12368

Request

COSMOS 3

1. During the past month, on how many days did you miss taking any of your study pills?

O Missed 0 days (took all) O Missed 1-4 days O Missed 5-8 days

O Missed 9-15 days O Missed 16-29 days O Missed all (took none)

2. Are you willing to continue taking the study pills? O No O Yes

If you are not willing to continue, what is the reason or reasons? Mark all that apply.

O Too inconvenient O Poor health O Lost interest O Side effects

O Have difficulty taking pills O Study is too demanding O No reason O Other

The questions below are very important to COSMOS. We would appreciate it if you would answer these questions again.

Birth date: ☐☐ / ☐☐ / ☐☐
month day year

Sex: O Male O Female

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

IF YES, specify type:

O Melanoma O Other skin cancer (for example: basal cell, squamous cell) O Not sure

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

4. Other than skin cancer, have you ever been diagnosed with another type of cancer? (For example, breast, lung, colon, or other type of cancer.)

O No O Yes (Specify: _____)

IF YES, was any cancer diagnosed within the past 2 years? O No O Yes

5. Have you ever had a heart attack? O No O Yes

6. Have you ever had a stroke? O No O Yes

7. Not including your study pills, do you regularly take a COCOA EXTRACT supplement (pills, capsules, or powder)? O No O Yes

8. Not including your study pills, do you regularly take a MULTIVITAMIN supplement? (Examples: One-A-Day, Centrum, PreserVision, Ocuvite)

O No O Yes

9. Not including your study pills, 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. Not including your study pills, how much TOTAL calcium do you take each day from nutritional supplements such as single tablets of calcium, multivitamins, 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

OFFICE USE ONLY: O 1 O 2 O 3 O 4 O 5 O 6

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11. Since you started taking your study pills, have you experienced any of the following? Mark No or Yes on each line.

a. Stomach upset or pain	○ No	○ Yes
b. Nausea	○ No	○ Yes
c. Constipation	○ No	○ Yes
d. Diarrhea	○ No	○ Yes
e. Skin rash	○ No	○ Yes
f. Skin discoloration	○ No	○ Yes
g. Fatigue or drowsiness	○ No	○ Yes
h. Dizziness	○ No	○ Yes
IF YES: When you rise from bed?	○ No	○ Yes
When you rise from a chair?	○ No	○ Yes
i. Frequent nosebleeds	○ No	○ Yes
j. Easy bruising	○ No	○ Yes
k. Blood in urine	○ No	○ Yes
l. Gastro-intestinal bleeding	○ No	○ Yes
IF YES: Did you have a blood transfusion?	○ No	○ Yes
Were you hospitalized?	○ No	○ Yes
m. Migraine	○ No	○ Yes
n. Lightheadedness	○ No	○ Yes
IF YES: When you rise from bed?	○ No	○ Yes
When you rise from a chair?	○ No	○ Yes

12. In general, would you say your health is: ○ Excellent ○ Very good ○ Good ○ Fair ○ Poor

13. Have you ever had any of the following circulatory (heart-related) health conditions or related treatments? Mark No or Yes on each line.

a. Coronary bypass surgery	○ No	○ Yes
b. Coronary angioplasty or stent (balloon used to unblock an artery)	○ No	○ Yes
c. Hospitalization for angina (chest pain)	○ No	○ Yes
d. Transient ischemic attack (TIA, mini-stroke)	○ No	○ Yes
e. Hypertension (high blood pressure)	○ No	○ Yes
f. Irregular heart rhythm	○ No	○ Yes
g. Heart failure (congestive heart failure)	○ No	○ Yes
h. Abdominal aortic aneurysm (dilation of aortic artery)	○ No	○ Yes
i. Intermittent claudication (pain in the legs while walking due to blocked arteries)	○ No	○ Yes
j. Peripheral artery surgery/stenting (procedure to unblock arteries in legs)	○ No	○ Yes
k. Carotid stenosis (blocked arteries in neck)	○ No	○ Yes
l. Carotid artery surgery/stenting (procedure to unblock arteries in neck)	○ No	○ Yes
m. Deep vein thrombosis (blood clot in legs)	○ No	○ Yes
n. Pulmonary embolism (blood clot in lungs)	○ No	○ Yes

14. Have you ever had any of the following health conditions or procedures? Mark No or Yes on each line.

a. Diabetes (Do not include diabetes if only when pregnant.)	○ No	○ Yes
b. Kidney stones	○ No	○ Yes
c. Kidney failure or dialysis	○ No	○ Yes
d. Any thyroid condition	○ No	○ Yes
e. Peptic ulcer	○ No	○ Yes
f. Cirrhosis of the liver or other severe liver disease	○ No	○ Yes
g. Colon or rectal polyps	○ No	○ Yes
h. Parkinson's disease	○ No	○ Yes
i. Multiple sclerosis	○ No	○ Yes
j. Cataract	○ No	○ Yes
k. Cataract surgery (extraction)	○ No	○ Yes
l. Uterine fibroids (women only)	○ No	○ Yes

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15. Have you ever had fibrocystic or other benign breast disease? ○ No ○ Yes

IF YES: Confirmed by breast biopsy? ○ No ○ Yes ○ Not sure

Confirmed by needle aspiration? ○ No ○ Yes ○ Not sure

16. Have you ever had periodontal disease (gum disease)? ○ No ○ Yes

IF YES, how many teeth have you lost?

○ None ○ 1-2 ○ 3-4 ○ 5-8 ○ 9-15 ○ 16 or more

17. Are you currently taking any of the following medications regularly? Include both over-the-counter and prescription drugs. Mark No or Yes on each line.

a. Aspirin (Example: Bayer, Bufferin, Anacin, Excedrin) ○ No ○ Yes

IF YES, in the past month, on how many days did you take it?

○ 1-3 days ○ 4-10 days ○ 11-20 days ○ More than 20 days

b. NSAIDs (Nonsteroidal Anti-Inflammatory Drugs, [Example: Aleve, Advil]) ○ No ○ Yes

c. Anitplatelet medication (Example: Clopidogrel, Plavix, Effient, Brilinta, Zontivity) ○ No ○ Yes

d. Anti-coagulant drugs (Example: Warfarin, Coumadin, Heparin, Pradaxa, Xarelto, Savaysa, Eliquis) ○ No ○ Yes

e. Corticosteroids or prednisone ○ No ○ Yes

f. Statin drugs to lower cholesterol (Example: Lipitor, Zocor, Mevacor, Pravachol, Crestor) ○ No ○ Yes

g. Non-statin drugs to lower cholesterol (Example: Niacin, Lopid, Questran, Colestid, Zetia, Praluent, Repatha) ○ No ○ Yes

h. Thyroid hormones (Example: Synthroid, Levoxyl, Levothroid) ○ No ○ Yes

i. Tamoxifen (Example: Nolvadex) ○ No ○ Yes

j. Serotonin reuptake inhibitor (Example: Celexa, Lexapro, Cipralex, Esertia, Prozac, Zoloft, Zelmid) ○ No ○ Yes

k. Aromatase inhibitor (Example: Arimidex, Aromasin, Femara) ○ No ○ Yes

l. Calcitriol (Example: Rocaltrol, Calcijex, Vectical) or Paricalcitol (Example: Zemplar) ○ No ○ Yes

m. Proton pump inhibitors (Example: Prilosec, Nexium) ○ No ○ Yes

n. Erectile dysfunction medications (Example: Cialis, Levitra, Viagra) (Men only) ○ No ○ Yes

o. Testosterone (Example: Androgel,Testim, Depo-Testosterone) ○ No ○ Yes

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

○ Fosamax (alendronate)
○ Prolia (denosumab)
○ Boniva (ibandronate)
○ Evista (raloxifene)
○ Forteo (teriparatide injection)
○ Reclast (zoledronic acid)
○ Actonel (risedronate)
○ Miacalcin or Fortical (calcitonin-salmon)
○ Other medication not listed
○ None of these medicatons

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19. These questions are about reproductive history for females. (If male, please skip to question #20.)

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

b. Have you had a hysterectomy (removal of uterus or womb)? O No O Yes

c. Have your ovaries been surgically removed?
O No O Yes, both ovaries O Yes, one ovary or don't know

d. How old were you when you had your first menstrual period (menses)?
O 9 or less O 10 O 11 O 12 O 13 O 14 O 15 O 16 O 17 or older

e. How old were you when you last had regular menstrual bleeding (a period)?
(Your best guess.) (If you are still having regular bleeding or periods, enter your current age.)
O 44 or younger O 45-49 O 50-54 O 55 or older

f. How many pregnancies lasting 6 months or more have you had?
O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 or more

g. How old were you at the end of your first pregnancy lasting at least 6 months?
O No pregnancy lasting at least 6 months O Less than 20 O 20-24 O 25-29 O 30-34 O 35-39 O 40-44 O 45 or older

20. During the past year, what was your approximate average time per week spent at each of the following recreational activities? Mark one 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)	O	O	O	O	O	O	O	O
b. Jogging (slower than 10 minute miles)	O	O	O	O	O	O	O	O
c. Running (10 minute miles or faster)	O	O	O	O	O	O	O	O
d. Bicycling (include stationary bike)	O	O	O	O	O	O	O	O
e. Aerobic exercise/aerobic dance/exercise machines	O	O	O	O	O	O	O	O
f. Lower intensity exercise/yoga/stretching/toning	O	O	O	O	O	O	O	O
g. Tennis, squash, or racquetball	O	O	O	O	O	O	O	O
h. Lap swimming	O	O	O	O	O	O	O	O
i. Weight lifting/strength training	O	O	O	O	O	O	O	O
j. Other (Specify activity: _____)	O	O	O	O	O	O	O	O

21. On average, how many flights of stairs (one flight is typically 10 steps) do you climb daily?
O None O 1-2 flights O 3-4 flights O 5-9 flights O 10-14 flights O 15 or more flights

22. What is your usual walking pace outdoors?
O Don't walk regularly O Easy, casual (less than 2 mph) O Normal, average (2-2.9 mph)
O Brisk pace (3-3.9 mph) O Very brisk/striding (4 mph or faster)

23. During the past month, how would you rate your sleep quality overall?
O Very good O Fairly good O Fairly bad O Very bad

24. On average, over a 24-hour period, about how many hours do you sleep? Round to the nearest hour.
O Less than 5 hours O 5 hours O 6 hours O 7 hours O 8 hours O 9 hours O 10 hours or more

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25. 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? Mark all that apply.

O Hip O Spine O Lower arm O Upper arm

O Lower leg O Upper leg O Foot O Other bones O None

26. In the past year, has a doctor or other health care provider told you that you had broken a bone? O No O Yes IF YES, which bone? (Mark all that apply)

O Hip O Spine O Lower arm O Upper arm O Lower leg O Upper leg O Foot O Other bones

27. In the past year, have you had an unintentional fall (coming to rest on the ground, floor or lower surface)? O No O Yes

IF YES, please answer the following:

a. Number of falls in the past year: O 1 O 2 O 3 or more

b. How many of these falls caused an injury and limited your regular activity for at least a day or made you see a doctor? O None O 1 O 2 O 3 or more

c. Were you evaluated by a health care provider or admitted to the hospital following any of the injuries? O No O Yes

28. Did your mother or father ever have a heart attack? If Yes, please mark at what age:

Mother: O No O Yes O Don't know	→	At what age? O Before 65 O 65 or older O Don't know
Father: O No O Yes O Don't know	→	At what age? O Before 65 O 65 or older O Don't know

29. Did any of your blood relatives (father, brother, mother, or sister) ever have any of the diseases that are listed in the left column? A blood relative does not include relatives by marriage or adoption only. For each disease, please mark "None", or the specific relative who had the diagnosis (mark all that apply), or "Don't know".

	None	Father	Any brother	Mother	Any sister	Don't know
a. High blood pressure	O	O	O	O	O	O
b. High cholesterol	O	O	O	O	O	O
c. Stroke	O	O	O	O	O	O
d. Diabetes	O	O	O	O	O	O
e. Hip fracture	O	O	O	O	O	O
f. Lung cancer	O	O	O	O	O	O
g. Colon, rectal, bowel, or intestine cancer	O	O	O	O	O	O
h. Breast cancer (female only)	O	O	O	O	O	O
i. Prostate cancer (male only)	O	O	O	O	O	O

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30. How much of the time during the *past 4 weeks...*

	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
Have you been a very nervous person?	O	O	O	O	O	O
Have you felt so down in the dumps nothing could cheer you up?	O	O	O	O	O	O
Have you felt calm and peaceful?	O	O	O	O	O	O
Have you felt downhearted and blue?	O	O	O	O	O	O
Have you been a happy person?	O	O	O	O	O	O

31. Have you ever had a diagnosis of depression, or regularly taken medicine or had counseling for depression?

O No O Yes

IF YES: Have you taken an antidepressant or had counseling in the past 2 years?

O No O Yes

32. 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?

O No O Yes

33. Do you have a pet? O No O Yes

What kind of pet(s) do you have? Mark all that apply.

O Dog O Cat O Small mammal (rabbit, gerbil, hamster)
O Bird O Fish O Reptile O Other_____

Are you the primary caregiver for at least one pet? O No O Yes

If you have a dog, do you regularly take your dog for a walk? O No O Yes

The following questions (#34-42) refer to swelling, fatigue, or shortness of breath and how they affect your life. If you have none of these symptoms, mark "Never over the past 2 weeks".

34. Over the past 2 weeks, how many times did you have swelling in your feet, ankles or legs when you woke up in the morning?

O Every morning O 3 or more times a week but not every day O 1-2 times a week O Less than once a week O Never over the past 2 weeks

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35. Over the past 2 weeks, on average, how many times has fatigue limited your ability to do what you want?

○ Several times per day ○ At least once per day ○ 3 or more times a week but not every day ○ 1-2 times a week ○ Less than once a week ○ Never over the past 2 weeks

36. Over the past 2 weeks, on average, how many times has shortness of breath limited your ability to do what you wanted?

○ All of the time ○ Several times per day ○ At least once per day ○ 3 or more times a week but not every day ○ 1-2 times a week ○ Less than once a week ○ Never over the past 2 weeks

Over the past 2 weeks, how much did fatigue or shortness of breath limit your:	**Extremely limited**	**Quite a bit limited**	**Moderately limited**	**Slightly limited**	**Not at all limited**
37. Showering and bathing?	○	○	○	○	○
38. Dressing yourself?	○	○	○	○	○
39. Walking one block on level ground?	○	○	○	○	○
40. Doing yard work, housework, or carrying groceries?	○	○	○	○	○
41. Climbing a flight of stairs without stopping?	○	○	○	○	○
42. Hurrying (as if to catch a bus) or jogging?	○	○	○	○	○

43. We would like to know how good or bad your health is today. The scale below is numbered from 0 (the worst health you can imagine) to 10 (the best health you can imagine).

Mark one circle below to indicate how your health is today.

Worst ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 Best

The worst health you can imagine

The best health you can imagine

44. In the past 10 years, have you had any of the following?

a. Test for blood in your stool (Hemoccult, guaiac)	○ No	○ Yes →	Number of exams:	○ 1	○ 2	○ 3	○ 4	○ 5 or more
b. Rectal exam	○ 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	○ No	○ Yes →	Number of exams:	○ 1	○ 2	○ 3	○ 4	○ 5 or more
f. Mammogram (women only)	○ No	○ Yes →	Number of exams:	○ 1	○ 2	○ 3	○ 4	○ 5 or more
g. Breast biopsy (women only)	○ No	○ Yes →	Number of exams:	○ 1	○ 2	○ 3	○ 4	○ 5 or more
h. Pap smear (women only)	○ No	○ Yes →	Number of exams:	○ 1	○ 2	○ 3	○ 4	○ 5 or more
i. Dental x-ray	○ No	○ Yes →	Number of exams:	○ 1	○ 2	○ 3	○ 4	○ 5 or more
j. PSA test (men only)	○ No	○ Yes →	Number of exams:	○ 1	○ 2	○ 3	○ 4	○ 5 or more

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45. In your lifetime, have you smoked 100 cigarettes or more? ○ No ○ Yes

IF YES:

a. How many years have you been (were you) a regular smoker? Do not count the times you stayed off cigarettes.

○ Less than 5 years ○ 5-9 years ○ 10-19 years
○ 20-29 years ○ 30-39 years ○ 40 or more years

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

○ Less than 5 ○ 5-14 ○ 15-24 ○ 25-34 ○ 35-44 ○ 45 or more

c. Do you currently smoke? ○ No ○ Yes

d. If a current smoker, on average, how many cigarettes per day do you smoke? (1 pack = 20 cigs.)

○ Less than 5 ○ 5-14 ○ 15-24 ○ 25-34 ○ 35-44 ○ 45 or more ○ Not a current smoker

46. Have you ever been married? ○ No ○ Yes

47. Which of the following statements below best describes the job of you and your partner? If you or your partner are not working now, or your partner is deceased, mark the job held the longest. If you have never had a partner, leave "Your partner" line blank.

	Homemaker, raising children, care of others	Managerial, professional specialty	Technical, sales, and administrative support	Service	Operators, fabricators, and laborers	Other
You:	○	○	○	○	○	○(Specify:_____)
Your partner:	○	○	○	○	○	○(Specify:_____)

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

Your social security number (for identification purposes 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