MONTHS AGO),* have you been NEWLY DIAGNOSED as having any of the following conditions? (Please check YES or NO for *ALL items* and PROVIDE DATE FOR EACH DIAGNOSIS.)

	Yes	No	Date of DX Month/Year
Myocardial infarction	☐	☐	_____
Pulmonary embolism	☐	☐	_____
Deep vein thrombosis	☐	☐	_____
Stroke	☐	☐	_____
Diabetes	☐	☐	_____
Skin cancer:			
Melanoma	☐	☐	_____
Basal cell	☐	☐	_____
Squamous invasive	☐	☐	_____
Squamous in situ	☐	☐	_____
Other skin: _____	☐	☐	_____
Cancer (non-skin): Site _____	☐	☐	_____
Coronary bypass (CABG)	☐	☐	_____
Coronary angioplasty (PTCA)	☐	☐	_____
Angina Pectoris	☐	☐	_____
Transient cerebral ischemia (TIA)	☐	☐	_____
Peptic ulcer	☐	☐	_____
Liver disease	☐	☐	_____
Renal disease	☐	☐	_____
Arthritis	☐	☐	_____

	Yes	No	Date of DX Month/Year
Bleeding hemorrhoids	☐	☐	_____
Non-bleeding hemorrhoids	☐	☐	_____
Melena	☐	☐	_____
Hematemesis	☐	☐	_____
Other GI bleeding: Site _____	☐	☐	_____
Gallstones	☐	☐	_____
Gallbladder removal	☐	☐	_____
Varicose veins	☐	☐	_____
Appendix removal	☐	☐	_____
Glaucoma	☐	☐	_____
Bronchitis	☐	☐	_____
Gout	☐	☐	_____
Carotid artery surgery	☐	☐	_____
Intermittent claudication	☐	☐	_____
Other peripheral artery surgery Site _____	☐	☐	_____
Subconjunctival hemorrhage	☐	☐	_____
Osteoporosis	☐	☐	_____
Periodontal disease	☐	☐	_____
Tooth loss in past year	☐	☐	_____ # ___

Other conditions requiring medical treatment _____

IF YES to ANY items in #8: Please provide details on back— especially for diagnosis, progression of disease and treatment.

PLEASE CONTINUE ON REVERSE

9. Date of birth: _____/_____/19_____ (Necessary for verification)
   Month Day Year

10. SINCE YOU FILLED OUT THE LAST QUESTIONNAIRE (ABOUT TWELVE MONTHS AGO):

	Yes	No	Date Month/Year
Have you had a cataract diagnosed in your RIGHT eye?	☐	☐	Diagnosis _____
Have you had a cataract extraction in your RIGHT eye?	☐	☐	Surgery _____
Have you had a cataract diagnosed in your LEFT eye?	☐	☐	Diagnosis _____
Have you had a cataract extraction in your LEFT eye?	☐	☐	Surgery _____

11. If you have any of the conditions listed in question 8 or 10, please complete and sign the following consent form. 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:

    Diagnosis: _____

    Name of hospital/physician _____

    Address _____

    City _____ State _____ Zip _____

    Dates of hospitalization/treatment _____

    Signed _____ Date _____

12. SINCE YOU FILLED OUT THE LAST QUESTIONNAIRE (ABOUT TWELVE MONTHS AGO), have you experienced any of the following? (Please check YES or NO for *ALL items.)*

	Yes	No		Yes	No
Symptoms suggestive of gastritis	☐	☐	Hematuria	☐	☐
Symptoms suggestive of peptic ulcer	☐	☐	Easy bruising	☐	☐
Nausea	☐	☐	Epistaxis	☐	☐
Constipation	☐	☐	Other bleeding	☐	☐
Diarrhea	☐	☐	Headache	☐	☐
Skin discoloration	☐	☐	Migraine	☐	☐

    Other symptoms _____

    Note: An enteric-coated preparation of the white pill is available upon request.

13. Have you ever had a vasectomy? ☐ Yes ☐ No Date _____/19 _____
    Month Year

14. Have you *ever* smoked cigarettes regularly?
    ☐ No
    ☐ Yes: Please answer each of the following:
    Age started smoking _____
    When you smoke (or smoked), on average how many cigarettes per day do (did) you smoke?
    ☐ Less than pack/day ☐ 1 pack/day ☐ 1–2 packs/day ☐ 2+ packs/day
    Usual brand of cigarettes _____ Filter: ☐ Yes ☐ No
    Age stopped smoking _____
    OR if currently smoking, check here ☐

    We would appreciate the following OPTIONAL information which helps us to maintain high follow-up rates:

15. The name and address of someone who could give us your new address should you move:

    Name _____ Address _____

    City _____ State _____ Zip _____

16. Your current telephone numbers should we need to reach you:

    Telephone: Home ( ) _____ Office ( ) _____