

COSMOS 4R



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.

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



<input type="text"/>	/	<input type="text"/>	/	<input type="text"/>
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 :	<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 is 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: _____	
d. When do you typically take your study pills? <input type="radio"/> Morning <input type="radio"/> Afternoon <input type="radio"/> Night			
e. Do you typically take your study pills with food? <input type="radio"/> No <input type="radio"/> 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, Ocuville)?

No Yes → Brand: _____

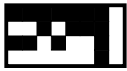
4. **NOT INCLUDING YOUR STUDY PILLS**, how much **TOTAL** vitamin D do you currently take from nutritional supplements such as single pills of vitamin D, multivitamins, calcium supplements (Calcium+D) or drugs that may include vitamin D (Example: Fosamax+D)?

Referring to package labels, please add up **ALL** your non-diet sources of vitamin D.

<input type="radio"/> None	<input type="radio"/> 400 IU or less/day	<input type="radio"/> 401-800 IU/day
<input type="radio"/> 801-1,000 IU/day	<input type="radio"/> 1,001-3,000 IU/day	<input type="radio"/> 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.

<input type="radio"/> None	<input type="radio"/> 500 mg or less/day	<input type="radio"/> 501-1,200 mg/day
<input type="radio"/> 1,201-1,500 mg/day	<input type="radio"/> Greater than 1,500 mg/day	



11986

COSMOS 4R

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"/>



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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"/>
jj. Celiac disease	<input type="radio"/> No <input type="radio"/> Yes	→	<input type="text"/> / <input type="text"/>
kk. Crohn's disease	<input type="radio"/> No <input type="radio"/> Yes	→	<input type="text"/> / <input type="text"/>
ll. Ulcerative colitis	<input type="radio"/> No <input type="radio"/> Yes	→	<input type="text"/> / <input type="text"/>

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

a. Stomach upset or pain	<input type="radio"/> No <input type="radio"/> Yes	j. Frequent nosebleeds	<input type="radio"/> No <input type="radio"/> Yes
b. Nausea	<input type="radio"/> No <input type="radio"/> Yes	k. Easy bruising	<input type="radio"/> No <input type="radio"/> Yes
c. Constipation	<input type="radio"/> No <input type="radio"/> Yes	l. Blood in urine	<input type="radio"/> No <input type="radio"/> Yes
d. Diarrhea	<input type="radio"/> No <input type="radio"/> Yes	m. Gastro-intestinal bleeding	<input type="radio"/> No <input type="radio"/> Yes
e. Skin rash	<input type="radio"/> No <input type="radio"/> Yes	IF YES: Did you have a blood transfusion? <input type="radio"/> No <input type="radio"/> Yes	
f. Skin discoloration	<input type="radio"/> No <input type="radio"/> Yes	Were you hospitalized? <input type="radio"/> No <input type="radio"/> Yes	
g. Fatigue or drowsiness	<input type="radio"/> No <input type="radio"/> Yes	n. Migraine	<input type="radio"/> No <input type="radio"/> Yes
h. Flu-like symptoms	<input type="radio"/> No <input type="radio"/> Yes	o. Other headaches	<input type="radio"/> No <input type="radio"/> Yes
i. Dizziness	<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		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		When you rise from a chair? <input type="radio"/> No <input type="radio"/> 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	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 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?	<input type="radio"/> None <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 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



11986

COSMOS 4R

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

No

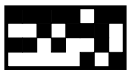
Yes →

a. Which bone(s)? Hip Upper leg (other than hip) Forearm/wrist
 Mark all that apply. 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?	<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	<input type="radio"/> No <input type="radio"/> Yes
b. Nonsteroidal anti-inflammatory drugs (NSAIDs) Examples: ibuprofen, Advil, Motrin, Nuprin, naproxen, Naprosyn, Aleve		<input type="radio"/> No <input type="radio"/> Yes
c. Antiplatelet medication 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. Proton pump inhibitors (PPIs) Examples: omeprazole, Prilosec, Prevacid, Protonix, Nexium, Aciphex		<input type="radio"/> No <input type="radio"/> Yes
l. Histamine-2 (H-2) Blockers Examples: Ranitidine, Zantac, Nizatidine, Axid, Famotidine, Pepcid, Tagamet		<input type="radio"/> No <input type="radio"/> Yes
m. Estrogen, alone or with progestin (do NOT include vaginal estrogen)		<input type="radio"/> No <input type="radio"/> Yes
n. Erectile dysfunction medications (men only) Examples: Cialis, Levitra, Viagra		<input type="radio"/> No <input type="radio"/> Yes
o. Testosterone Examples: Androgel, Testim, Depo-Testosterone		<input type="radio"/> No <input type="radio"/> Yes
p. Tamoxifen Examples: Nolvadex, Soltamox		<input type="radio"/> No <input type="radio"/> Yes
q. Serotonin reuptake inhibitors (SRIs) Examples: Celexa, Lexapro, Cipralex, Esertia, Prozac, Zoloft, Zeldmid		<input type="radio"/> No <input type="radio"/> Yes
r. Gonadotropin-releasing hormone (GnRH) agonist Examples: Leuprolide, Lupron, Goserelin, Zoladex		<input type="radio"/> No <input type="radio"/> Yes



11986

COSMOS 4R



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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)

- Fosamax (alendronate)
- Prolia (denosumab)
- Boniva (ibandronate)
- Evista (raloxifene)
- Tymlos (abaloparatide injection)
- Forteo (teriparatide injection)
- Reclast (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
- 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)
- None of these medications

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

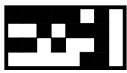
- No
- Yes

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

- No
- Yes

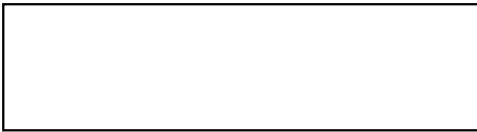
14. Please indicate if you are **CURRENTLY** taking any of the medications listed below, and the reason for use.

	For high blood pressure	For other reasons or not sure	Not taking this
a. Beta-blockers (Examples: atenolol, metoprolol)	<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"/>



11986

COSMOS 4R



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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): | | | b. LOWER BLOOD PRESSURE NUMBER (diastolic): | | |
|--|-------------------------------|-------------------------------------|---|-----------------------------|-------------------------------------|
| <input type="radio"/> less than 110 | <input type="radio"/> 130-139 | <input type="radio"/> 160-169 | <input type="radio"/> less than 65 | <input type="radio"/> 75-79 | <input type="radio"/> 90-94 |
| <input type="radio"/> 110-119 | <input type="radio"/> 140-149 | <input type="radio"/> 170-179 | <input type="radio"/> 65-69 | <input type="radio"/> 80-84 | <input type="radio"/> 95-99 |
| <input type="radio"/> 120-129 | <input type="radio"/> 150-159 | <input type="radio"/> 180 or higher | <input type="radio"/> 70-74 | <input type="radio"/> 85-89 | <input type="radio"/> 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.

<input type="radio"/> less than 140	<input type="radio"/> 160-179	<input type="radio"/> 200-219	<input type="radio"/> 240-259	<input type="radio"/> 280-299	<input type="radio"/> 320 or higher
<input type="radio"/> 140-159	<input type="radio"/> 180-199	<input type="radio"/> 220-239	<input type="radio"/> 260-279	<input type="radio"/> 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. 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"/>



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21. 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

22. 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)

23. **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

24. **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

25. 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

26. 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

27. 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

28. 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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Dressing yourself?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Walking one block on level ground?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Doing yard work, housework, or carrying groceries?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Climbing a flight of stairs without stopping?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Hurrying (as if to catch a bus) or jogging?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



11986

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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. 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

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

■ 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