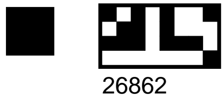

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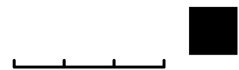
☐ Request

COSMOS 6M



Your birth date: ☐☐ / ☐☐ / ☐☐ (month / day / year)

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

XXX-XX - ☐☐☐☐

We most recently mailed you a supply of study pills on: ____________

USING THIS DATE AS YOUR STARTING POINT, please answer the following questions:

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

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 main reason?

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

The following questions (#2-12) 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)?

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. 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.

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

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.

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

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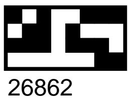
6. SINCE THE DATE OF STUDY PILL MAILING IN THE GRAY BOX ON PAGE 1, have you been NEWLY DIAGNOSED with any of the following? Please answer NO/YES on each line. IF YES, please provide the month / year of the diagnosis in the boxes provided.

		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 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)	O No O Yes →	☐☐ / ☐☐

7. SINCE THE DATE OF STUDY PILL MAILING IN THE GRAY BOX ON PAGE 1, 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. 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
i. Flu-like symptoms	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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8. SINCE THE DATE OF STUDY PILL MAILING IN THE GRAY BOX ON PAGE 1, 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

9. SINCE THE DATE OF STUDY PILL MAILING IN THE GRAY BOX ON PAGE 1, 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

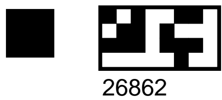
10. Do you get a pain or discomfort in either leg or buttock when you walk?

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

Over →



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11. SINCE THE DATE OF STUDY PILL MAILING IN THE GRAY BOX ON PAGE 1, 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

12. Have you <u>ever</u> been diagnosed with one of the following conditions by a doctor?
Mark No or Yes on each line.
IF YES, please provide the month / year of the diagnosis.

			Month / Year of diagnosis:
a. Atrial fibrillation	O No	O Yes	☐☐ / ☐☐
b. Macular degeneration	O No	O Yes	☐☐ / ☐☐
c. Glaucoma	O No	O Yes	☐☐ / ☐☐
d. Intermittent claudication (pain in legs while walking due to blocked arteries)	O No	O Yes	☐☐ / ☐☐

■ **Please provide your phone numbers in the event that we need to contact you to clarify any of your responses. Thanks.**

HOME PHONE (☐☐☐) ☐☐☐ - ☐☐☐☐

CELL PHONE (☐☐☐) ☐☐☐ - ☐☐☐☐

WORK PHONE (☐☐☐) ☐☐☐ - ☐☐☐☐

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

■ **Would you like to fill out questionnaires online?** O Yes O No

■ **If you would like to receive information about the study by e-mail, please provide your e-mail address below.**

■ **E-mail address:** ____________________