 Please use pencil if possible! Thank you

1. **What is your current weight (pounds)?**

2. **What is the difference between your highest and lowest weight during the last two years?**
   ◯ 50 or more lbs. ◯ 30–49 lbs. ◯ 15–29 lbs. ◯ 10–14 lbs. ◯ 5–9 lbs. ◯ 2–4 lbs. ◯ No change

3. **Current Marital Status:** ◯ Married ◯ Divorced/Separated ◯ Widowed ◯ Never Married

4. **Living Arrangement:** ◯ Alone ◯ With Wife ◯ With Other Family ◯ Nursing Home ◯ Other

5. **Work Status:** ◯ Full-time ◯ Part-time ◯ Retired ◯ Disabled ◯ Unemployed

6. **Do you currently smoke cigarettes?**
   ◯ No ◯ Yes → **Please mark your average number of cigarettes per day:**
   ◯ 1–4 cigarettes ◯ 5–14 ◯ 15–24 ◯ 25–34 ◯ 35–44 ◯ 45 or more

7. **Do you currently smoke a pipe or cigars daily?** ◯ Neither ◯ Pipe ◯ Cigars

8. **In the past 2 years, have you had . . .**

... a physical exam?	◯ No	◯ Yes, for symptoms	◯ Yes, for routine screening
... a rectal exam?	◯ No	◯ Yes, for symptoms	◯ Yes, for routine screening
... an eye exam?	◯ No	◯ Yes, for symptoms	◯ Yes, for routine screening
... blood cholesterol check?	◯ No	◯ Yes, for symptoms	◯ Yes, for routine screening
... blood glucose check?	◯ No	◯ Yes, for symptoms	◯ Yes, for routine screening
... screening for PSA?	◯ No	◯ Yes, for symptoms	◯ Yes, for routine screening

   If "yes" for PSA screening, was your PSA elevated? ◯ No ◯ Unknown ◯ Yes

9. **In the past 4 years, have you had a prostate biopsy or rectal ultrasound (for prostate exam)?** ◯ No ◯ Unknown ◯ Yes

10a. **Over the past month, how many times per night did you typically get up to urinate?**
   ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5+/Night

10b. **During the past month, please indicate how frequently you had these urinary symptoms:**

% OF TIME EXPERIENCED SYMPTOMS	0%	10%	25%	50%	75%	Almost 100%
Sensation of incomplete bladder emptying	◯	◯	◯	◯	◯	◯
Having to urinate again after less than 2 hours	◯	◯	◯	◯	◯	◯
Stopping and starting several times during urination	◯	◯	◯	◯	◯	◯
Found it difficult to postpone urinating	◯	◯	◯	◯	◯	◯
Weak urinary stream	◯	◯	◯	◯	◯	◯
Had to push or strain to begin urination	◯	◯	◯	◯	◯	◯

11. **Have you had a colonoscopy or sigmoidoscopy since January 1, 1998?**
   ◯ No ◯ Yes → **Reason(s)?** ◯ Bleeding in stool ◯ Family history of colon cancer ◯ Positive test for occult fecal blood ◯ Abdominal pain ◯ Diarrhea or constipation ◯ Routine screening (no symptoms) or follow-up

12. **What is your normal walking pace?** ◯ Easy (<2 mph) ◯ Average (2–2.9 mph) ◯ Brisk (3–3.9 mph) ◯ Fast (4+ mph)

13. **In a typical week, how many days a week do you spend a total of 30 minutes participating in the following types of exercise?**
   a. **Vigorous exercise (e.g., running or jogging):**
   ◯ 0 days/wk ◯ 1 day/wk ◯ 2 days/wk ◯ 3 days/wk ◯ 4 days/wk ◯ 5 days/wk ◯ 6 days/wk ◯ 7 days/wk
   b. **Moderate exercise (e.g., brisk walking):**
   ◯ 0 days/wk ◯ 1 day/wk ◯ 2 days/wk ◯ 3 days/wk ◯ 4 days/wk ◯ 5 days/wk ◯ 6 days/wk ◯ 7 days/wk
   c. **Easy exercise (e.g., gardening or average easy walking):**
   ◯ 0 days/wk ◯ 1 day/wk ◯ 2 days/wk ◯ 3 days/wk ◯ 4 days/wk ◯ 5 days/wk ◯ 6 days/wk ◯ 7 days/wk

14. **During the past year, what was your average total time per week at each activity?**

AVERAGE TOTAL TIME PER WEEK	NONE	1–4 Min.	5–19 Min.	20–39 Min.	40–89 Min.	1.5 Hrs.	2–3 Hrs.	4–6 Hrs.	7–10 Hrs.	11–20 Hrs.	21–30 Hrs.	31–40 Hrs.	40+ Hrs.
Sitting at work	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Sitting or driving (e.g., car, bus or train)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Sitting or lying watching TV or VCR	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Sitting at home reading	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Other sitting at home (e.g., at desk or eating)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Walking to work or for exercise (including golf)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Jogging (slower than 10 minutes/mile)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Running (10 minutes/mile or faster)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Bicycling (including stationary machine)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Lap swimming	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Tennis	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Squash or Racquetball	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Calisthenics, Rowing, stair or ski machine, etc.	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Weightlifting or weight machine	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Heavy outdoor work (e.g., digging, chopping)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

15. **Do you have difficulty with your balance?** ◯ No ◯ Yes

16. **Do you have difficulty climbing a flight of stairs or walking eight blocks due to a physical impairment?** ◯ No ◯ Yes

17. **How many flights of stairs (not steps) do you climb daily? (Do not include time spent on stair or exercise machines.)**
   ◯ No flights ◯ 1–2 flights ◯ 3–4 flights ◯ 5–9 flights ◯ 10–14 flights ◯ 15 or more flights

THIS IS YOUR ID

18. IS THIS YOUR DATE OF BIRTH?

○ Yes
○ No → IF NO, please indicate your date of birth.

MONTH	DAY	YEAR

19. Since January 1, 1998, have you had any of the following professionally diagnosed conditions?

Leave blank for NO, mark here for YES

Condition	YES	Before 1998	1998	1999	2000
High blood pressure	Ⓨ	○	○	○	○
Diabetes mellitus	Ⓨ	○	○	○	○
Elevated cholesterol	Ⓨ	○	○	○	○
Elevated triglycerides	Ⓨ	○	○	○	○
Coronary artery bypass or coronary angioplasty	Ⓨ	○	○	○	○
Myocardial infarction (heart attack)	Ⓨ	○	○	○	○
Hospitalized for this MI? ○ No ○ Yes					
Angina pectoris	Ⓨ	○	○	○	○
Confirmed by angiogram? ○ No ○ Yes					
Deep vein thrombosis	Ⓨ	○	○	○	○
TIA (Transient Ischemic Attack)	Ⓨ	○	○	○	○
Stroke (CVA)	Ⓨ	○	○	○	○
Carotid artery surgery	Ⓨ	○	○	○	○
Intermittent claudication	Ⓨ	○	○	○	○
Surgery or angioplasty for arterial disease of the leg	Ⓨ	○	○	○	○
Pulmonary embolus	Ⓨ	○	○	○	○
Aortic aneurysm	Ⓨ	○	○	○	○
Heart-rhythm disturbance	Ⓨ	○	○	○	○
Gout	Ⓨ	○	○	○	○
Rheumatoid arthritis	Ⓨ	○	○	○	○
Other arthritis (e.g., osteoarthritis)	Ⓨ	○	○	○	○
Vasectomy	Ⓨ	○	○	○	○
Diverticulitis or Diverticulosis	Ⓨ	○	○	○	○
Prostatic enlargement, surgically treated (e.g., TURP)	Ⓨ	○	○	○	○
Prostate cancer	Ⓨ	○	○	○	○
Colon or rectal polyp	Ⓨ	○	○	○	○
Cancer of colon or rectum	Ⓨ	○	○	○	○
Basal cell skin cancer	Ⓨ	○	○	○	○
Squamous cell skin cancer	Ⓨ	○	○	○	○
Melanoma	Ⓨ	○	○	○	○
Solar or actinic keratosis	Ⓨ	○	○	○	○
Lymphoma or Leukemia	Ⓨ	○	○	○	○
Other cancer	Ⓨ	○	○	○	○
Please specify site and year:					
Glaucoma	Ⓨ	○	○	○	○
Cataract (1st Diagnosis)	Ⓨ	○	○	○	○
Cataract extraction	Ⓨ	○	○	○	○
Macular degeneration	Ⓨ	○	○	○	○
Osteoporosis	Ⓨ	○	○	○	○
Hip replacement	Ⓨ	○	○	○	○
Periodontal disease with bone loss	Ⓨ	○	○	○	○
Leukoplakia or other oral precancerous lesion	Ⓨ	○	○	○	○

19. (Continued) Since January 1, 1998, have you had any of the following professionally diagnosed conditions?

Leave blank for NO, mark here for YES

Condition	YES	Before 1998	1998	1999	2000
Gallstones	Ⓨ	○	○	○	○
a. How was diagnosis made? ○ X-ray/ultrasound ○ Other					
b. Gallstone symptoms? ○ No ○ Yes					
Gall bladder removal	Ⓨ	○	○	○	○
Kidney stones	Ⓨ	○	○	○	○
Gastric or duodenal ulcer	Ⓨ	○	○	○	○
Ulcerative colitis/Crohn's disease	Ⓨ	○	○	○	○
Parkinson's disease	Ⓨ	○	○	○	○
Multiple Sclerosis	Ⓨ	○	○	○	○
ALS (Amyotrophic Lateral Sclerosis)	Ⓨ	○	○	○	○
Alcohol dependence problem	Ⓨ	○	○	○	○
Pneumonia (X-ray confirmed)	Ⓨ	○	○	○	○
Asthma	Ⓨ	○	○	○	○
Emphysema or chronic bronchitis (COPD)	Ⓨ	○	○	○	○
Chronic renal failure	Ⓨ	○	○	○	○
Active TB (x-ray or culture Dx)	Ⓨ	○	○	○	○
Other major illness or surgery since January 1998	Ⓨ	○	○	○	○

Please specify:

20. Current Medication *(mark if used 2+ times/week)*

○ Acetaminophen (e.g., Tylenol)
Days/week: ○ 1 ○ 2-3 ○ 4-5 ○ 6+ days
Tablets/wk: ○ 1-2 ○ 3-5 ○ 6-14 ○ 15+ tablets

○ Aspirin or aspirin-containing products (e.g., Alka-Seltzer with aspirin)
Days/week: ○ 1 ○ 2-3 ○ 4-5 ○ 6+ days
Tablets/wk: ○ 1-2 ○ 3-5 ○ 6-14 ○ 15+ tablets
Usual dose/tab: ○ 50-99 mg ○ 100-249 ○ 250-349 ○ 350+

○ Ibuprofen (e.g., Advil, Motrin, Nuprin)
Days/week: ○ 1 ○ 2-3 ○ 4-5 ○ 6+ days
Tablets/wk: ○ 1-2 ○ 3-5 ○ 6-14 ○ 15+ tablets

○ Other anti-inflammatory analgesics, 2+ times/week (e.g., Aleve, Naprosyn, Relafen, Ketoprofen, Anaprox)

○ Steroid taken orally (e.g., Prednisone, Medrol)

○ "Statin" cholesterol-lowering drugs (e.g., Mevacor (lovastatin), Pravachol (pravastatin), Zocor (simvastatin), Lipitor)
Years used: ○ 0-2 yrs ○ 3-5 yrs ○ 6-9 yrs ○ 10+ yrs

○ Other cholesterol-lowering drug (e.g., Niaspan, Sloniacin (niacin), Lopid (gemfibrozil), Tricor (fenofibrate), Questran (cholestyramine), Colestin)

○ H2 blocker (e.g., Tagamet, Zantac, Axid)

○ Finasteride (Proscar, Propecia)

○ Alpha-blocker for BPH (e.g., Hytrin, Minipress)

○ Beta-blocker (e.g., Inderal, Metoprolol, Atenolol)

○ Furosemide-like diuretic (e.g., Lasix, Bumex)

○ Thiazide diuretic (HCTZ)

○ Calcium blocker (e.g., Calan, Procardia, Cardizem)

○ Other antihypertensive (e.g., Vasotec, Captopril)

○ Prozac, Zoloft, Paxil, Celexa

○ Tricyclic antidepressant (e.g., Elavil, Sinequan)

○ Other antidepressant (e.g., Nardil, Marplan)

○ Tranquilizer (Valium, Xanax)

○ Coumadin (Warfarin)

○ Digoxin (e.g., Lanoxin)

○ Other regular medication (no need to specify)

○ No regular medication

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21. Do you currently take multi-vitamins? (Please report other individual vitamins in question 22.)

○ No ○ Yes → If Yes, a) How many do you take per week?
○ 2 or less ○ 3-5 ○ 6-9 ○ 10 or more

b) Type of multivitamin? (Mark all that apply)
○ Regular Potency ○ High Potency ○ Super Potency ○ Antioxidant ○ Stress
○ Theragran or Mega Potency ○ Exercise ○ Vision ○ Men's Formula
○ Senior Formula ○ includes Minerals ○ Includes Iron

c) What specific brand do you usually use? → List complete name including manufacturer and formula

Ex: Squibb Theragran M
Ex: AARP Alphabet II Formula 843 Multivitamins and Minerals

22. Not counting multi-vitamins, do you take any of the following preparations:

Supplement									
Vitamin A	○ No	○ Yes, seasonal only ○ Yes, most months	If Yes,	Dose per day:	○ Less than 8,000 IU	○ 8,000 to 12,000 IU	○ 13,000 to 22,000 IU	○ 23,000 IU or more	○ Don't know
Beta-Carotene	○ No	○ Yes	If Yes,	Dose per day:	○ Less than 8,000 IU	○ 8,000 to 12,000 IU	○ 13,000 to 22,000 IU	○ 23,000 IU or more	○ Don't know
Vitamin C	○ No	○ Yes, seasonal only ○ Yes, most months	If Yes,	Dose per day:	○ Less than 400 mg.	○ 400 to 700 mg.	○ 750 to 1250 mg.	○ 1300 mg. or more	○ Don't know
Vitamin B6	○ No	○ Yes	If Yes,	Dose per day:	○ Less than 10 mg.	○ 10 to 39 mg.	○ 40 to 79 mg.	○ 80 mg. or more	○ Don't know
Vitamin E	○ No	○ Yes	If Yes,	Dose per day:	○ Less than 100 IU	○ 100 to 250 IU	○ 300 to 500 IU	○ 600 IU or more	○ Don't know
Calcium (Include Calcium in Tums, etc.) (1 Tum = 200 mg. elemental calcium)	○ No	○ Yes	If Yes,	Dose per day (elemental calcium):	○ Less than 400 mg.	○ 400 to 900 mg.	○ 901 to 1300 mg.	○ 1301 mg. or more	○ Don't know
Selenium	○ No	○ Yes	If Yes,	Dose per day:	○ Less than 80 mcg.	○ 80 to 130 mcg.	○ 140 to 250 mcg.	○ 260 mcg. or more	○ Don't know
Niacin	○ No	○ Yes	If Yes,	Dose per day:	○ Less than 50 mg.	○ 50 to 300 mg.	○ 400 to 800 mg.	○ 900 mg. or more	○ Don't know
Zinc	○ No	○ Yes	If Yes,	Dose per day:	○ Less than 25 mg.	○ 25 to 74 mg.	○ 75 to 100 mg.	○ 101 mg. or more	○ Don't know

Are there other supplements that you take on a regular basis?
○ Metamucil/Citrucil ○ Potassium ○ Chromium ○ Folic Acid ○ Iron ○ Vitamin D
○ Cod Liver Oil ○ Magnesium ○ Lecithin ○ B-Complex ○ Other (Please specify)
○ Vitamin B12 ○ Melatonin ○ Saw Palmetto ○ Ginkgo Biloba
○ Coenzyme Q10 ○ DHEA ○ Brewer's Yeast ○ Garlic Supplements
○ Ginseng ○ St. John's Wort ○ Fish oil ○ Lycopene

23. How many teeth have you lost since January 1, 1998? ○ None ○ 1 ○ 2 ○ 3 ○ 4 ○ 5-9 ○ 10+

24. How many of your permanent teeth have had a cavity since 1996? ○ None ○ 1 ○ 2 ○ 3 ○ 4 ○ 5-9 ○ 10+

25. How many of your permanent teeth have had root canal since 1996?
○ None ○ 1 ○ 2 ○ 3 ○ 4 ○ 5-9 ○ 10+

26. Please indicate total hours of actual sleep in a typical 24-hour period:
○ 5 hours or less ○ 6 hours ○ 7 hours ○ 8 hours ○ 9 hours ○ 10 hours ○ 11+ hours

27. Do you snore? ○ Every night ○ Most nights ○ A few nights a week ○ Occasionally ○ Almost never

28. Did any of your natural family members ever have glaucoma?
○ None ○ Mother ○ Father ○ Sibling ○ Child ○ Don't know

29. Your most recent Serum Cholesterol (if within the last five years):
○ Unknown ○ <140 mg/dl ○ 140-159 ○ 160-179 ○ 180-199 ○ 200-219 ○ 220-239 ○ 240-269 ○ 270-299 ○ 300-329 ○ 300+ mg/dl

30. What is your current usual blood pressure?
Systolic: ○ Unknown ○ <105 mm Hg ○ 105-114 ○ 115-124 ○ 125-134 ○ 135-144 ○ 145-154 ○ 155-164 ○ 165-174 ○ 175+
Diastolic: ○ Unknown ○ <65 mm Hg ○ 65-74 ○ 75-84 ○ 85-89 ○ 90-94 ○ 95-104 ○ 105+

31. How frequently do you have a bowel movement?
○ More than once a day ○ Daily ○ Every other day ○ Every 3-4 days ○ Every 5-6 days ○ Once a week or less

32. How often do you use a laxative? (Include softeners, bulk agents and suppositories)
○ Daily ○ At least once a week ○ 1-4 times a month ○ Less than once a month ○ Never

33. Since January 1, 1998, have you had any of these fractures?
○ None ○ Hip (exclude pelvis) ○ Wrist (Colles or distal forearm)

If hip or wrist, please specify date and circumstances.
If a fall, include site, surface and height of fall. → Month __________ , 19 ______

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This question asks about your sexual function and sexual satisfaction. If you are using any erectile function treatment, please respond as if you were not on treatment. Many of the questions are very personal, but they will help us understand important issues that many men face. You may ignore any questions that you feel are too sensitive or personal.

34. A. Please rate your ability (without treatment) to have and maintain an erection good enough for intercourse for the following time periods:

	Very Poor	Poor	Fair	Good	Very Good
Before 1986	◯	◯	◯	◯	◯
1986–1989	◯	◯	◯	◯	◯
1990–1994	◯	◯	◯	◯	◯
1995 or later	◯	◯	◯	◯	◯
In the last 3 months	◯	◯	◯	◯	◯

B. How would you rate each of the following during the last 3 months?

	Very Poor	Poor	Fair	Good	Very Good
Your level of sexual desire?	◯	◯	◯	◯	◯
Your ability to reach orgasm (climax)?	◯	◯	◯	◯	◯

C. How would you describe the usual quality of your erections during the last 3 months?

◯ None at all ◯ Spontaneous morning erections only ◯ Not firm enough for any sexual activity
◯ Firm enough for masturbation and foreplay only ◯ Just firm enough for intercourse ◯ Full function

D. Overall, how big a problem has your sexual function been for you during the last 3 months?

◯ No problem ◯ Very small problem ◯ Small problem ◯ Moderate problem ◯ Big problem

E. Overall, how would you rate your ability to function sexually during the last 3 months?

◯ Very Poor ◯ Poor ◯ Fair ◯ Good ◯ Very Good

F. Have you ever had surgery or treatment to correct problems with erections?

◯ No ◯ Yes ➡ a. ◯ Penile Implant ◯ Vacuum Suction ◯ Testosterone
◯ Oral Medication (e.g., Viagra) ◯ MUSE ◯ Other

b. **During the past 3 months** have you had the following treatment to correct problems with erections?
◯ Viagra ◯ Shots or penile injection ◯ Vacuum Suction ◯ MUSE ◯ Other

G. If you have had a problem with erectile function, at what age did you first experience difficulty?

◯ No problem ◯ Before age 30 ◯ 30–39 ◯ 40–49 ◯ 50–59 ◯ 60–64 ◯ 65–69 ◯ 70–74 ◯ 75 or older

35. Have you ever suffered from head trauma with loss of consciousness?

◯ No ◯ Yes ➡ a. At what age? ◯ 0–9 ◯ 10–19 ◯ 20–29 ◯ 30–39 ◯ 40–49 ◯ 50–59 ◯ 60–69 ◯ 70–79 ◯ 80+
b. Cause? ◯ Car accident ◯ Sport injury ◯ Fall ◯ Other
c. How long did you lose consciousness? ◯ <15 minutes ◯ 15 min.– 1 hour ◯ >1 hour

36. Have you ever received a blood transfusion (exclude transfusions of your own blood)?

◯ No ◯ Yes ➡ a. Number of episodes? ◯ 1 ◯ 2 ◯ 3 ◯ 4 or more
b. Age at first transfusion? ◯ Before age 30 ◯ 30–34 ◯ 35–39 ◯ 40–44 ◯ 45–49 ◯ 50–54 ◯ 55–59 ◯ 60–64 ◯ 65–69 ◯ 70–74 ◯ 75–79 ◯ 80–84 ◯ 85+
c. Age at most recent transfusion? ◯ 30–34 ◯ 35–39 ◯ 40–44 ◯ 45–49 ◯ 50–54 ◯ 55–59 ◯ 60–64 ◯ 65–69 ◯ 70–74 ◯ 75–79 ◯ 80–84 ◯ 85+

37. How often do you think about your race?

◯ Never ◯ Once a year ◯ Once a month ◯ Once a week ◯ Once a day ◯ Once an hour ◯ Constantly

38. Do you have an unreasonable fear of being in enclosed spaces such as stores, elevators, etc.?

◯ Often ◯ Sometimes ◯ Never

39. Do you find yourself worrying about getting some incurable illness?

◯ Often ◯ Sometimes ◯ Never

40. Are you afraid of heights? ◯ Very ◯ Moderately ◯ Not at all

41. Do you feel panicky in crowds? ◯ Always ◯ Sometimes ◯ Never

42. Do you worry unduly when relatives are late coming home? ◯ Yes ◯ No

43. Do you feel more relaxed indoors? ◯ Definitely ◯ Sometimes ◯ Not particularly

44. Do you dislike going out alone? ◯ Yes ◯ No

45. Do you feel uneasy traveling on buses or trains, even if they are not crowded?

◯ Very ◯ A little ◯ Not at all

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

Name: ______________________ **Relationship:** ______________________

Address: ____

Thank you! Please return forms in prepaid return envelope to
Dr. Walter Willett, 677 Huntington Ave., Boston, MA 02115