43250

Request

COSMOS 3R

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. 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**:	○ Missed 0 days (took all)	○ Missed 1-4 days	○ Missed 5-8 days
	○ Missed 9-15 days	○ Missed 16-29 days	○ Missed all days (took none)
b. Orange capsules in a **typical month**:	○ Missed 0 days (took all)	○ Missed 1-4 days	○ Missed 5-8 days
	○ Missed 9-15 days	○ Missed 16-29 days	○ 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?

○ Difficulty taking pills ○ Frequent travel

○ Chronic illness ○ Other: _____

d. When do you typically take your study pills? ○ Morning ○ Afternoon ○ Night

e. Do you typically take your study pills with food? ○ No ○ Yes

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

○ No ○ Yes → Brand: _____

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

○ No ○ 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.

○ 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

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.

○ None ○ 500 mg or less/day ○ 501-1,200 mg/day

○ 1,201-1,500 mg/day ○ Greater than 1,500 mg/day

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

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 →	/
jj. Celiac disease	○ No ○ Yes →	/
kk. Crohn's disease	○ No ○ Yes →	/
ll. Ulcerative colitis	○ No ○ Yes →	/

7. 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

8. 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 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 or more
c. Were you evaluated by a health care provider or admitted to the hospital following any of the injuries?	○ No ○ Yes

9. 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.
○ Hip ○ Upper leg (other than hip) ○ Forearm/wrist
○ Pelvis ○ Upper arm/shoulder ○ Spine ○ Other

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

10. 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, Aleve, Advil, Motrin, Naprosyn	○ No ○ Yes
c. Antiplatelet medication Examples: clopidogrel, Plavix, prasugrel, Effient, Brilinta, Zontivity, ticagrelor	○ No ○ Yes
d. Anti-coagulant drugs Examples: warfarin, Coumadin, heparin, Pradaxa, dabigatran, Xarelto, rivaroxaban, Savaysa, Eliquis, Lovenox	○ 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: niacin, Lopid, Questran, Colestid, Zetia, Praluent, Repatha	○ No ○ Yes
h. Thyroid hormones Examples: Synthroid, Levoxyl, Levothroid, levothyroxine	○ No ○ Yes
i. Aromatase inhibitors Examples: Arimidex, Aromasin, Femara	○ No ○ Yes
j. Calcitriol Examples: Rocaltrol, Calcijex, Vectical or Paricalcitol (Zemplar)	○ No ○ Yes
k. Proton pump inhibitors (PPIs) Examples: omeprazole, Prilosec, Prevacid, Protonix, Nexium, Aciphex	○ No ○ Yes
l. Histamine-2 (H-2) Blockers Examples: Ranitidine (Zantac), Nizatidine (Axid)	○ No ○ Yes
m. Estrogen, alone or with progestin (do NOT include vaginal estrogen)	○ No ○ Yes
n. Erectile dysfunction medications (men only) Examples: Cialis, Levitra, Viagra	○ No ○ Yes
o. Testosterone Examples: Androgel, Testim, Depo-Testosterone	○ No ○ Yes
p. Tamoxifen Examples: Nolvadex, Soltamox	○ No ○ Yes
q. Serotonin reuptake inhibitors (SRIs) Examples: Celexa, Lexapro, Cipralex, Esertia, Prozac, Zoloft, Zelmid	○ No ○ Yes
r. Gonadotropin-releasing hormone (GnRH) agonist Examples: Lupron (Leuprolide), Goserelin (Zoladex)	○ No ○ Yes

11. 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)

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

b. Diabetes medications (Mark all that apply)

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

12. In the **PAST YEAR**, have you had your blood sugar levels (glucose) (fasting or non-fasting) or hemoglobin A1c measured?

○ No ○ Yes

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

○ No ○ Yes

14. 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)	○	○	○
d. Loop diuretics (Examples: furosemide (Lasix), torsemide)	○	○	○
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)	○	○	○

15. How many years ago was your most recent **blood pressure** measurement?

○ Less than 1 year ago ○ 1-2 years ago ○ 3-5 years ago ○ More than 5 years ago ○ Don't know

16. 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

17. How many years ago was your most recent **blood cholesterol** test?

○ Less than 1 year ago ○ 1-2 years ago ○ 3-5 years ago ○ More than 5 years ago ○ Don't know

18. The level of total cholesterol in the blood is given as one number, usually 3-digits in length. Do you know your most recent **total cholesterol** level?

○ No ○ Yes

IF YES: Please mark the bubble below that best matches your most recent total cholesterol level. Mark only one bubble.

○ less than 140	○ 160-179	○ 200-219	○ 240-259	○ 280-299	○ 320 or higher
○ 140-159	○ 180-199	○ 220-239	○ 260-279	○ 300-319	

19. 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

20. In the **PAST YEAR**, do you think your memory has become better or worse?

○ Better ○ Worse ○ No change in the past year

21. 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?	○	○	○	○	○

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

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

23. 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

24. 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

25. IN THE PAST YEAR, have you had 2 weeks or more during which you felt sad, blue, or depressed, or lost pleasure in things that you usually cared about or enjoyed?

○ No ○ Yes

26. 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

27. Over the past 2 weeks, how many times did you have **swelling** in your feet, ankles or legs when you woke up in the morning?

○ Every morning ○ 3 or more times per week but not every day ○ 1-2 times per week ○ Less than once per week ○ Never over the past 2 weeks

28. Over the past 2 weeks, on average, how many times has **fatigue** limited your ability to do what you wanted?

○ Several times per day ○ At least once per day ○ 3 or more times per week but not every day ○ 1-2 times per week ○ Less than once per week ○ Never over the past 2 weeks

29. Over the past 2 weeks, on average, how many times has **shortness of breath** limited your ability to do what you wanted?

○ All of the time ○ Several times per day ○ At least once per day ○ 3 or more times per week but not every day ○ 1-2 times per week ○ Less than once per week ○ Never over the past 2 weeks

30. Over the past 2 weeks, how much did fatigue or shortness of breath limit your:

	Extremely limited	Quite a bit limited	Moderately limited	Slightly limited	Not at all limited
a. Showering and bathing?	○	○	○	○	○
b. Dressing yourself?	○	○	○	○	○
c. Walking one block on level ground?	○	○	○	○	○
d. Doing yard work, housework, or carrying groceries?	○	○	○	○	○
e. Climbing a flight of stairs without stopping?	○	○	○	○	○
f. Hurrying (as if to catch a bus) or jogging?	○	○	○	○	○

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

32. In the **PAST 3 YEARS**, did you lose five (5) or more pounds?

○ No ○ Yes

IF YES, was this weight loss on purpose? ○ No ○ Yes

33. 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**

34. Please provide us with the name, phone number and address of 2 individuals (not living in your household) whom we have permission to contact in the event that we are unable to contact you directly.

CONTACT 1

Name _____

Phone (☐☐☐) ☐☐☐ - ☐☐☐☐

Address _____

_____

Relationship ○ Family ○ Friend ○ Neighbor ○ Other

CONTACT 2

Name _____

Phone (☐☐☐) ☐☐☐ - ☐☐☐☐

Address _____

_____

Relationship ○ Family ○ Friend ○ Neighbor ○ Other

■ 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.**

■ E-mail address: _____

■ Corrected E-mail address: _____

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