20124 Request

COSMOS 18M

Below is the birthdate that we have on file for you. <u>If the birthday below is correct, please go to Question 1</u>.

month / day / year

If the birthday to the left is not correct, please provide the CORRECTED date of birth information below, then go to Question 1:

month / day / year

1. For each study pill, please describe how many you missed taking <u>during a typical month</u>:

a. Gray tablet: (per typical month)	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)
b. Orange capsules: (per typical month)	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)

c. If you missed taking your study pills more than 8 days in a typical month, what was the <u>main</u> reason?

O Traveling O Surgery O Other (Specify: _____)
O Difficulty taking pills O Illness

2. IN THE PAST 6 MONTHS, have you been NEWLY DIAGNOSED with any of the following? Please answer NO/YES on each line. IF YES, please provide the month / year of the diagnosis in the boxes provided.

		Month / Year of diagnosis:
a. Skin cancer IF YES, which type of skin cancer: O Melanoma O Squamous or basal cell O Not Sure	O No O Yes →	/
b. Cancer other than skin cancer (Specify Site: _____)	O No O Yes →	/
c. A recurrence of a previous cancer (cancer that came back) (Specify Site: _____)	O No O Yes →	/
d. Heart attack or myocardial infarction	O No O Yes →	/
e. Coronary artery bypass surgery	O No O Yes →	/
f. Coronary angioplasty or stent (balloon used to unblock an artery)	O No O Yes →	/
g. Stroke	O No O Yes →	/
h. Mini-stroke (TIA)	O No O Yes →	/
i. Heart failure (congestive heart failure) IF YES, were you hospitalized? O No O Yes	O No O Yes →	/

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

Over →

3. IN THE PAST 6 MONTHS, have you experienced any of the following? Please answer NO/YES for each item in both the left and right columns.

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

4. IN THE PAST 6 MONTHS, have you had an unintentional fall (coming to rest on the ground, floor, or lower surface)?

O No O Yes

IF YES, please answer each of the following questions:

a. Number of falls	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 0 falls 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 O No falls resulted in an injury

5. IN THE PAST 6 MONTHS, have you experienced any change in your hair, nails, skin or bowel movements? Please mark one answer on each line.

	Significantly increased	Slightly increased	NO CHANGE	Slightly decreased	Significantly decreased
a. Overall hair volume	O	O	O	O	O
b. Hair shine	O	O	O	O	O
c. Nail strength	O	O	O	O	O
d. Nail growth rate	O	O	O	O	O
e. Overall skin health	O	O	O	O	O
f. Skin smoothness	O	O	O	O	O
g. Frequency of bowel movements	O	O	O	O	O

6. Do you get a pain or discomfort in either leg or buttock when you walk?

○ No ○ Yes ○ I am unable to walk

If YES, please answer each of the following questions:

	Left Leg			Right Leg		
	No	Yes	Not sure	No	Yes	Not sure
a. Does this pain ever begin when you are standing still or sitting?	○	○	○	○	○	○
b. In what part of the leg or buttock do you feel it?						
Pain includes calf	○	○	○	○	○	○
Pain includes thigh	○	○	○	○	○	○
Pain includes buttock	○	○	○	○	○	○
c. Do you get the pain when you walk uphill or in a hurry?	○	○	○	○	○	○
d. Do you get the pain when you walk at an ordinary pace or on level ground?	○	○	○	○	○	○
e. Does the pain ever disappear while you are walking?	○	○	○	○	○	○
f. Do you have to stop or slow down if you get the pain while walking?	○	○	○	○	○	○
g. Does the pain lessen/stop if you stand still?	○	○	○	○	○	○
h. Does the pain lessen/stop in 10 minutes or less if you stand still?	○	○	○	○	○	○

7. IN THE PAST 6 MONTHS, have you noticed a change in your leg or buttock pain while walking?

○ Significantly decreased ○ Slightly decreased ○ No change

○ Slightly increased ○ Significantly increased ○ Never get pain while walking

○ Unable to walk

8. IN THE PAST 6 MONTHS, have you been NEWLY DIAGNOSED with any of the following?
Mark No or Yes on each line.
IF YES, please provide the month / year of the diagnosis in the boxes provided.

		Month / Year of diagnosis:
a. Atrial fibrillation	○ No ○ Yes	☐☐ / ☐☐
b. Macular degeneration	○ No ○ Yes	☐☐ / ☐☐
c. Glaucoma	○ No ○ Yes	☐☐ / ☐☐

COSMOS 18M

Below are the phone numbers that we have on file for you. If the numbers below are correct, no further information is required.

If the phone numbers to the left are not correct or have changed, please provide UPDATED phone numbers below.

HOME PHONE ( ) - → HOME PHONE ( ) -

CELL PHONE ( ) - → CELL PHONE ( ) -

WORK PHONE ( ) - → WORK PHONE ( ) -

What is your preferred contact: ○ **Home phone** ○ **Cell phone** ○ **Work phone** ○ **No difference**

- **Would you like to fill out questionnaires online?** ○ Yes ○ No
- **If you would like to receive information about the study by e-mail, please provide your e-mail address below.**
- **E-mail address:** _____

If you have any questions about the study, please call us at 1-800-633-6913 or email us at COSMOSTRIAL@PARTNERS.ORG.