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COSMOS 2

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

What is your sex? O Male O Female

First, a few questions about your health history:

1. **Have you ever been diagnosed with skin cancer?** O No O Yes

   IF YES, please specify type: O Melanoma O Other skin cancer (e.g., basal cell, squamous cell) O Not sure

   Was any skin cancer diagnosed within the past 2 years? O No O Yes

2. **OTHER THAN skin cancer, have you ever been diagnosed with another type of cancer (e.g. breast, lung, prostate, colon, or other type of cancer)?** O No O Yes

   IF YES, please specify type(s) other than skin cancer: ______________________________

   Was any cancer diagnosed within the past 2 years? O No O Yes

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3. **Have you ever had a heart attack or a stroke?** O No O Yes

4. **Have you ever had coronary bypass surgery (CABG) OR a coronary angioplasty (PTCA, when a balloon is used to open a blockage in an artery) OR a stent?** O No O Yes

The next several questions ask about your use of nutritional supplements. A supplement is a product, often in the form of a pill, which provides vitamins, minerals, or fatty acids.

5. **Do you regularly take a COCOA EXTRACT supplement (pills, capsules or powder)?** O No O Yes

   IF YES: Are you willing to stop taking these supplements in order to participate in this trial? (You will NOT have to restrict intake of chocolate, hot chocolate or mocha beverages.) O No O Yes

6. **Do you regularly take a MULTIVITAMIN supplement?** O No O Yes

   IF YES: Are you willing to stop taking a multivitamin supplement in order to participate in this trial? (You will be allowed to take up to 1,200 mg of calcium and /or up to 1,000 IU of vitamin D supplements.) O No O Yes

7. **NOT including your diet, how much TOTAL calcium do you take each day from nutritional supplements such as single tablets of calcium, multivitamins, or Os-Cal, Citracal, Calcium+D, VIACTIV, or Tums? Referring to package labels, please add up ALL your non-diet sources of calcium.**

   O None O 500 mg or less/day O 501-1,200 mg/day O 1,201-1,500 mg/day O Greater than 1,500 mg/day

8. **Are you willing to limit your TOTAL intake of calcium from nutritional supplements to 1,200 mg or less per day in order to participate in this trial?** O No O Yes

9. **NOT including your diet, how much TOTAL vitamin D do you take each day from nutritional supplements such as single tablets of vitamin D, multivitamins, 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 400 IU or less/day O 401-800 IU/day O 801-1,000 IU/day O greater than 1,000 IU/day

10. **Are you willing to limit your TOTAL intake of vitamin D from nutritional supplements to 1,000 IU or less per day in order to participate in this trial?** O No O Yes

11. **The cocoa extract contains a very small amount of caffeine (less than the amount in 1/5 cup of coffee). Do you have extreme sensitivity to caffeine that would prevent you from taking a cocoa extract supplement?**

    O No O Yes

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12. **How tall are you without your shoes on?** [ ] feet AND [ ][ ] inches

13. **How much do you weigh without your shoes on?** [ ][ ][ ] pounds

14. **In the PAST 2 YEARS, did you lose five (5) or more pounds at any time?** ○ No ○ Yes

IF YES, was this weight loss on purpose? ○ No ○ Yes

15. **Have you EVER had your blood glucose (fasting or non-fasting) or hemoglobin A1c measured?**

○ No ○ Yes

IF YES, how many years ago was your most recent blood glucose or hemoglobin A1c test?

○ Less than 1 year ago ○ 1-2 years ago ○ 3-5 years ago ○ More than 5 years ago ○ Don't know

16. **Have you EVER been diagnosed with diabetes? (Women only: other than diabetes when you were pregnant.)** ○ No ○ Yes

IF YES:

a. When were you diagnosed with diabetes?

○ Less than 1 year ago ○ 1-2 yrs. ago ○ 3-5 yrs. ago ○ 6-10 yrs. ago ○ More than 10 yrs. ago

b. Were you diagnosed with diabetes before age 30? ○ No ○ Yes

c. How is your diabetes currently being treated? (mark all that apply)

○ Diet ○ Exercise ○ Insulin injections ○ Non-insulin injections (Ex: Exenatide, Byetta, Bydureon, Victoza, Symlin)

○ Metformin/Glucophage ○ Other oral glucose-lowering pills ○ Don't know

17. **When was your last eye exam?**

○ Less than 1 year ago ○ 1-2 yrs. ago ○ 3-5 yrs. ago ○ More than 5 yrs. ago ○ Never had an eye exam

18. **Have you EVER had macular degeneration?** ○ No ○ Yes

19. **The following questions are about sleep, pain, and stress in the past 7 days.**

In the past 7 days...	**Not at all**	**A little bit**	**Somewhat**	**Quite a bit**	**Very much**
My sleep was refreshing.	○	○	○	○	○
I had a problem with my sleep.	○	○	○	○	○
I had difficulty falling asleep.	○	○	○	○	○
I feel fatigued.	○	○	○	○	○
I have trouble starting things because I am tired.	○	○	○	○	○
How much did pain interfere with your day to day activities?	○	○	○	○	○
How run-down did you feel on average?	○	○	○	○	○

In the past 7 days...	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
I felt fearful.	○	○	○	○	○
I found it hard to focus on anything other than my anxiety.	○	○	○	○	○
My worries overwhelmed me.	○	○	○	○	○
I felt uneasy.	○	○	○	○	○

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The following questions have to do with blood pressure:

20. Has a physician EVER told you that you have high blood pressure? ○ No ○ Yes ○ Don't know

21. Have you EVER taken prescription medication to control high blood pressure? ○ No ○ Yes ○ Don't know

IF YES: Are you currently taking any prescription medication(s) to control high blood pressure? ○ No ○ Yes

22. Are you CURRENTLY taking any of the following prescription medications?
Mark one answer for each row

	Taking for high blood pressure	Taking for other reasons, or not sure	Not currently taking this medication
a. Beta-blockers (Ex: atenolol, metoprolol)	○	○	○
b. Calcium channel blockers (Ex: amlodipine, diltiazem)	○	○	○
c. Diuretics (Ex: hydrochlorothiazide, furosemide)	○	○	○
d. ACE inhibitors (Ex: lisinopril, enalapril)	○	○	○
e. Angiotensin receptor blockers (Ex: losartan, irbesartan)	○	○	○
f. Aldosterone receptor blockers (Ex: spironolactone, eplerenone)	○	○	○
g. Alpha-blockers (Ex: terazosin, doxazosin)	○	○	○

23. How many years ago was your most recent blood pressure measurement?

○ Less than 1 year ago ○ 1-2 years ago ○ 3-5 years ago ○ More than 5 years ago ○ Don't know

24. Blood pressure is represented as two numbers, an UPPER NUMBER (systolic) and a LOWER NUMBER (diastolic). For example, a systolic blood pressure of 110 and diastolic blood pressure of 70 is written as 110/70.

Do you know your most recent blood pressure measurement? ○ No ○ Yes

IF YES: Please mark the bubbles below that best match your most recent blood pressure measurement. Mark only one bubble for UPPER and one bubble for LOWER.

UPPER BLOOD PRESSURE NUMBER (systolic):

○ less than 110 ○ 130-139 ○ 160-169
○ 110-119 ○ 140-149 ○ 170-179
○ 120-129 ○ 150-159 ○ 180 or higher

LOWER BLOOD PRESSURE NUMBER (diastolic):

○ less than 65 ○ 75-79 ○ 90-94
○ 65-69 ○ 80-84 ○ 95-99
○ 70-74 ○ 85-89 ○ 100 or higher

25. How many years ago was your most recent blood cholesterol test?

○ Less than 1 year ago ○ 1-2 years ago ○ 3-5 years ago ○ More than 5 years ago ○ Don't know

26. The level of total cholesterol in the blood is given as one number, usually 3-digits in length. Do you know your most recent total cholesterol level?

○ No ○ Yes →

IF YES: Please mark the bubble below that best matches your most recent total cholesterol level. Mark only one bubble.

○ less than 140 ○ 140-159 ○ 160-179 ○ 180-199 ○ 200-219 ○ 220-239
○ 240-259 ○ 260-279 ○ 280-299 ○ 300-319 ○ 320 or higher

27. In the PAST YEAR, have you been hospitalized for heart failure or congestive heart failure? ○ No ○ Yes

IF YES, how many times in the past year? ○ 1 ○ 2 ○ 3 or more

28. In the PAST YEAR, have you been treated in the emergency room (but not hospitalized) for heart failure or congestive heart failure? ○ No ○ Yes

IF YES, how many times in the past year? ○ 1 ○ 2 ○ 3 or more

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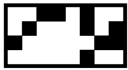
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29. As a participant in the COSMOS trial, you may have an opportunity to participate in other smaller studies, called sub-studies, that are related to the supplements that we are studying (cocoa extract and multivitamins).

Would you be willing to learn about additional sub-studies? (One example of a sub-study would be about memory.)

O No O Yes O Not sure

30. An additional valuable part of the COSMOS trial is to look at amounts of cocoa flavanols (found in cocoa extract), nutrients (found in a multivitamin), and other factors (biomarkers) in blood samples provided by participants. The blood samples for this trial would be drawn at a later date by a health care professional.

Would you be willing to have a blood sample drawn as part of the COSMOS trial? (You can still take part in the COSMOS trial if you prefer not to have a blood draw).

O No O Yes O Not sure

In the event that we need to reach you to clarify any of your responses, please provide your contact information here.

HOME PHONE ( ) -

CELL PHONE ( ) -

WORK PHONE ( ) -

What is your preferred method of contact?

O **Home phone** O **Cell phone**

O **Work phone** O **No difference**

O

→ **E-MAIL ADDRESS:** ____________________

Thank you!

Please check that you answered each question. Then, place your completed form *and* your signed consent (only the back page of the consent form) in the enclosed pre-paid envelope.

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