17326

Request

COSMOS OBS 1

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.

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. Do you currently take a **COCOA EXTRACT** supplement (pills, capsules, or powder)?

○ No ○ Yes → Brand: _____

2. Do you currently take a **MULTIVITAMIN** supplement?

○ No ○ Yes → **IF YES**, please answer the following question:

What specific brand (any formulation) do you usually use?

○ One-A-Day ○ Ocuvite

○ PreserVision ○ Centrum/Centrum Silver ○ Other: → Brand: _____

3. 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

○ 1,001-2,000 IU/day ○ 2,001-3,000 IU/day ○ 3,001-4,000 IU/day ○ Greater than 4,000 IU/day

4. 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

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

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

OFFICE USE ONLY: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Over →

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: ○ Melanoma ○ Squamous or basal cell ○ Not sure	○ No ○ Yes →	/
b. Cancer other than skin cancer (Specify Site: _____)	○ No ○ Yes →	/
c. A recurrence of a previous cancer (cancer that came back), invasive or in situ (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) **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 artery 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 **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

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	○ 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 →	/
IF YES, how many teeth have you lost? ○ None ○ 1-2 ○ 3-4 ○ 5-8 ○ 9-15 ○ 16 or more		
hh. Intermittent claudication (pain in legs while walking due to blocked arteries)	○ No ○ Yes →	/
ii. Uterine fibroids (women only)	○ No ○ Yes →	/

7. Did you receive the influenza (flu) vaccination **AFTER AUGUST 2021**?

○ No ○ Yes

8. Have you **EVER** been diagnosed by a doctor or healthcare professional as having had or probably having had the coronavirus (COVID-19)?

○ No ○ Yes

IF YES: a. Please provide date (Month/Year) of diagnosis: / (month / year)

b. Have you **EVER** been hospitalized due to COVID-19? ○ No ○ Yes

IF YES: i. When were you hospitalized? (Month/Year) / (month / year)

ii. Did you require treatment in an Intensive Care Unit (ICU)? ○ No ○ Yes

9. Have you **EVER** been tested for the coronavirus (COVID-19, SARS-CoV-2) and/or its antibodies?

○ No ○ Yes

IF YES: a. Have you had at least one test with a **POSITIVE** result? ○ No ○ Yes

b. Please provide the date (Month/Year) of your **FIRST POSITIVE** test: / (month / year)

10. Have you received at least one dose of a COVID-19 vaccine?

○ No ○ Yes

IF YES: a. When did you **FIRST** get the vaccine? (Month/Year) / (month / year)

Date of **SECOND** dose, if applicable: / (month / year)

b. Which vaccine did you receive? ○ Moderna ○ Pfizer-BioNTech ○ Johnson & Johnson

c. Have you received a booster shot? ○ No ○ Yes

IF YES: Which booster did you receive? ○ Moderna ○ Pfizer-BioNTech ○ Johnson & Johnson

11. Since January 2020 (**PAST 2 YEARS**), have you experienced any of these symptoms that may occur with conditions such as allergies, colds and flu, COVID-19 or when taking certain medications?

		Duration of symptom				Is this symptom CURRENTLY present?
	Did not have this symptom	Less than 2 weeks	2 weeks to less than 8 weeks	8 weeks to less than 6 months	6 months or more	
a. Fever	○	○	○	○	○	○ Yes
b. Persistent cough	○	○	○	○	○	○ Yes
c. Chills or sweats	○	○	○	○	○	○ Yes
d. Headache	○	○	○	○	○	○ Yes
e. Sore throat	○	○	○	○	○	○ Yes
f. Hoarseness	○	○	○	○	○	○ Yes
g. Loss of smell or taste	○	○	○	○	○	○ Yes
h. Shortness of breath/ difficulty breathing	○	○	○	○	○	○ Yes
i. Chest pain/tightness	○	○	○	○	○	○ Yes
j. Muscle aches	○	○	○	○	○	○ Yes
k. Abdominal pain	○	○	○	○	○	○ Yes
l. Diarrhea	○	○	○	○	○	○ Yes
m. Confusion or “brain fog”	○	○	○	○	○	○ Yes
n. Malaise- a general feeling of illness, discomfort, uneasiness	○	○	○	○	○	○ Yes
o. Sleep disturbance	○	○	○	○	○	○ Yes
p. Unusual fatigue	○	○	○	○	○	○ Yes

12. 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

13. 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 ○ 4 ○ 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?	○ None ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 or more
c. Were you evaluated by a health care provider or admitted to the hospital following any of the injuries?	○ No ○ Yes

14. 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)? Mark all that apply. ○ Knee ○ Pelvis ○ Hip ○ Upper leg (other than hip or pelvis) ○ Forearm/wrist ○ Upper arm/shoulder ○ Spine

○ Other:_____

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

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

15. 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)

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

b. Diabetes medications (Mark all that apply)

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

16. 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) **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	○ No ○ Yes
b. Nonsteroidal anti-inflammatory drugs (NSAIDs) (Examples: ibuprofen, Advil, Motrin, Nuprin, naproxen, Naprosyn, Aleve)	○ No ○ Yes
c. Antiplatelet medications (Examples: clopidogrel, Plavix, prasugrel, Effient, ticagrelor, Brilinta, Zontivity)	○ No ○ Yes
d. Anti-coagulant drugs (Examples: warfarin, Coumadin, heparin, dabigatran, Pradaxa, rivaroxaban, Xarelto, Savaysa, Eliquis)	○ No ○ Yes
e. Corticosteroids or prednisone	○ No ○ Yes
f. Statin drugs to lower cholesterol (Examples: Lipitor, Zocor, Mevacor, Pravachol, Crestor)	○ No ○ Yes
g. Non-statin drugs to lower cholesterol (Examples: Nexletol, Lopid, Questran, Colestid, Zetia, Praluent, Repatha)	○ No ○ Yes
h. Thyroid medications (Examples: levothyroxine, Synthroid, Levoxyl, Levothroid)	○ No ○ Yes
i. Aromatase inhibitors (Examples: Arimidex, Aromasin, Femara)	○ No ○ Yes
j. Calcitriol (Examples: Rocaltrol, Calcijex, Vectical or Paricalcitol, Zemplar)	○ No ○ Yes
k. Estrogen, alone or with progestin (do NOT include vaginal estrogen)	○ No ○ Yes
l. Tamoxifen (Example: Nolvadex)	○ No ○ Yes
m. Lithium	○ No ○ Yes
n. Serotonin reuptake inhibitor (Examples: Celexa, Lexapro, Cipralex, Esertia, Prozac, Zoloft)	○ No ○ Yes

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

○ No ○ Yes

18. 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. Thiazide diuretics (Examples: hydrochlorothiazide, chlorthalidone, Moduretic, Dyazide, indapamide)	○	○	○
d. Loop diuretics (Examples: furosemide, Lasix, torsemide, Bumex, ethacrynic acid)	○	○	○
e. ACE-inhibitors (Examples: lisinopril, enalapril)	○	○	○
f. Angiotensin receptor blockers (Examples: valsartan, irbesartan, Entresto)	○	○	○
g. Aldosterone receptor blockers (Examples: spironolactone, eplerenone)	○	○	○
h. Alpha-blockers (Examples: terazosin, doxazosin)	○	○	○

19. 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

20. 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?	○	○	○	○	○

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

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

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

22. 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

23. 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?	○	○	○
b. Can you dress and undress yourself?	○	○	○
c. Can you use the toilet by yourself?	○	○	○
d. Can you get in and out of bed by yourself?	○	○	○
e. Can you feed yourself?	○	○	○

24. 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

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

	Better	No change	Minimally worse	Noticeably worse	Much worse
a. Recalling information when I really try	○	○	○	○	○
b. Remembering names and faces of new people I meet	○	○	○	○	○
c. Remembering things that have happened recently	○	○	○	○	○
d. Recalling conversations a few days later	○	○	○	○	○

26. IN THE PAST YEAR, 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	○	○	○	○	○
b. Hair shine	○	○	○	○	○
c. Nail strength	○	○	○	○	○
d. Nail growth rate	○	○	○	○	○
e. Overall skin health	○	○	○	○	○
f. Skin smoothness	○	○	○	○	○
g. Frequency of bowel movements	○	○	○	○	○

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. 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. Pneumonia **IF YES**, were you hospitalized? ○ No ○ Yes	○ No ○ Yes	☐☐ / ☐☐
b. Dry eye syndrome or dry eye disease	○ No ○ Yes	☐☐ / ☐☐
c. Multiple sclerosis	○ No ○ Yes	☐☐ / ☐☐

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

30. IN THE PAST YEAR, did you lose five (5) or more pounds?

○ No ○ Yes

IF YES, was this weight loss on purpose?

○ No ○ Yes

31. 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

32. 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**

■ 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