7032

Request **COSMOS 1R**

**Your birth date:**

month / day / year

**Last 4 digits of your social security number:**
(for identification purposes ONLY)

XXX-XX -

**1. For each study pill, please describe how many you missed <u>during a typical month in the past year</u>.**

| | | | |
|---|---|---|---|
| a. Gray tablet: (in a typical month) | ○ Missed 0 days (took all) | ○ Missed 1-4 days | ○ Missed 5-8 days |
| | ○ Missed 9-15 days | ○ Missed 16-29 days | ○ Missed all (took none) |
| b. Orange capsules: (in a typical month) | ○ Missed 0 days (took all) | ○ Missed 1-4 days | ○ Missed 5-8 days |
| | ○ Missed 9-15 days | ○ Missed 16-29 days | ○ 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?

○ Difficulty taking pills ○ Illness ○ Surgery

○ Traveling ○ Other (Specify: _____)

***The following questions (#2-20) ask about your current use of supplements and recent health conditions:***

**2. NOT INCLUDING YOUR STUDY PILLS, do you currently take a COCOA EXTRACT supplement (pills, capsules, or powder)?**

○ No ○ Yes → Brand: _____

**3. NOT INCLUDING YOUR STUDY PILLS, do you currently take a MULTIVITAMIN supplement (Examples: One-A-Day, Centrum, PreserVision, Ocuvite)?**

○ No ○ Yes → Brand: _____

**4. NOT INCLUDING YOUR STUDY PILLS, how much TOTAL vitamin D do you currently take from nutritional supplements such as single pills 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.**

○ None ○ 400 IU or less/day ○ 401-800 IU/day

○ 801-1,000 IU/day ○ Greater than 1,000 IU/day

**5. NOT INCLUDING YOUR STUDY PILLS, how much TOTAL calcium do you currently take from nutritional supplements such as single pills 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.**

○ None ○ 500 mg or less/day ○ 501-1,200 mg/day

○ 1,201-1,500 mg/day ○ Greater than 1,500 mg/day

**6. IN THE PAST YEAR, 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<br>IF YES, which type: ○ Melanoma ○ Squamous or basal cell ○ Not sure | ○ No ○ Yes → | / |
| b. Cancer other than skin cancer<br>(Specify Site: _____) | ○ No ○ Yes → | / |
| c. A recurrence of a previous cancer (cancer that came back), invasive or in situ<br>(Specify Site: _____) | ○ No ○ Yes → | / |
| d. Heart attack or myocardial infarction | ○ No ○ Yes → | / |
| e. Hospitalization for angina (chest pain) | ○ No ○ Yes → | / |
| f. Stroke | ○ No ○ Yes → | / |
| g. Transient ischemic attack (TIA, mini-stroke) | ○ No ○ Yes → | / |
| h. Heart failure (congestive heart failure)<br>IF YES, were you hospitalized? ○ No ○ Yes | ○ No ○ Yes → | / |
| i. Atrial fibrillation | ○ No ○ Yes → | / |
| j. Irregular heart rhythm other than atrial fibrillation | ○ No ○ Yes → | / |
| k. Coronary bypass surgery | ○ No ○ Yes → | / |
| l. Coronary angioplasty or stent (balloon used to unblock an artery) | ○ No ○ Yes → | / |
| m. Carotid artery surgery/stenting (procedure to unblock arteries in neck) | ○ No ○ Yes → | / |
| n. Peripheral artery surgery/stenting (procedure to unblock arteries in legs) | ○ No ○ Yes → | / |
| o. Carotid stenosis (blocked arteries in neck) | ○ No ○ Yes → | / |
| p. Deep vein thrombosis (blood clot in legs) | ○ No ○ Yes → | / |
| q. Pulmonary embolism (blood clot in lungs) | ○ No ○ Yes → | / |
| r. Abdominal aortic aneurysm (dilation of aortic artery) | ○ No ○ Yes → | / |
| s. Hypertension (high blood pressure) | ○ No ○ Yes → | / |
| t. Diabetes | ○ No ○ Yes → | / |
| u. Kidney stones | ○ No ○ Yes → | / |
| v. Kidney failure or dialysis | ○ No ○ Yes → | / |
| w. Any thyroid condition<br>IF YES: ○ Under-active ○ Over-active ○ Other | ○ No ○ Yes → | / |
| x. Peptic ulcer | ○ No ○ Yes → | / |
| y. Cirrhosis of the liver or other severe liver disease | ○ No ○ Yes → | / |
| z. Colon or rectal polyps | ○ No ○ Yes → | / |



**continue question 6 on next page**

**6. IN THE PAST YEAR, have you been NEWLY DIAGNOSED with any of the following?**

| | | Month / Year of diagnosis: |
|---|---|---|
| aa. Parkinson's disease | ○ No ○ Yes → | / |
| bb. Macular degeneration | ○ No ○ Yes → | / |
| cc. Glaucoma | ○ No ○ Yes → | / |
| dd. Cataract | ○ No ○ Yes → | / |
| ee. Cataract surgery | ○ No ○ Yes → | / |
| ff. Retinal "pucker", tear, detachment, or any retinal surgery | ○ No ○ Yes → | / |
| gg. Celiac disease | ○ No ○ Yes → | / |
| hh. Periodontal disease (gum disease) | ○ No ○ Yes → | / |
| ii. Uterine fibroids (women only) | ○ No ○ Yes → | / |

**7. IN THE PAST YEAR, have you experienced any of the following?**
**Please answer NO/YES on each item in both the left and right columns.**

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

**8. IN THE PAST YEAR, have you had an unintentional fall (coming to rest on the ground, floor, or lower surface)?** ○ No ○ Yes

**IF YES, please answer each of the following questions:**

| | |
|---|---|
| a. Number of falls | ○ 1 ○ 2 ○ 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? | ○ 0 falls ○ 1 ○ 2 ○ 3 or more |
| c. Were you evaluated by a health care provider or admitted to the hospital following any of the injuries? | ○ No ○ Yes<br>○ No falls resulted in an injury |

**9. In the PAST YEAR, has a doctor or other health care provider told you that you had broken a bone?**

○ No
○ Yes →

**9.a Which bone?** Mark all that apply. ○ Hip ○ Forearm/shoulder ○ Spine ○ Other

**9.b Please provide the date (month/year) when the break occurred:** ☐☐ / ☐☐ (month / year)

**10. Are you CURRENTLY taking any of the following medications regularly?**
**Include both over-the-counter and prescription drugs. (Mark all that apply.)**

○ a. Aspirin (Examples: Bayer, Bufferin, Anacin, Excedrin)
IF YES, how many days did you take it in the past month? ○ 1-3 days ○ 4-10 days ○ 11-20 days ○ more than 20 days

○ b. Nonsteroidal anti-inflammatory drugs (NSAIDs) (Examples: ibuprofen, Aleve, Advil, Motrin, Naprosyn)

○ c. Antiplatelet medication (Examples: clopidogrel, Plavix, prasugrel, Effient, Brilinta, Zontivity, ticagrelor)

○ d. Anti-coagulant drugs
(Examples: warfarin, Coumadin, heparin, Pradaxa, dabigatran, Xarelto, rivaroxaban, Savaysa, Eliquis)

○ e. Corticosteroids or prednisone

○ f. Statin drugs to lower cholesterol (Examples: Lipitor, Zocor, Mevacor, Pravachol, Crestor)

○ g. Non-statin drugs to lower cholesterol (Examples: niacin, Lopid, Questran, Colestid, Zetia, Praluent, Repatha)

○ h. Thyroid hormones (Examples: Synthroid, Levoxyl, Levothroid, levothyroxine)

○ i. Aromatase inhibitors (Examples: Arimidex, Aromasin, Femara)

○ j. Calcitriol (Examples: Rocaltrol, Calcijex, Vectical ) or Paricalcitol (Example: Zemplar)

○ k. Proton pump inhibitors (PPIs) (Examples: omeprazole, Prilosec, Prevacid, Protonix, Nexium, Aciphex)

○ l. Estrogen, alone or with progestin (do NOT include vaginal estrogen)

○ m. Erectile dysfunction medications (Examples: Cialis, Levitra, Viagra) (men only)

○ n. Testosterone (Examples: Androgel, Testim, Depo-Testosterone)

○ o. Tamoxifen (Examples: Nolvadex, Soltamox)

○ p. Serotonin reuptake inhibitors (SRIs)
(Examples: Celexa, Lexapro, Cipralex, Esertia, Prozac, Zoloft, Zelmid)

**10. Are you CURRENTLY taking any of the following medications regularly? Include both over-the-counter and prescription drugs.**

q. Drugs for bone loss (Mark all that apply)

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

r. Diabetes medications (Mark all that apply)

- ○ Insulin injections
- ○ Non-insulin injections (Examples: exenatide, Byetta,Trulicity)
- ○ Glucophage (metformin)
- ○ Jardiance
- ○ Victoza
- ○ Other oral drugs (Examples: Avandia, Glucotrol, Prandin, Januvia, Starlix, Actos)
- ○ None of these medications

**11. Are you CURRENTLY taking any medications for high blood pressure?**

○ No ○ Yes

**12. Please indicate if you are CURRENTLY taking any of the medications listed below, and the reason for use.**

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

**13. Do you currently smoke cigarettes?**

○ No ○ Yes

**13.a If a current smoker, on average, how many cigarettes <u>per day</u> 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

**14. 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 | Some-what | Quite a bit | Very much |
|---|---|---|---|---|---|
| a. My sleep was refreshing. | ○ | ○ | ○ | ○ | ○ |
| b. I had a problem with my sleep. | ○ | ○ | ○ | ○ | ○ |
| c. I had difficulty falling asleep. | ○ | ○ | ○ | ○ | ○ |
| d. I feel fatigued. | ○ | ○ | ○ | ○ | ○ |
| e. I have trouble starting things because I am tired. | ○ | ○ | ○ | ○ | ○ |
| f. How much did pain interfere with your day-to-day activities? | ○ | ○ | ○ | ○ | ○ |
| g. How run-down did you feel on average? | ○ | ○ | ○ | ○ | ○ |

**15. DURING THE PAST MONTH, how would you rate your sleep quality overall?**

○ Very good ○ Fairly good ○ Fairly bad ○ Very bad

**16. On average, over a 24-hour period, about how many hours do you sleep? Round to the nearest hour.**

○ Less than 5 hours ○ 5 hours ○ 6 hours ○ 7 hours

○ 8 hours ○ 9 hours ○ 10 hours or more

**17. In the PAST YEAR, do you think your memory has become better or worse?**

○ Better ○ Worse ○ No change in the past year

| **18. 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 |
|---|---|---|---|---|---|---|
| a. Have you been a very nervous person? | ○ | ○ | ○ | ○ | ○ | ○ |
| b. Have you felt so down in the dumps nothing could cheer you up? | ○ | ○ | ○ | ○ | ○ | ○ |
| c. Have you felt calm and peaceful? | ○ | ○ | ○ | ○ | ○ | ○ |
| d. Have you felt downhearted and blue? | ○ | ○ | ○ | ○ | ○ | ○ |
| e. Have you been a happy person? | ○ | ○ | ○ | ○ | ○ | ○ |

**19. IN THE PAST YEAR, have you had a diagnosis of depression?**

○ No ○ Yes

**19.a IF YES, have you regularly taken medicine or had counseling for depression?**

○ No ○ Yes

**20. IN THE PAST YEAR, 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?**

○ No ○ Yes

***The following questions (#21-24) 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".***

**21. Over the past 2 weeks, how many times did you have <u>swelling</u> in your feet, ankles or legs when you woke up in the morning?**

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

**22. Over the past 2 weeks, on average, how many times has <u>fatigue</u> limited your ability to do what you wanted?**

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

**23. Over the past 2 weeks, on average, how many times has <u>shortness of breath</u> 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 per week but not every day ○ 1-2 times per week ○ Less than once per week ○ Never over the past 2 weeks

**24. 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 |
|---|---|---|---|---|---|
| a. Showering and bathing? | ○ | ○ | ○ | ○ | ○ |
| b. Dressing yourself? | ○ | ○ | ○ | ○ | ○ |
| c. Walking one block on level ground? | ○ | ○ | ○ | ○ | ○ |
| d. Doing yard work, housework, or carrying groceries? | ○ | ○ | ○ | ○ | ○ |
| e. Climbing a flight of stairs without stopping? | ○ | ○ | ○ | ○ | ○ |
| f. Hurrying (as if to catch a bus) or jogging? | ○ | ○ | ○ | ○ | ○ |

**25. 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

**26. 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 <u>most recent</u> blood pressure?** ○ 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.**

**<u>a. UPPER BLOOD PRESSURE NUMBER (systolic):</u>**

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

**<u>b. LOWER BLOOD PRESSURE NUMBER (diastolic):</u>**

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

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

○ No ○ Yes

**27.a IF YES, how many years ago was your most recent blood glucose or hemoglobin A1c measurement?**

○ Less than 1 year ago ○ 1-2 years ago ○ 3-5 years ago ○ More than 5 years ago
○ Never had these measurements ○ Don't know

**28. How much do you currently weigh without your shoes on?** ☐☐☐ pounds

**29. 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** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

■ **Please provide your phone numbers and/or email in the event that we need to contact you. Thanks!**

HOME PHONE ( ☐☐☐ ) ☐☐☐ - ☐☐☐☐

CELL PHONE ( ☐☐☐ ) ☐☐☐ - ☐☐☐☐

WORK PHONE ( ☐☐☐ ) ☐☐☐ - ☐☐☐☐

■ **E-mail address:** _____

**What is your preferred contact?** ○ **Home phone** ○ **Cell phone** ○ **Work phone** ○ **Email** ○ **Any of the above**