

Please use a 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.

| | | | | |
|----------------------|---|----------------------|---|----------------------|
| <input type="text"/> | / | <input type="text"/> | / | <input type="text"/> |
| 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:

| | | | | |
|----------------------|---|----------------------|---|----------------------|
| <input type="text"/> | / | <input type="text"/> | / | <input type="text"/> |
| month | | day | | year |

1. During a **typical month in 2020**, please describe how many days you missed each study pill.

| | | | |
|--|--|---|---|
| a. Gray tablet in a typical month : | <input type="radio"/> Missed 0 days (took all) | <input type="radio"/> Missed 1-4 days | <input type="radio"/> Missed 5-8 days |
| | <input type="radio"/> Missed 9-15 days | <input type="radio"/> Missed 16-29 days | <input type="radio"/> Missed all days (took none) |
| b. Orange capsules in a typical month : | <input type="radio"/> Missed 0 days (took all) | <input type="radio"/> Missed 1-4 days | <input type="radio"/> Missed 5-8 days |
| | <input type="radio"/> Missed 9-15 days | <input type="radio"/> Missed 16-29 days | <input type="radio"/> 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 was the <u>main reason</u> ? | | | |
| | <input type="radio"/> Difficulty taking pills | <input type="radio"/> Frequent travel | |
| | <input type="radio"/> Chronic illness | <input type="radio"/> Other: _____ | |

2. **NOT INCLUDING YOUR STUDY PILLS, IN DECEMBER 2020** how much **TOTAL** vitamin D did you 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
- 1,001-3,000 IU/day
- Greater than 3,000 IU/day

3. **NOT INCLUDING YOUR STUDY PILLS, IN DECEMBER 2020** how much **TOTAL** calcium did you 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

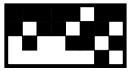
4. At the beginning of the trial, you were randomly assigned (like a flip of a coin) to either active or placebo for each study pill.

If you had to guess, for each, what do you think you were assigned to?

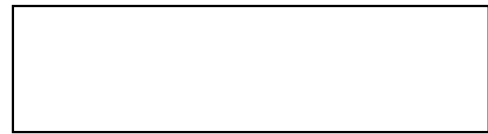
- a. Gray tablet (multivitamin agent): Active Placebo No idea
- b. Orange capsules (cocoa extract agent): Active Placebo No idea

5. Did you get a flu vaccination **AFTER AUGUST 2020**?

- No
- Yes
- Not Sure



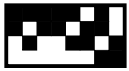
46669



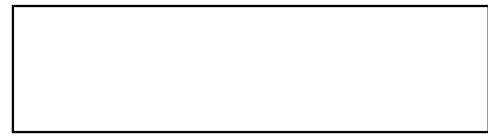
Please use a ball-point pen to complete the form.

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.Month / Year
of diagnosis:

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



46669



Please use a 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 | <input type="radio"/> No <input type="radio"/> Yes → | <input type="text"/> / <input type="text"/> |
| bb. Macular degeneration | <input type="radio"/> No <input type="radio"/> Yes → | <input type="text"/> / <input type="text"/> |
| cc. Glaucoma | <input type="radio"/> No <input type="radio"/> Yes → | <input type="text"/> / <input type="text"/> |
| dd. Cataract | <input type="radio"/> No <input type="radio"/> Yes → | <input type="text"/> / <input type="text"/> |
| ee. Cataract surgery | <input type="radio"/> No <input type="radio"/> Yes → | <input type="text"/> / <input type="text"/> |
| ff. Retinal "pucker", tear, detachment, or any retinal surgery | <input type="radio"/> No <input type="radio"/> Yes → | <input type="text"/> / <input type="text"/> |
| gg. Periodontal disease (gum disease) | <input type="radio"/> No <input type="radio"/> Yes → | <input type="text"/> / <input type="text"/> |
| IF YES , how many teeth have you lost? <input type="radio"/> None <input type="radio"/> 1-2 <input type="radio"/> 3-4 <input type="radio"/> 5-8 <input type="radio"/> 9-15 <input type="radio"/> 16 or more | | |
| hh. Intermittent claudication (pain in legs while walking due to blocked arteries) | <input type="radio"/> No <input type="radio"/> Yes → | <input type="text"/> / <input type="text"/> |
| ii. Uterine fibroids (women only) | <input type="radio"/> No <input type="radio"/> Yes → | <input type="text"/> / <input type="text"/> |

7. Has a doctor or another healthcare professional diagnosed you as having had or probably having had the coronavirus (COVID-19)?

 No Yes Not Sure**IF YES:** a. Please provide date (Month/Year) of diagnosis:

| | | |
|----------------------|---|----------------------|
| <input type="text"/> | / | <input type="text"/> |
| month | | year |

b. Was this confirmed by a COVID-19 test? No Yes

c. What kind of test(s) did you have? Mark all that apply.

- Nasal swab (testing for presence of the virus)
- Saliva test (testing for presence of the virus or for antibodies/immune response)
- Throat swab (testing for presence of the virus)
- Blood test (testing for antibodies, immune response)

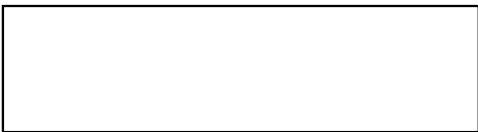
d. Which test(s) came back positive? Mark all that apply.

- None of the tests Throat swab
- Nasal swab Blood test
- Saliva test

e. Were you hospitalized? No Yesf. Did you require treatment in an Intensive Care Unit (ICU)? No Yes

8. When was your last eye exam?

 Less than 1 year ago 1-2 yrs. ago 3-5 yrs. ago More than 5 yrs. ago Never had an eye exam



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

9. IN THE PAST YEAR, have you experienced any of the following?

| | | |
|--|--------------------------|---------------------------|
| a. Stomach upset or pain | <input type="radio"/> No | <input type="radio"/> Yes |
| b. Nausea | <input type="radio"/> No | <input type="radio"/> Yes |
| c. Constipation | <input type="radio"/> No | <input type="radio"/> Yes |
| d. Diarrhea | <input type="radio"/> No | <input type="radio"/> Yes |
| e. Skin rash | <input type="radio"/> No | <input type="radio"/> Yes |
| f. Skin discoloration | <input type="radio"/> No | <input type="radio"/> Yes |
| g. Fatigue or drowsiness | <input type="radio"/> No | <input type="radio"/> Yes |
| h. Flu-like symptoms | <input type="radio"/> No | <input type="radio"/> Yes |
| i. Dizziness | <input type="radio"/> No | <input type="radio"/> Yes |
| IF YES: When you rise from bed? | <input type="radio"/> No | <input type="radio"/> Yes |
| When you rise from a chair? | <input type="radio"/> No | <input type="radio"/> Yes |

| | | |
|--|--------------------------|---------------------------|
| j. Frequent nosebleeds | <input type="radio"/> No | <input type="radio"/> Yes |
| k. Easy bruising | <input type="radio"/> No | <input type="radio"/> Yes |
| l. Blood in urine | <input type="radio"/> No | <input type="radio"/> Yes |
| m. Gastro-intestinal bleeding | <input type="radio"/> No | <input type="radio"/> Yes |
| IF YES: Did you have a blood transfusion? | <input type="radio"/> No | <input type="radio"/> Yes |
| Were you hospitalized? | <input type="radio"/> No | <input type="radio"/> Yes |
| n. Migraine | <input type="radio"/> No | <input type="radio"/> Yes |
| o. Other headaches | <input type="radio"/> No | <input type="radio"/> Yes |
| p. Lightheadedness | <input type="radio"/> No | <input type="radio"/> Yes |
| IF YES: When you rise from bed? | <input type="radio"/> No | <input type="radio"/> Yes |
| When you rise from a chair? | <input type="radio"/> No | <input type="radio"/> Yes |

10. Do you currently smoke cigarettes?

No Yes

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

11. 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:

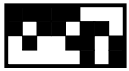
| | | | | | | |
|--|----------------------------|---------------------------|-------------------------|-------------------------|---------------------------------|---------------------------------|
| a. Number of falls | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 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? | <input type="radio"/> None | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 or more |
| c. Were you evaluated by a health care provider or admitted to the hospital following any of the injuries? | <input type="radio"/> No | <input type="radio"/> Yes | | | | |

12. IN THE PAST YEAR, has a doctor or other health care provider told you that you had broken a bone?

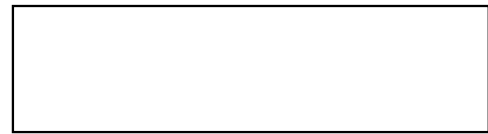
No

Yes →

| | | | | |
|--|---|---|-----------------------------|--|
| a. Which bone(s)? | <input type="radio"/> Knee | <input type="radio"/> Pelvis | <input type="radio"/> Hip | <input type="radio"/> Upper leg (other than hip or pelvis) |
| Mark all that apply. | <input type="radio"/> Forearm/wrist | <input type="radio"/> Upper arm/shoulder | <input type="radio"/> Spine | |
| | <input type="radio"/> Other: _____ | | | |
| b. Please provide the date (month/year) when the break occurred: | <input type="text"/> / <input type="text"/> | <input type="text"/> / <input type="text"/> | | |
| | month | year | | |



46669



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

13. 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)

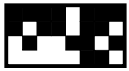
- | | | |
|--|---|---|
| <input type="radio"/> Fosamax (alendronate) | <input type="radio"/> Forteo (teriparatide injection) | <input type="radio"/> Evenity (romosozumab) |
| <input type="radio"/> Prolia (denosumab) | <input type="radio"/> Pamidronate | <input type="radio"/> Other medication not listed |
| <input type="radio"/> Boniva (ibandronate) | <input type="radio"/> Reclast or zometa (zoledronic acid) | <input type="radio"/> None of these medications |
| <input type="radio"/> Evista (raloxifene) | <input type="radio"/> Actonel (risedronate) | |
| <input type="radio"/> Tymlos (abaloparatide injection) | <input type="radio"/> Miacalcin or Fortical (calcitonin-salmon) | |

b. Diabetes medications (Mark all that apply)

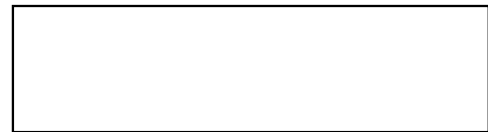
- | | |
|--|---|
| <input type="radio"/> Insulin injections | <input type="radio"/> Non-insulin injections (Examples: exenatide, Byetta, Trulicity, Victoza) |
| <input type="radio"/> Glucophage (metformin) | <input type="radio"/> Sulfonylurea (Examples: Glucotrol (glipizide), glimepiride, chlorpropamide) |
| <input type="radio"/> Jardiance | <input type="radio"/> Other oral drugs (Examples: Avandia, Prandin, Januvia, Starlix, Actos) |
| <input type="radio"/> Invokana | <input type="radio"/> None of these medications |

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

- | | |
|---|--|
| a. Aspirin (Examples: Bayer, Bufferin, Anacin, Excedrin) | <input type="radio"/> No <input type="radio"/> Yes |
| IF YES , how many days did you take it in the past month? | |
| <input type="radio"/> 1-3 days <input type="radio"/> 4-10 days <input type="radio"/> 11-20 days <input type="radio"/> more than 20 days | |
| b. Nonsteroidal anti-inflammatory drugs (NSAIDs) (Examples: ibuprofen, Advil, Motrin, Nuprin, naproxen, Naprosyn, Aleve) | <input type="radio"/> No <input type="radio"/> Yes |
| c. Antiplatelet medications (Examples: clopidogrel, Plavix, prasugrel, Effient, ticagrelor, Brilinta, Zontivity) | <input type="radio"/> No <input type="radio"/> Yes |
| d. Anti-coagulant drugs (Examples: warfarin, Coumadin, heparin, dabigatran, Pradaxa, rivaroxaban, Xarelto, Savaysa, Eliquis, Lovenox) | <input type="radio"/> No <input type="radio"/> Yes |
| e. Corticosteroids or prednisone | <input type="radio"/> No <input type="radio"/> Yes |
| f. Statin drugs to lower cholesterol (Examples: Lipitor, Zocor, Mevacor, Pravachol, Crestor) | <input type="radio"/> No <input type="radio"/> Yes |
| g. Non-statin drugs to lower cholesterol (Examples: niacin, Lopid, Questran, Colestid, Zetia, Praluent, Repatha) | <input type="radio"/> No <input type="radio"/> Yes |
| h. Thyroid hormones (Examples: levothyroxine, Synthroid, Levoxyl, Levothroid) | <input type="radio"/> No <input type="radio"/> Yes |
| i. Aromatase inhibitors (Examples: Arimidex, Aromasin, Femara) | <input type="radio"/> No <input type="radio"/> Yes |
| j. Calcitriol (Examples: Rocaltrol, Calcijex, Vectical or Paricalcitol, Zemplar) | <input type="radio"/> No <input type="radio"/> Yes |
| k. Estrogen, alone or with progestin (do NOT include vaginal estrogen) | <input type="radio"/> No <input type="radio"/> Yes |
| l. Tamoxifen (Examples: Nolvadex, Soltamox) | <input type="radio"/> No <input type="radio"/> Yes |



46669



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

15. Have you used any of the following devices for the purpose of health and activity tracking in the last year?

| Device | Ever used/worn in last year? | How often have you worn/used in last year? |
|--|--|---|
| a. Wearable activity or fitness tracker (e.g., Fitbit, Apple Watch, Garmin, Samsung, Oura ring) | <input type="radio"/> No <input type="radio"/> Yes → | <input type="radio"/> Some of the time <input type="radio"/> Most or all of the time |
| b. Home-based blood pressure monitor (Omron Evolv, ParaMed Digital Blood Pressure monitor) | <input type="radio"/> No <input type="radio"/> Yes → | <input type="radio"/> Some of the time <input type="radio"/> Most or all of the time |
| c. Continuous glucose monitor (e.g., Medtronic Guardian, Dexcom) | <input type="radio"/> No <input type="radio"/> Yes → | <input type="radio"/> Some of the time <input type="radio"/> Most or all of the time |

16. If you currently use a device listed above, would you be willing to share your data for a future study?

 No Yes

17. Would you be interested in receiving a device and wearing it as part of a future study?

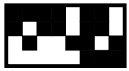
 No Yes18. Are you **CURRENTLY** taking any medications for high blood pressure? No Yes19. Please indicate if you are **CURRENTLY** taking any of the medications listed below, and the reason for use.

| | For high blood pressure | For other reasons or not sure | Not taking this |
|---|-------------------------|-------------------------------|-----------------------|
| a. Beta-blockers (Examples: atenolol, metoprolol) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| b. Calcium channel blockers (Examples: amlodipine, diltiazem) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| c. Thiazide diuretics (Examples: hydrochlorothiazide, chlorthalidone, Moduretic, Dyazide, indapamide) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| d. Loop diuretics (Examples: furosemide, Lasix, torsemide, Bumex, ethacrynic acid) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| e. ACE-inhibitors (Examples: lisinopril, enalapril) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| f. Angiotensin receptor blockers (Examples: valsartan, irbesartan, Entresto) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| g. Aldosterone receptor blockers (Examples: spironolactone, eplerenone) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| h. Alpha-blockers (Examples: terazosin, doxazosin) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

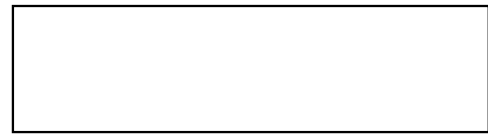
20. Blood pressure is represented as two numbers, an **UPPER NUMBER** (systolic) and a **LOWER NUMBER** (diastolic). For example, a systolic blood pressure of 110 and diastolic blood pressure of 70 is written as 110/70.Do you know your **most recent** blood pressure measurement? No Yes

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



46669

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

21. 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) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| b. Jogging (slower than 10 minute miles) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| c. Running (10 minute miles or faster) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| d. Bicycling (include stationary bike) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| e. Aerobic exercise/aerobic dance/exercise machines | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| f. Lower intensity exercise/yoga/stretching/toning | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| g. Tennis, squash, or racquetball | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| h. Lap swimming | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| i. Weight lifting/strength training | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| j. Other (Specify activity: _____) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

22. 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

23. What is your usual walking pace outdoors?

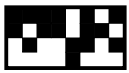
- Don't walk regularly Easy, casual (less than 2 mph) Normal, average (2-2.9 mph)
 Brisk pace (3-3.9 mph) Very brisk/striding (4 mph or faster)

24. How much help (if any) do you need to do the following routine activities for yourself? Help is defined as getting assistance from another person or using a device.

| | By myself without help | With some help | Unable to do this myself |
|---|------------------------|-----------------------|--------------------------|
| a. Can you take a bath or shower? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| b. Can you dress and undress yourself? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| c. Can you use the toilet by yourself? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| d. Can you get in and out of bed by yourself? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| e. Can you feed yourself? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

25. Fill in the circle for each question that best fits your **CURRENT** ability level compared to the **START OF THE TRIAL**.

| | Better | No change | Minimally worse | Noticeably worse | Much worse |
|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| a. Recalling information when I really try | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| b. Remembering names and faces of new people I meet | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| c. Remembering things that have happened recently | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| d. Recalling conversations a few days later | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |



46669

COSMOS JAN '21

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

26. In the **PAST YEAR**, has your memory changed?

No Yes

IF YES, which best describes the change? My memory is **BETTER**

My memory is **WORSE** but this does not worry me

My memory is **WORSE** and this worries me

27. In the **PAST YEAR**, have you had a diagnosis of depression?

No Yes

IF YES, have you regularly taken medicine or had counseling for depression?

No Yes

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

| | | |
|--|--|--|
| | | |
|--|--|--|

 pounds

29. In the **PAST YEAR**, did you lose five (5) or more pounds?

No Yes

IF YES, was this weight loss on purpose?

No Yes

30. 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 | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 | <input type="radio"/> 6 | <input type="radio"/> 7 | <input type="radio"/> 8 | <input type="radio"/> 9 | <input type="radio"/> 10 | Best |
|--------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|--------------------------|-------------|

31. The following information assists us in classifying our study population and is considered **OPTIONAL**. Which of these income ranges represents your **TOTAL** household income in the past year?

- Under \$15,000 \$15,000 to 29,999 \$30,000 to 49,999 \$50,000 to 69,999
- \$70,000 to 89,999 \$90,000 to 120,000 over \$120,000

■ 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.**

■ Email address: _____

■ Corrected Email address: _____

■ What is your preferred contact? Home phone Cell phone Work phone Email