VITATOPS STUDY FOLLOW-UP DATA FORM (7 Year)

Patient Initials: _____ VITATOPS No: _____ Today's Date: _____

Please write your current:

Address: _____ Phone Number: _____

_____

PLEASE CIRCLE YOUR RESPONSE TO THESE QUESTIONS

1. Did you have to see your doctor or go to hospital for **any** health problems in the last six months (for example, a stroke, heart attack or operations to open blood vessels)? Yes/No

   If yes, please complete the table below:

Health Incident 1: Date of Health Problem:	
Name of Doctor (if not seen in hospital) or Hospital:	
Doctor's Address & Phone Number:	
Specify the Health Problem:	

Health Incident 2: Date of Health Problem:	
Name of Doctor (if not seen in hospital) or Hospital:	
Doctor's Address & Phone Number:	
Specify the Health Problem:	

Health Incident 3: Date of Health Problem:	
Name of Doctor (if not seen in hospital) or Hospital:	
Doctor's Address & Phone Number:	
Specify the Health Problem:	

Please record any other health incidents (if more than 3) on the back of this page.

2. Did you have any surgery/procedure on your blood vessels in the last six months? Yes/No

   If yes, please specify the type of surgery/procedure_____

3. What is your current blood pressure? (if known) _____ / _____

Health Incident 4: Date of Health Problem:	
Name of Doctor (if not seen in hospital) or Hospital:	
Doctor's Address & Phone Number:	
Specify the Health Problem:	

Health Incident 5: Date of Health Problem:	
Name of Doctor (if not seen in hospital) or Hospital:	
Doctor's Address & Phone Number:	
Specify the Health Problem:	

Health Incident 6: Date of Health Problem:	
Name of Doctor (if not seen in hospital) or Hospital:	
Doctor's Address & Phone Number:	
Specify the Health Problem:	

4. Are you a current smoker? Yes / No
5. Do you have an abnormal heart rate (irregular pulse)? Yes / No
6. Do you have any heart problems (ischaemic heart disease) Yes / No
7. Do you have pain in the legs that is brought on by walking (due to poor blood supply)? Yes / No

8. Are you taking any medications for:

a) thinning the blood (for example aspirin, plavix, cardiprin) Yes / No

b) anti-coagulation (for example warfarin, coumadin) Yes / No

c) high blood pressure(for example coversyl, tritace) Yes / No

b) high cholesterol (for example zocor, lipitor, pravachol) Yes / No

e) diabetes (either diet controlled or medication) Yes / No

f) depression (for example sertraline) Yes / No

g) Are you currently taking medication for the 'Sertraline - Anti-depressant' trial? Yes / No

Please list below all the medications you are currently taking (dosage not required):

_____

_____

_____

9. On average, how many times per week have you been taking the VITATOPS trial medication since your last follow up? Please circle only ONE of the choices below.
   - (0) times per week
   - (1-2) times per week
   - (3-4) times per week
   - (5-6) times per week
   - (7) times per week

10. Did you **stop** taking the VITATOPS trial medication at all since the last follow-up?

Yes, temporarily Yes, permanently No

If Yes, please specify dates and reason for ceasing the VITATOPS trial medication

_____

11. Are you taking any alternative therapies, vitamins/minerals **other than** the VITATOPS trial medication? Yes / No

If yes, please specify the brand name of alternative therapies, vitamins/minerals

_____

12. Independence Score (0) (1) (2) (3) (4) (5)
(please refer to the back of this sheet for categories and circle your answer)

13. Have you been diagnosed with dementia since your last VITATOPS follow-up? Yes / No

14. Have you been treated for depression since your last VITATOPS follow-up? Yes / No

Please forward this completed form to the VITATOPS Trial Office in the stamped self-addressed envelope. Thank you for completing this form.

INDEPENDENCE SCORE

0) Complete recovery from your stroke, no symptoms

1) Minor symptoms that do not interfere with lifestyle

2) Symptoms that lead to some restriction in lifestyle but do not interfere with your capacity to look after yourself

3) Symptoms that significantly restrict your lifestyle, requiring a small amount of help, from someone else, with activities of daily living (e.g. eating, walking, showering or going to the toilet)

4) Symptoms that require a moderate amount of help from someone else, though not needing constant attention

5) Severe symptoms that require a lot of help from someone else, needing constant attention day and night