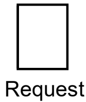


COSMOS OBS 3

23355 Request

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

Date of birth on file: ☐☐ / ☐☐ / ☐☐ (month / day / year) If this date of birth is incorrect, please call us at (800) 633-6913.

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 → 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

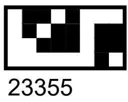
○ 1,001-2,000 IU/day ○ 2,001-3,000 IU/day ○ 3,001-4,000 IU/day ○ Greater than 4,000 IU/day

4. 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 diagnosis.

		Month / Year of diagnosis (MM/YY):
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. Coronary artery bypass surgery	○ No ○ Yes →	☐☐ / ☐☐
j. Coronary angioplasty or stent (balloon used to unblock an artery)	○ No ○ Yes →	☐☐ / ☐☐
k. Carotid artery surgery/stenting (procedure to unblock arteries in neck)	○ No ○ Yes →	☐☐ / ☐☐
l. Peripheral artery surgery/stenting (procedure to unblock arteries in legs)	○ No ○ Yes →	☐☐ / ☐☐

OFFICE USE ONLY: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Over →

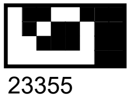

23355

COSMOS OBS 3

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

5. 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 diagnosis.

Condition	No / Yes	Month / Year of diagnosis (MM/YY):
a. Atrial fibrillation	O No O Yes →	__ __ / __ __
b. Irregular heart rhythm other than atrial fibrillation	O No O Yes →	__ __ / __ __
c. Deep vein thrombosis (blood clot in legs)	O No O Yes →	__ __ / __ __
d. Pulmonary embolism (blood clot in lungs)	O No O Yes →	__ __ / __ __
e. Hypertension (high blood pressure)	O No O Yes →	__ __ / __ __
f. Diabetes	O No O Yes →	__ __ / __ __
g. Kidney stones	O No O Yes →	__ __ / __ __
h. Kidney failure or dialysis	O No O Yes →	__ __ / __ __
i. Any thyroid condition **IF YES**: O Under-active O Over-active O Other	O No O Yes →	__ __ / __ __
j. Cirrhosis of the liver or other severe liver disease	O No O Yes →	__ __ / __ __
k. Parkinson's disease	O No O Yes →	__ __ / __ __
l. Macular degeneration	O No O Yes →	__ __ / __ __
m. Glaucoma	O No O Yes →	__ __ / __ __
n. Cataract	O No O Yes →	__ __ / __ __
o. Cataract surgery	O No O Yes →	__ __ / __ __
p. Retinal "pucker", tear, detachment, or any retinal surgery	O No O Yes →	__ __ / __ __
q. Periodontal disease (gum disease) **IF YES**, how many teeth have you lost? O None O 1-2 O 3-4 O 5-8 O 9-15 O 16 or more	O No O Yes →	__ __ / __ __
r. Intermittent claudication (pain in legs while walking due to blocked arteries)	O No O Yes →	__ __ / __ __
s. Depression **IF YES**, have you regularly taken medicine or had counseling for depression? O No O Yes	O No O Yes →	__ __ / __ __
t. Multiple sclerosis	O No O Yes →	__ __ / __ __
u. Coronavirus (COVID-19) **IF YES**, was this confirmed by a positive COVID-19 test? O No O Yes **IF YES**, were you hospitalized? O No O Yes → **IF YES**, did you require treatment in an Intensive Care Unit (ICU)? O No O Yes	O No O Yes →	__ __ / __ __ (hospitalized) __ __ / __ __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COSMOS OBS 3

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

6. IN THE PAST YEAR, have you received any of the following vaccines? Mark all that apply.

O COVID-19 O Influenza (flu) O Respiratory Syncytial Virus (RSV) O Shingles O Pneumonia

7. IN THE PAST YEAR, 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 O 4 O 5 or more
b. How many of these falls caused an injury and limited your regular activity for at least a day?	O None O 1 O 2 O 3 O 4 O 5 or more
c. Were you evaluated by a health care provider or admitted to the hospital following any of the injuries? **IF YES**, please provide the most recent date (month/year) you were evaluated: ☐☐ / ☐☐ (month / year)	O No O Yes

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

O No
O Yes →

a. Which bone(s)? Mark all that apply. O Knee O Pelvis O Hip O Upper leg (other than hip or pelvis) O Forearm/wrist O Upper arm/shoulder O Spine O Other:______________________________

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

9. Have you **EVER** been diagnosed with sleep apnea?

O No
O Yes →

a. When were you diagnosed? Month and year (MM/YY) of diagnosis: ☐☐ / ☐☐ (month / year)

b. Did you receive treatment? O No O Yes

IF YES, which treatment? O CPAP / pressure device O Other device or treatment

10. Have you **EVER** been diagnosed with fatty liver disease?

O No
O Yes →

a. Month and year (MM/YY) of diagnosis: ☐☐ / ☐☐ (month / year)

b. Confirmed by liver biopsy? O No O Yes

c. Confirmed by liver imaging? O No O Yes

IF YES, which type? O CT scan O Ultrasound O MRI

11. Have you **EVER** been diagnosed with chronic viral hepatitis?

O No O Yes → **IF YES:** Month and year (MM/YY) of diagnosis: ☐☐ / ☐☐ (month / year)

12. Are you **CURRENTLY** taking any of the following medications for diabetes regularly? **IF YES**, mark **ALL** that apply. Include both over-the-counter and prescription drugs.

O Insulin injections
O Glucophage (metformin)
O SGLT2 inhibitors (e.g. Jardiance, Farxiga, Invokana)
O Non-insulin injections (e.g. exenatide, Trulicity, Ozempic, Victoza, Adlyxin, Mounjaro)
O Combination pills (e.g. Invokamet, Xigduo, Synjardy, Glyxambi)
O Other oral drugs (e.g. Rybelsus, Avandia, Glucotrol, Prandin, Januvia, Starlix, Actos)
O None of these medications

Over →

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. Aspirin (e.g. Bayer, Bufferin, Anacin, Excedrin)	O No	O Yes
b. Nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g. ibuprofen, Advil, Motrin, Nuprin, naproxen, Naprosyn, Aleve)	O No	O Yes
c. Antiplatelet medications (e.g. clopidogrel, Plavix, prasugrel, Effient, ticagrelor, Brilinta)	O No	O Yes
d. Anti-coagulant drugs (e.g. warfarin, Coumadin, heparin, dabigatran, Pradaxa, rivaroxaban, Xarelto, Savaysa, Eliquis)	O No	O Yes
e. Corticosteroids or prednisone	O No	O Yes
f. Statin drugs to lower cholesterol (e.g. Lipitor, Zocor, Mevacor, Pravachol, Crestor)	O No	O Yes
g. Non-statin drug to lower cholesterol (e.g. Nexletol, Lopid, Questran, Colestid, Zetia, Praluent, Repatha)	O No	O Yes
h. Aromatase inhibitors (e.g. Arimidex, Aromasin, Femara)	O No	O Yes
i. Estrogen, alone or with progestin (do NOT include vaginal estrogen)	O No	O Yes
j. Lithium	O No	O Yes
k. Serotonin reuptake inhibitor (e.g. Celexa, Lexapro, Cipralex, Esertia, Prozac, Zoloft)	O No	O Yes
l. Medications for high blood pressure	O No	O Yes
m. Prescription weight loss medications (e.g. Wegovy, Mounjaro)	O No	O Yes
n. Bone loss or osteoporosis medications	O No	O Yes

IF YES, please mark the medication(s) you are taking:
O Fosamax (alendronate) O Prolia (denosumab) O Reclast or Zometa (zoledronic acid) O Other medication

14. 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.	O	O	O	O	O
b. I had a problem with my sleep.	O	O	O	O	O
c. I had difficulty falling asleep.	O	O	O	O	O
d. I feel fatigued.	O	O	O	O	O
e. I have trouble starting things because I am tired.	O	O	O	O	O
f. How much did pain interfere with your day-to-day activities?	O	O	O	O	O
g. How run-down did you feel on average?	O	O	O	O	O

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

O Very good O Fairly good O Fairly bad O Very bad

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

16. 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

17. 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?	○	○	○

18. 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	○	○	○	○	○

19. 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

20. Please provide us with the name, phone number and address of an individual (not living in your household) whom we have permission to contact in the event that we are unable to contact you directly.

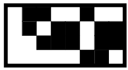
Individual's Name: ______________________________

Phone Number: (___) ___ - ____

Address Line 1: ______________________________

Address Line 2: ______________________________

Relationship: ○ Family ○ Friend ○ Neighbor ○ Other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COSMOS OBS 3

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

21. Have you used any of the following integrative health services?	**Ever in your lifetime?**	**At least once over the last 12 months?**
a. Manual therapies (e.g. chiropractic, spinal manipulation, massage)	O No O Yes	O No O Yes
b. Mind-body therapies (e.g. mindfulness, meditation, Tai Chi, Qi Gong, yoga, hypnosis)	O No O Yes	O No O Yes
c. Herbal products	O No O Yes	O No O Yes
d. Acupuncture	O No O Yes	O No O Yes
e. Spiritual practices (e.g. religion, prayer)	O No O Yes	O No O Yes
f. Cannabis, psychedelics	O No O Yes	O No O Yes

22. Would you be interested in participating in a study involving any of the specified therapies? **IF YES,** please mark all that apply.

O Manual therapies O Mind-body therapies O Herbal products O Not interested in any studies

O Acupuncture O Spiritual practices O Cannabis, psychedelics

23. How much do you currently weigh without your shoes on? [ ][ ][ ] pounds

24. What is your usual walking pace outdoors?

O Don't walk regularly O Easy, casual (less than 2 mph) O Normal, average (2-2.9 mph)

O Brisk pace (3-3.9 mph) O Very brisk/striding (4 mph or faster)

25. 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 O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10 **Best**

■ Please provide your phone number and/or email in the event that we need to contact you. Thanks!

PREFERRED PHONE NUMBER: ([ ][ ][ ]) [ ][ ][ ] - [ ][ ][ ][ ] This is my: O Home phone O Cell 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: ______________________________