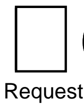

# COSMOS 2R

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Request

**Please use ball-point pen to complete the form.**

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

__ __ / __ __ / __ __
month / day / year

If the birthday to the left is incorrect, 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 **during a typical month in the past year**.

| | | | |
|---|---|---|---|
| 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 main reason?

○ Difficulty taking pills ○ Illness ○ Surgery

○ Traveling ○ Other - Specify: ____________________

**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

OFFICE USE ONLY: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5



**Over** →

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# COSMOS 2R

**Please use ball-point pen to complete the form.**

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.

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



**continue question 6 on next page**

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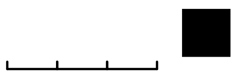
# COSMOS 2R



**Please use ball-point pen to complete the form.**

**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. Periodontal disease (gum disease) | ○ No | ○ Yes → | __ __ / __ __ |
| hh. Intermittent claudication (pain in legs while walking due to blocked arteries) | ○ 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 |
| 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. Flu-like symptoms | ○ No | ○ Yes |
| i. Dizziness | ○ No | ○ Yes |
| **IF YES**: When you rise from bed? | ○ No | ○ Yes |
| When you rise from a chair? | ○ No | ○ Yes |

| | | |
|---|---|---|
| j. Frequent nosebleeds | ○ No | ○ Yes |
| k. Easy bruising | ○ No | ○ Yes |
| l. Blood in urine | ○ No | ○ Yes |
| m. Gastro-intestinal bleeding | ○ No | ○ Yes |
| **IF YES**: Did you have a blood transfusion? | ○ No | ○ Yes |
| Were you hospitalized? | ○ No | ○ Yes |
| n. Migraine | ○ No | ○ Yes |
| o. Other headaches | ○ No | ○ Yes |
| p. Lightheadedness | ○ No | ○ Yes |
| **IF YES**: When you rise from bed? | ○ 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 |



Over →

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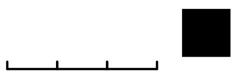
# COSMOS 2R



**Please use ball-point pen to complete the form.**

**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(s)? Mark all that apply.
○ Hip ○ Upper leg (other than hip) ○ Forearm/wrist
○ Pelvis ○ Upper arm/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.

a. Aspirin — ○ No ○ Yes
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) — ○ No ○ Yes
Examples: ibuprofen, Aleve, Advil, Motrin, Naprosyn

c. Antiplatelet medication — ○ No ○ Yes
Examples: clopidogrel, Plavix, prasugrel, Effient, Brilinta, Zontivity, ticagrelor

d. Anti-coagulant drugs — ○ No ○ Yes
Examples: warfarin, Coumadin, heparin, Pradaxa, dabigatran, Xarelto, rivaroxaban, Savaysa, Eliquis

e. Corticosteroids or prednisone — ○ No ○ Yes

f. Statin drugs to lower cholesterol — ○ No ○ Yes
Examples: Lipitor, Zocor, Mevacor, Pravachol, Crestor

g. Non-statin drugs to lower cholesterol — ○ No ○ Yes
Examples: niacin, Lopid, Questran, Colestid, Zetia, Praluent, Repatha

h. Thyroid hormones — ○ No ○ Yes
Examples: Synthroid, Levoxyl, Levothroid, levothyroxine

i. Aromatase inhibitors — ○ No ○ Yes
Examples: Arimidex, Aromasin, Femara

j. Calcitriol — ○ No ○ Yes
Examples: Rocaltrol, Calcijex, Vectical or Paricalcitol (Zemplar)

k. Proton pump inhibitors (PPIs) — ○ No ○ Yes
Examples: omeprazole, Prilosec, Prevacid, Protonix, Nexium, Aciphex

l. Estrogen, alone or with progestin (do NOT include vaginal estrogen) — ○ No ○ Yes

m. Erectile dysfunction medications (men only) — ○ No ○ Yes
Examples: Cialis, Levitra, Viagra

n. Testosterone — ○ No ○ Yes
Examples: Androgel, Testim, Depo-Testosterone

o. Tamoxifen — ○ No ○ Yes
Examples: Nolvadex, Soltamox

p. Serotonin reuptake inhibitors (SRIs) — ○ No ○ Yes
Examples: Celexa, Lexapro, Cipralex, Esertia, Prozac, Zoloft, Zelmid

q. Gonadotropin-releasing hormone (GnRH) agonist — ○ No ○ Yes
Examples: Lupron (Leuprolide)

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# COSMOS 2R

**Please use ball-point pen to complete the form.**

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

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

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

b. Diabetes medications (Mark all that apply)

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

**12.** In the **PAST YEAR**, have you had your blood sugar levels (glucose) (fasting or non-fasting) or hemoglobin A1c measured?

○ No ○ Yes

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

○ No ○ Yes

**14.** 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, chlorthalidone, 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) | ○ | ○ | ○ |



**Over** ⟶

# COSMOS 2R

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**Please use ball-point pen to complete the form.**

**15.** Have you **EVER** been diagnosed with one of the following conditions by a doctor?
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. Celiac disease | ○ No | ○ Yes | ☐☐ / ☐☐ |
| b. Crohn's disease | ○ No | ○ Yes | ☐☐ / ☐☐ |
| c. Ulcerative colitis | ○ No | ○ Yes | ☐☐ / ☐☐ |

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

○ No ○ Yes

**16.a** 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

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

○ Better ○ Worse ○ No change in the past year

**18. This question applies to WOMEN who have given birth. If this does not apply to you, please skip to question 19.**

Did you ever breastfeed your child/children?

○ No ○ Yes → **IF YES**, please answer each of the following questions:

**18.a** How many months **in total** (all births combined) did you breastfeed?

○ Less than 1 month ○ 7-11 months ○ 24-35 months

○ 1-3 months ○ 12-17 months ○ 36 months or more

○ 4-6 months ○ 18-23 months ○ Cannot remember

**18.b** What was your age (in years) when you **FIRST** breastfed?

○ Less than 20 ○ 20-24 yrs old ○ 25-29 yrs old ○ 30-34 yrs old ○ 35-39 yrs old ○ 40 or older

**19.** 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) | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| b. Jogging (slower than 10 minute miles) | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| c. Running (10 minute miles or faster) | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| d. Bicycling (include stationary bike) | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| e. Aerobic exercise/aerobic dance/exercise machines | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| f. Lower intensity exercise/yoga/stretching/toning | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| g. Tennis, squash, or racquetball | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| h. Lap swimming | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| i. Weight lifting/strength training | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| j. Other (Specify activity:________________________) | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

**20.** On average, how many flights of stairs (one flight is typically 10 steps) do you climb daily?

○ None ○ 1-2 flights ○ 3-4 flights ○ 5-9 flights ○ 10-14 flights ○ 15 or more flights

**21.** What is your usual walking pace outdoors?

○ Don't walk regularly ○ Easy, casual (less than 2 mph) ○ Normal, average (2-2.9 mph)
○ Brisk pace (3-3.9 mph) ○ Very brisk/striding (4 mph or faster)

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

○ No ○ Yes

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

○ No ○ Yes

**23. 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

**24.** 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?

○ 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

**25.** Over the past 2 weeks, on average, how many times has **fatigue** 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

**26.** 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 per week but not every day ○ 1-2 times per week ○ Less than once per week ○ Never over the past 2 weeks

**27.** 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? | ○ | ○ | ○ | ○ | ○ |



**Over** →

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# COSMOS 2R

**Please use ball-point pen to complete the form.**

**28.** 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

**29.** 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.**

**a. 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 |

**b. 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 |

**30.** How much do you currently weigh without your shoes on? [ | | ] pounds

**31.** 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).

Fill in one bubble below to indicate how your health is today.

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

- Last 4 digits of your social security number: (for identification purposes **ONLY**) XXX-XX - [ | | | ]
- Please provide your phone numbers and/or email in the event that we need to contact you. Thanks!

HOME PHONE ( ) -

CELL PHONE ( ) -

WORK PHONE ( ) -

- This is the email address that we have on file for you. **If the email is incorrect, please provide your correct email address below.**
- E-mail address: ______________________
- Corrected E-mail address: ______________________
- What is your preferred contact? ○ Home phone ○ Cell phone ○ Work phone ○ Email