1. Your current weight?

POUNDS

2. Do you currently smoke cigarettes? (exclude pipe or cigars)

○ No
○ Yes ➡ How many/day? ○ 1-4 ○ 5-14 ○ 15-24 ○ 25-34 ○ 35-44 ○ 45+

3. In the past two years, have you had a screening for PSA?

○ No ○ Yes, for symptoms ○ Yes, for routine screening

If Yes, what was your PSA level?

○ <2 ○ 2-2.9 ○ 3-3.9 ○ 4-5.9 ○ 6-7.9 ○ 8-9.9 ○ 10-14.9
○ 15+ ○ Elevated, unknown ○ Normal, unknown ○ Don't know

4. In the past two years have you had . . . *(If yes, mark all that apply)*

	No	Yes, for Screening	Yes, for Symptoms
A physical exam?	N	Y	Y
Exam by eye doctor?	N	Y	Y
Prostate biopsy?	N	Y	Y
Fasting blood sugar?	N	Y	Y

Upper endoscopy?	N No	Y Yes
(Virtual) CT Colonoscopy?	N No	Y Yes
Colonoscopy?	N No	Y Yes
Sigmoidoscopy?	N No	Y Yes

Initial reason(s) you had this Colonoscopy/Sigmoidoscopy?

○ Visible blood
○ Diarrhea/constipation
○ Barium enema
○ Prior polyps
○ Abdominal pain
○ Occult fecal blood
○ Fecal or stool DNA testing
○ Family history of colon cancer
○ Follow-up of (virtual) CT colonoscopy
○ Asymptomatic or routine screening

5. Your current marital status? ○ Married ○ Divorced/separated ○ Widowed ○ Never married

6. Your current living arrangement: *(Mark all that apply)*

○ Alone
○ With wife/partner
○ With other family
○ Assisted living
○ Nursing home
○ Senior/retirement housing or community exclusively for people age 55+
○ Other

7. Over the past year, have you had a discussion with any of your healthcare providers about the kind of medical care you would want if you were faced with a serious illness?

○ No, and I do not intend to do so anytime soon
○ No, but I have considered doing so
○ Yes, I have discussed these matters with my healthcare provider

8. Have you established any form of advance care planning for yourself in the event of serious illness? *(Mark all that apply)*

○ Healthcare proxy/durable power of attorney for healthcare
○ Physician Orders for Life Sustaining Treatment (POLST)
○ Living Will
○ Not sure
○ Other
○ None of these

9. Is this your correct date of birth? ➡

○ Yes
○ No ➡ **If No, please write correct date.** MONTH / DAY / YEAR

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10. Since January 1, 2014, have you had any of these clinician-diagnosed illnesses?
Leave blank for "NO", mark here for "YES" →

	YEAR OF DIAGNOSIS			
	Before 2014	2014	2015	2016
Prostatic enlargement, treated by drugs, surgery, or laser (Y)				
Prostate cancer (Y)				
Kidney cancer (Y)				
Bladder cancer (Y)				
Colon or rectal polyp (benign) (Y)				
Cancer of the colon or rectum (Y)				
Leukemia or Lymphoma (Y)				
Melanoma (Y)				
Basal cell skin cancer (Y)				
Squamous cell skin cancer (Y)				
Other cancer (Y) Specify site of other cancer →				
Diabetes mellitus (Y)				
Elevated cholesterol (Y)				
High blood pressure (Y)				
Myocardial infarction (heart attack) Hospitalized for MI? (N) No (Y) Yes				
Angina pectoris Confirmed by angiogram? (N) No (Y) Yes				
Coronary bypass, angioplasty, or stent (Y)				
Congestive heart failure (Y)				
Stroke (CVA) (Y)				
TIA (transient ischemic attack) (Y)				
Peripheral artery disease or claudication of legs (not varicose veins) (Y)				
Carotid surgery (endarterectomy) (Y)				
Pulmonary embolus or deep vein thrombosis (Y)				
Atrial fibrillation (Y)				

10. (continued)
Leave blank for "NO", mark here for "YES" →

	YEAR OF DIAGNOSIS			
	Before 2014	2014	2015	2016
Osteoarthritis (Y)				
Osteoporosis (Y)				
Hip fracture (Y)				
Hip or knee replacement (ever) (Y)				
Depression, clinician-diagnosed (ever) (Y)				
Diverticulitis or diverticulosis (Y)				
Glaucoma (Y)				
Macular degeneration of retina (Y)				
Cataract—1st (Dx) (Y)				
Cataract extraction (Y)				
Parkinson's disease (Y)				
Lou Gehrig's disease/ Amyotrophic Lateral Sclerosis (ALS) (Y)				
Alzheimer's or other type of dementia (e.g., vascular, FTD, Lewy Body) (Y)				
Kidney stones (Y)				
Ulcerative colitis or Crohn's or microscopic colitis (Y)				
Gastric/duodenal ulcer (Y)				
Barrett's esophagus (Y)				
Celiac disease (Y)				
Gallbladder removal (Y)				
Gout (Y)				
Fatty liver disease (ever) (Y)				
Viral hepatitis (B or C) (ever) (Y)				
Other liver disease or cirrhosis (ever) (Y)				
Other major illness or surgery since January 2014 (Y)				

Please specify: Date:

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11. Do you have difficulty with your balance?

○ No ○ Occasionally ○ Often

12. What is your usual walking pace outdoors?

○ Unable to walk ○ 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)

13. Do you usually use a cane, walker or wheelchair/scooter?
(Mark all that apply)

○ No ○ Cane ○ Walker ○ Wheelchair/scooter ○ Unable to walk

14. DURING THE PAST YEAR, what was your average time PER WEEK spent at each of the following recreational activities?

	TIME PER WEEK									
	Zero	1-4 Min.	5-19 Min.	20-59 Min.	One Hour	1-1.5 Hrs.	2-3 Hrs.	4-6 Hrs.	7-10 Hrs.	11+ Hrs.
Walking for exercise or walking for transportation or errands	○	○	○	○	○	○	○	○	○	○
Jogging (slower than 10 minutes/mile)	○	○	○	○	○	○	○	○	○	○
Running (10 minutes/mile or faster)	○	○	○	○	○	○	○	○	○	○
Bicycling: **stationary exercise bike** Intensity: ○ Low ○ Medium ○ High	○	○	○	○	○	○	○	○	○	○
Bicycling: **outside, separated from traffic (e.g., bike path)** Intensity: ○ Low ○ Medium ○ High	○	○	○	○	○	○	○	○	○	○
Bicycling: **outside on road** Intensity: ○ Low ○ Medium ○ High	○	○	○	○	○	○	○	○	○	○
Tennis, squash, or racquetball Racquet sport intensity: ○ Low ○ Medium ○ High	○	○	○	○	○	○	○	○	○	○
Lap swimming Swimming intensity: ○ Low ○ Medium ○ High	○	○	○	○	○	○	○	○	○	○
Other aerobic exercise (aerobic dance, ski or stair machine, etc.)	○	○	○	○	○	○	○	○	○	○
Lower intensity exercise (yoga, stretching, toning)	○	○	○	○	○	○	○	○	○	○
Other vigorous activities (e.g., lawn mowing)	○	○	○	○	○	○	○	○	○	○
Weight training or resistance exercises (include free weights or resistance machines) — Arm weights	○	○	○	○	○	○	○	○	○	○
Weight training or resistance exercises (include free weights or resistance machines) — Leg weights	○	○	○	○	○	○	○	○	○	○

15. DURING THE PAST YEAR, on average, how many <u>HOURS PER WEEK</u> did you spend:

	TIME PER WEEK								
	Zero Hrs.	One Hour	2-5 Hrs.	6-10 Hrs.	11-20 Hrs.	21-40 Hrs.	41-60 Hrs.	61-90 Hrs.	Over 90 Hrs.
Standing or walking around at work or away from home?	○	○	○	○	○	○	○	○	○
Standing or walking around at home?	○	○	○	○	○	○	○	○	○
Sitting at work or away from home or while driving?	○	○	○	○	○	○	○	○	○
Sitting at home while watching TV/DVD/movies?	○	○	○	○	○	○	○	○	○
Other sitting at home (e.g., reading, meal times, at desk)?	○	○	○	○	○	○	○	○	○

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16. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? *(Mark one response on each line)*

	Yes, Limited A Lot	Yes, Limited A Little	No, Not Limited At All
Vigorous activities, like running, lifting heavy objects, strenuous sports	○	○	○
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	○	○	○
Lifting or carrying groceries	○	○	○
Climbing *several* flights of stairs	○	○	○
Climbing *one* flight of stairs	○	○	○
Bending, kneeling, or stooping	○	○	○
Walking *more than one mile*	○	○	○
Walking *several blocks*	○	○	○
Walking *one block*	○	○	○
Bathing or dressing yourself	○	○	○
Getting in and out of a bed or chair	○	○	○

17. Please indicate the times of day that you usually eat : Include meals and snacks. (For snacks, count juice and non-diet soda, but exclude coffee and diet soda.) *(Mark all that apply)*

○ Before breakfast ○ Breakfast ○ Between breakfast and lunch ○ Lunch ○ Between lunch and dinner
○ Dinner ○ Between dinner and bed time ○ After going to bed

18. How many days per week do you have breakfast (more than coffee or tea?)

○ Never ○ 1/wk ○ 2 ○ 3 ○ 4 ○ 5 ○ 6

19. On average, during the past year, on how many days did you consume an alcoholic beverage of any type?

○ No days ○ Less than one/month ○ 1 day/mo ○ 2-4 days/mo ○ 1-2 days/wk ○ 3-4 days/wk
○ 5-6 days/wk ○ 7 days/wk

20. In a typical month, what is the largest number of drinks of beer, wine, and/or liquor you have in one day?

○ None ○ 1 drink/day ○ 2 ○ 3 ○ 4 ○ 5-6 ○ 7-9 ○ 10-14 ○ 15 or more drinks/day

21. For each alcoholic beverage, fill in the circle indicating how often on average you have used the amount specified during the past year.

BEVERAGES	Never, or less than once per month	1–3 per month	1 per week	2–4 per week	5–6 per week	1 per day	2–3 per day	4–5 per day	6+ per day
Beer, regular (1 glass, bottle, can)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Light Beer, e.g., Bud Light (1 glass, bottle, can)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Red wine (5 oz. glass)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
White wine (5 oz. glass)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Liquor, e.g., vodka, gin, etc. (1 drink or shot)	○	○	Ⓦ	○	○	Ⓓ	○	○	○

22. Outside of your employment, do you provide regular care to any of the following? *(Mark one response on each line. For people to whom you do not provide regular care, mark "Zero hours")*

	HOURS PER WEEK					
	Zero Hrs.	1-8 Hrs.	9-20 Hrs.	21-35 Hrs.	36-72 Hrs.	73+ Hrs.
Your grandchildren	○	○	○	○	○	○
Disabled or ill spouse/partner	○	○	○	○	○	○
Disabled or ill parent or other person	○	○	○	○	○	○

23. Regular Medication *(Mark if used regularly in past 2 years)*

Analgesics

- ○ Acetaminophen (e.g., Tylenol)
  - Days per week: ○ 1 ○ 2-3 ○ 4-5 ○ 6+ days
  - Total tablets per week: ○ 1-2 ○ 3-5 ○ 6-14 ○ 15+ tablets
- ○ Low dose or "Baby" aspirin (100mg or less/tablet)
  - Days per week: ○ 1 ○ 2-3 ○ 4-5 ○ 6+ days
  - Total tablets per week: ○ 1-2 ○ 3-5 ○ 6-14 ○ 15+ tablets
- ○ Aspirin or aspirin-containing products (325mg or more/tablet)
  - Days per week: ○ 1 ○ 2-3 ○ 4-5 ○ 6+ days
  - Total tablets per week: ○ 1-2 ○ 3-5 ○ 6-14 ○ 15+ tablets
- ○ Ibuprofen (e.g., Advil, Motrin, Nuprin)
  - Days per week: ○ 1 ○ 2-3 ○ 4-5 ○ 6+ days
  - Total tablets per week: ○ 1-2 ○ 3-5 ○ 6-14 ○ 15+ tablets
- ○ Celebrex (COX-2 inhibitors)
  - Days per week: ○ 1 ○ 2-3 ○ 4-5 ○ 6+ days
- ○ Other anti-inflammatory analgesics, 2+ times/week (e.g., Aleve, Naprosyn, Relafen, Ketoprofen, Anaprox)

Other Regularly Used Medications

- ○ Thiazide diuretic ○ Lasix ○ Potassium
- ○ Calcium channel blocker (e.g., Calan, Procardia, Cardizem, Norvasc)
- ○ Beta-blocker (e.g., Metoprolol, Lopressor, Tenormin, Corgard)
- ○ ACE inhibitors (e.g., Capoten, Vasotec, Zestril)
- ○ Angiotensin receptor blocker (e.g., valsartan (Diovan), losartan (Cozaar), irbesartan (Avapro))
- ○ Other anti-hypertensive (e.g., clonidine, doxazosin)
- ○ Coumadin ○ Pradaxa/Xarelto/Eliquis
- ○ Clopidogrel or Ticlopidine (e.g., Plavix or Ticlid)
- ○ Digoxin ○ Antiarrhythmic
- "Statin" cholesterol-lowering drug:
  - ○ Mevacor (lovastatin)
  - ○ Pravachol (pravastatin)
  - ○ Zocor (simvastatin)
  - ○ Lipitor (atorvastatin)
  - ○ Crestor
  - ○ Other
- ○ Other cholesterol-lowering drug
- ○ Steroids taken orally (e.g., Prednisone, Decadron, Medrol)
- ○ Insulin ○ Metformin (glucophage) ○ Avandia or Actos
- ○ Other oral hypoglycemic medication
- ○ Opioid pain medications (e.g., codeine, Percocet, Vicodin, tramadol)
- ○ Alpha blocker for BPH (e.g., Hytrin (terazosin), Flomax)
- ○ SSRIs (e.g., Celexa, Lexapro, Prozac, Paxil, Zoloft, Luvox, fluoxetine, citalopram)
- ○ Tricyclics (e.g., amitriptyline, nortriptyline, imipramine)
- ○ SNRIs/Other antidepressants (e.g., Wellbutrin, Effexor, Remeron, Cymbalta, veniafaxine, bupropion)
- ○ Minor tranquilizers (e.g., Valium, Xanax, Ativan)
- ○ Prilosec, Nexium, Prevacid, Protonix, Aciphex
- ○ H2 blocker (e.g., Pepcid, Zantac, Axid, Tagamet)
- ○ Aricept, Exelon, Razadyne ○ Namenda
- ○ Finasteride/Proscar ○ Propecia ○ Avodart
- ○ Ambien, Sonata, Lunesta or zolpidem
- ○ Other prescription sleep medications (e.g., Trazadone, Rozerem)
- ○ Other regular medications (no need to specify)

24. Have you ever been diagnosed with diverticulitis of the colon that required antibiotics or hospitalization? (24)

○ No ○ Yes

If Yes: a) Total number of episodes: (a)
○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ >5

b) Year(s) of all episodes: (b)
○ Before 2012 ○ 2012 ○ 2013 ○ 2014 ○ 2015 ○ 2016+

c) Surgery for diverticulitis? (c)
○ No surgery ○ After first episode ○ After second episode ○ After later episode

25. Have you ever been diagnosed with diverticular bleeding that required a blood transfusion and/or hospitalization? (25)

○ No ○ Yes

If Yes: a) Total number of episodes: (a)
○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ >5

b) Year(s) of all episodes: (b)
○ Before 2012 ○ 2012 ○ 2013 ○ 2014 ○ 2015 ○ 2016+

c) Surgery for diverticular bleeding? (c)
○ No surgery ○ After first episode ○ After second episode ○ After later episode

26. Have you ever been diagnosed with diverticulosis of the colon without diverticulitis or diverticular bleeding? (26)

○ No ○ Yes ○ Don't know

27. In the past two years, have you had gastrointestinal bleeding that required hospitalization or a transfusion? (27)

○ Yes → Site(s): ○ Esophagus ○ Stomach ○ Duodenum
○ No ○ Colon/Rectum ○ Other ○ Site(s) unknown

28. How frequently do you have a bowel movement? (28)

○ More than once a day ○ Daily ○ Every other day ○ Every 3 days or less

29. How often do you use a laxative (such as softeners, bulking agents, fiber supplements or suppositories?) (29)

○ Never ○ Less than once/month ○ 1-3 times/month ○ About once/week
○ 2-3 times/week ○ 4-5 times/week ○ Daily ○ More than once/day

30. Are you circumcised (foreskin absent) or uncircumcised (foreskin present)? (30)

○ Circumcised ○ Uncircumcised ○ Don't know

31. During the past three months, how would you rate your ability (without treatment) to have and maintain an erection good enough for intercourse? (31)

○ Very Poor ○ Poor ○ Fair ○ Good ○ Very Good

32. Do you have unpleasant leg sensations (like crawling, paraesthesias, or pain) combined with leg restlessness and the urge to move? (32)

○ No ○ Once a month or less ○ 2-4 times/month ○ 5-14 times/month ○ 15+ times/month

If Yes: a) Do these symptoms occur only at rest and does moving improve them? ○ Yes ○ No (a)

b) Are these symptoms worse in the evening/night compared with the morning? ○ Yes ○ No (b)

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33. Has your spouse (or sleep partner) told you that you appear to "act out your dreams" while sleeping (punched or flailed arms in the air, shouted or screamed), which has occurred at least three times?

○ No ○ Yes ○ I do not have a sleep partner

34. Do you have any problems with your sense of smell, such as not being able to smell things or things not smelling the way they are supposed to for at least 3 months?

○ No ○ Yes ○ Don't know

If yes, which problem do you have, not being able to smell things or things not smelling the way they are supposed to?

○ Loss of smell ○ Things don't smell right ○ Don't know

35. Please estimate an average of the time when you fall asleep and wake up, over the past 2 years on WORK-FREE DAYS, when you were without obligations and not using an alarm clock to wake up:

I usually fall asleep at ☐☐ hour ☐☐ minute ○ AM ○ PM (This is NOT when you get into bed)

I usually wake up at ☐☐ hour ☐☐ minute ○ AM ○ PM (This may NOT be when you get OUT of bed)

○ I always use alarm clock to wake up on free days

36. If your work or other commitments would allow it, what time would you prefer to go to sleep and wake up?

I prefer to fall asleep at ☐☐ hour ☐☐ minute ○ AM ○ PM

I prefer to wake up at ☐☐ hour ☐☐ minute ○ AM ○ PM

37. One hears about morning and evening types of people. Which ONE of these types do you consider yourself to be?

○ Definitely a morning type ○ More of a morning type ○ More of an evening person
○ Definitely an evening type ○ Neither

38. Please rate your ability to do the following activities. *(Mark one answer for each row)*

Are you able to . . .	Without Help	With Some Help	Unable
a) **Get to places out of walking distance**	○ Drive car, travel alone on bus, train, or taxi	○ Need someone to help you or go with you	○ Unable to travel except by ambulance, etc.
b) **Go shopping for groceries or clothes (assuming you had transportation)**	○ Can shop by yourself, assuming you had transportation	○ Need someone to help you on all shopping trips	○ Completely unable to do any shopping
c) **Prepare your own meals**	○ Plan and cook full meals yourself	○ Can prepare some things. Unable to cook full meals	○ Completely unable to prepare any meals
d) **Do your own housework**	○ Can clean floors, bathroom, etc.	○ Need help with heavy housework & cleaning	○ Completely unable to do any housework
e) **Handle your own money**	○ Write checks, pay bills, etc. by yourself	○ Can manage day-to-day buying. Need help with checkbook & paying bills	○ Completely unable to handle money
f) **Handle your medications**	○ Able to keep track of and take meds yourself	○ Need someone to help manage medications	○ Completely unable to manage medications

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39. Please answer Yes or No for each of the following questions about your memory:

Have you recently experienced any change in your ability to remember things?	◯ Yes	◯ No
Do you have more trouble than usual remembering recent events?	◯ Yes	◯ No
Do you have more trouble than usual remembering a short list of items, such as a shopping list?	◯ Yes	◯ No
Do you have trouble remembering things from one second to the next?	◯ Yes	◯ No
Do you have difficulty in understanding or following spoken instructions?	◯ Yes	◯ No
Do you have more trouble than usual following a group conversation or a plot in a TV program due to your memory?	◯ Yes	◯ No

40. Choose the best answer for how you felt the *past month:*

Are you basically satisfied with your life?	◯ Yes	◯ No
Have you dropped many of your activities and interests?	◯ Yes	◯ No
Do you feel that your life is empty?	◯ Yes	◯ No
Do you often get bored?	◯ Yes	◯ No
Are you in good spirits most of the time?	◯ Yes	◯ No
Are you afraid that something bad is going to happen to you?	◯ Yes	◯ No
Do you feel happy most of the time?	◯ Yes	◯ No
Do you often feel helpless?	◯ Yes	◯ No
Do you prefer to stay home, rather than going out and doing new things?	◯ Yes	◯ No
Do you feel that you have more problems with memory than most?	◯ Yes	◯ No
Do you think it is wonderful the way you are now?	◯ Yes	◯ No
Do you feel pretty worthless the way you are now?	◯ Yes	◯ No
Do you feel full of energy?	◯ Yes	◯ No
Do you feel that your situation is hopeless?	◯ Yes	◯ No
Do you think that most people are better off than you are?	◯ Yes	◯ No

41. What is your heart rate after sitting 10-15 minutes (e.g., after completing this form)? _____ (/Min)

42. Please indicate the name of someone at a DIFFERENT PERMANENT ADDRESS to whom we might write in the event we are unable to contact you:

Name: _____ **Address:** _____

Relationship: _____ _____

Email/Phone #: _____