17330

Request

COSMOS 30M

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. During a **typical month in the past year**, please describe how many days you missed each study pill.

a. Gray tablet in a **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 days (took none)
b. Orange capsules in a **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 days (took none)

c. In question 1a or 1b above, if you indicated missing 9 or more days in a typical month, what is the main reason?

O Difficulty taking pills O Frequent travel
O Chronic illness O Other: _____

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

O No O Yes → Brand: _____

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

O No O Yes → Brand: _____

4. 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: 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 →	/

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

Over →

4. 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:
e. Coronary 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 →	☐☐ / ☐☐
j. Atrial fibrillation	O No O Yes →	☐☐ / ☐☐
k. Macular degeneration	O No O Yes →	☐☐ / ☐☐
l. Glaucoma	O No O Yes →	☐☐ / ☐☐

5. IN THE PAST 6 MONTHS, 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	O No	O Yes
b. Nausea	O No	O Yes
c. Constipation	O No	O Yes
d. Diarrhea	O No	O Yes
e. Skin rash	O No	O Yes
f. Skin discoloration	O No	O Yes
g. Fatigue or drowsiness	O No	O Yes
h. Flu-like symptoms	O No	O Yes
i. Dizziness	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

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

6. 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

7. 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

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

O No O Yes O 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?	O	O	O	O	O	O
b. In what part of the leg or buttock do you feel it?						
Pain includes calf	O	O	O	O	O	O
Pain includes thigh	O	O	O	O	O	O
Pain includes buttock	O	O	O	O	O	O
c. Do you get the pain when you walk uphill or in a hurry?	O	O	O	O	O	O
d. Do you get the pain when you walk at an ordinary pace or on level ground?	O	O	O	O	O	O
e. Does the pain ever disappear while you are walking?	O	O	O	O	O	O
f. Do you have to stop or slow down if you get the pain while walking?	O	O	O	O	O	O
g. Does the pain lessen/stop if you stand still?	O	O	O	O	O	O
h. Does the pain lessen/stop in 10 minutes or less if you stand still?	O	O	O	O	O	O

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

- O Significantly decreased
- O Slightly decreased
- O No change
- O Slightly increased
- O Significantly increased
- O Never get pain while walking
- O Unable to walk

10. What is your **CURRENT** marital status?

- O Married
- O Widowed
- O Domestic Partnership
- O Separated
- O Divorced
- O Never married

11. Your **CURRENT** living arrangement: **Mark all that apply.**

- O Alone
- O With spouse or partner
- O With pet(s)
- O With other family
- O With other people

12. Do you **CURRENTLY** live in any of the following special residential settings? **Mark all that apply.**

- O Nursing home
- O Senior/retirement housing or community exclusively for people age 55+
- O Assisted living facility
- O None of these settings

13. What is your **CURRENT** work status? **Mark all that apply.**

- O Retired
- O Full-time paid
- O Part-time paid
- O Not employed
- O Full-time volunteer
- O Part-time volunteer
- O Unable to work/Disability

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 ( ) -

- 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? O Home phone O Cell phone O Work phone O Email