BIOMETRICS

What is your current weight without clothing ?
* must provide value

Whole number only

* must provide value
- Pounds (lbs)
- Kilograms (kg)

reset

What is your current height without shoes, measured in
* must provide value

- Feet & Inches
- Centimeters

reset

Enter values below

* must provide value
ft

* must provide value
in

* must provide value
cm

What was your average blood pressure for the past 6 months?

XXX/XX
mmHg

- I don't know my blood pressure

Have you had your blood cholesterol measured?
* must provide value

- Yes
- No
- I don't know

reset

Date of most recent results or diagnosis
* must provide value

MM/YYYY
Month/Year (as MM/YYYY)

Total Cholesterol (most recent result or diagnosis)
* must provide value

- Desirable (< 200 mg/dL)
- Borderline High (200-240 mg/dL)
- High (>240 mg/dL)
- Don't Know

reset

LDL Cholesterol (most recent result or diagnosis)
* must provide value

- Desirable (< 130 mg/dL)
- Borderline High (130-159 mg/dL)
- High (>160 mg/dL)
- Don't Know

reset

HDL Cholesterol (most recent result or diagnosis)
* must provide value

- Good (>50 mg/dL)
- Intermediate (35-50 mg/dL)
- At Risk (< 35 mg/dL)
- Don't Know

reset

Triglycerides (most recent result or diagnosis)
* must provide value

- Desirable (< 150 mg/dL)
- Borderline High (150-199 mg/dL)
- High (200-499 mg/dL)
- Very High (>=500 mg/dL)
- Don't Know

reset

HEALTH HISTORY - Diagnoses

HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?
(Check for Yes, if Yes, enter Date of Diagnosis & Recurrence Date if applicable)

Breast Cancer

- Yes

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Breast Cancer Date of Diagnosis
* must provide value
MM/YYYY
Month/Year (as MM/YYYY)

Breast Cancer Recurrence Date
MM/YYYY
Month/Year (as MM/YYYY)

Colon Cancer
☐ Yes

Colon Cancer Date of Diagnosis
* must provide value
MM/YYYY
Month/Year (as MM/YYYY)

Colon Cancer Recurrence Date
MM/YYYY
Month/Year (as MM/YYYY)

Melanoma
☐ Yes

Melanoma Cancer Date of Diagnosis
* must provide value
MM/YYYY
Month/Year (as MM/YYYY)

Melanoma Cancer Recurrence Date
MM/YYYY
Month/Year (as MM/YYYY)

Ovarian Cancer
☐ Yes

Ovarian Cancer Date of Diagnosis
* must provide value
MM/YYYY
Month/Year (as MM/YYYY)

Ovarian Cancer Recurrence Date
MM/YYYY
Month/Year (as MM/YYYY)

Prostate Cancer
☐ Yes

Prostate Cancer Date of Diagnosis
* must provide value
MM/YYYY
Month/Year (as MM/YYYY)

Prostate Cancer Recurrence Date
MM/YYYY
Month/Year (as MM/YYYY)

Other Cancer
☐ Yes

Other Cancer (Specify)

Other Cancer Date of Diagnosis
* must provide value
MM/YYYY
Month/Year (as MM/YYYY)

Other Cancer Recurrence Date
MM/YYYY
Month/Year (as MM/YYYY)

HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?
(Check for Yes; if Yes, enter Date of Diagnosis)

Alzheimers (and other dementias)
☐ Yes

Alzheimers Date of Diagnosis
* must provide value
MM/YYYY
Month/Year (as MM/YYYY)

Angina Pectoris
☐ Yes

Angina Pectoris Date of Diagnosis
* must provide value
MM/YYYY
Month/Year (as MM/YYYY)

Celiac Disease
☐ Yes

Celiac Diseases Date of Diagnosis
* must provide value
MM/YYYY
Month/Year (as MM/YYYY)

Chronic Fatigue
☐ Yes

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Chronic Fatigue Date of Diagnosis
* must provide value
MM/YYYY
Month/Year (as MM/YYYY)

Eczema or Serious Rash
☐ Yes

Eczema or Serious Rash Date of Diagnosis
* must provide value
MM/YYYY
Month/Year (as MM/YYYY)

Fibromyalgia
☐ Yes

Fibromyalgia Date of Diagnosis
* must provide value
MM/YYYY
Month/Year (as MM/YYYY)

Gluten Intolerance
☐ Yes

Gluten Intolerance Date of Diagnosis
* must provide value
MM/YYYY
Month/Year (as MM/YYYY)

Heart Attack
☐ Yes

Heart Attack Date of Diagnosis
* must provide value
MM/YYYY
Month/Year (as MM/YYYY)

Hypertension
☐ Yes

Hypertension Date of Diagnosis
* must provide value
MM/YYYY
Month/Year (as MM/YYYY)

Kidney Failure
☐ Yes

Kidney Failure Date of Diagnosis
* must provide value
MM/YYYY
Month/Year (as MM/YYYY)

Kidney Stones
☐ Yes

Kidney Stones Date of Diagnosis
* must provide value
MM/YYYY
Month/Year (as MM/YYYY)

Lactose Intolerance
☐ Yes

Lactose Intolerance Date of Diagnosis
* must provide value
MM/YYYY
Month/Year (as MM/YYYY)

Multiple Sclerosis
☐ Yes

Multiple Sclerosis Date of Diagnosis
* must provide value
MM/YYYY
Month/Year (as MM/YYYY)

Myasthenia Gravis
☐ Yes

Myasthenia Gravis Date of Diagnosis
* must provide value
MM/YYYY
Month/Year (as MM/YYYY)

Non-alcoholic Fatty Liver Disease
☐ Yes

Non-alcoholic Fatty Liver Disease Date of Diagnosis
* must provide value
MM/YYYY
Month/Year (as MM/YYYY)

Parkinsons
☐ Yes

Parkinsons Date of Diagnosis
* must provide value
MM/YYYY
Month/Year (as MM/YYYY)

Pneumonia
☐ Yes

Pneumonia Date of Diagnosis
MM/YYYY

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* must provide value

Month/Year (as MM/YYYY)

Stroke ☐ Yes

Stroke Date of Diagnosis
* must provide value
MM/YYYY
Month/Year (as MM/YYYY)

Type 1 Diabetes ☐ Yes

Type 1 Diabetes Date of Diagnosis
* must provide value
MM/YYYY
Month/Year (as MM/YYYY)

Type 2 Diabetes ☐ Yes

Type 2 Diabetes Date of Diagnosis
* must provide value
MM/YYYY
Month/Year (as MM/YYYY)

Other Disease ☐ Yes

Other Disease (Specify)
* must provide value

Other Date of Diagnosis
* must provide value
MM/YYYY
Month/Year (as MM/YYYY)

HEALTH HISTORY - Pregnancy

Have you had a pregnancy end, for any reason, within the last 6 months?
* must provide value
○ Yes
○ No
reset

End date
* must provide value
Today M-D-Y
MM-DD-YYYY

Was it a full term birth?
* must provide value
○ Yes
○ No
reset

What was the gestational age at birth?
* must provide value

What was the method of delivery?
* must provide value
○ Vaginal delivery
○ Cesarean section with labor
○ Cesarean section without labor
○ Miscarriage
reset

DURING THIS PAST PREGNANCY, DID YOU EXPERIENCE ANY OF THE FOLLOWING CONDITIONS OF PREGNANCY?
(check for 'Yes' and add Date of Diagnosis)

Gestational Diabetes ☐ Yes

Gestational Diabetes Date of Diagnosis
* must provide value
MM/YYYY
Month/Year (as MM/YYYY)

Pregnancy-induced Hypertension ☐ Yes

Pregnancy-induced Hypertension Date of Diagnosis
* must provide value
MM/YYYY
Month/Year (as MM/YYYY)

Pre-eclampsia ☐ Yes

Pre-eclampsia Date of Diagnosis
* must provide value
MM/YYYY
Month/Year (as MM/YYYY)

Eclampsia ☐ Yes

Eclampsia Date of Diagnosis
MM/YYYY

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* must provide value

Month/Year (as MM/YYYY)

HELLP Syndrome

Yes

HELLP Syndrome Date of Diagnosis

* must provide value

MM/YYYY

Month/Year (as MM/YYYY)

Pre-term Labor

Yes

Pre-term Labor Date of Diagnosis

* must provide value

MM/YYYY

Month/Year (as MM/YYYY)

HEALTH HISTORY - Pregnancy (Cont.)

Are you currently breastfeeding?

* must provide value

Yes
No

reset

Are you currently pregnant?

* must provide value

Yes
No

reset

Expected Due Date

* must provide value

Today M-D-Y

MM-DD-YYYY

FOR THIS CURRENT PREGNANCY, HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?
(Check for 'Yes')

Gestational Diabetes

Yes

Pregnancy-induced Hypertension

Yes

Pre-eclampsia

Yes

Eclampsia

Yes

HELLP Syndrome

Yes

Pre-term Labor

Yes

RECENT HEALTH HISTORY

In the last 6 months have you fallen?

* must provide value

Yes
No

reset

If yes, how many times?

* must provide value

In the last 6 months have you broken a bone?

* must provide value

Yes
No

reset

If yes, how many times?

* must provide value

If yes, specify which bone(s)

* must provide value

If yes, specify reason

* must provide value

In the last 6 months have you had a cold lasting at least 3 days?

* must provide value

Yes
No

reset

If yes, how many times did you have a cold?

* must provide value

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In the last 6 months have you had the flu with fever?
* must provide value
Yes
No
reset

If yes, how many times did you have the flu?
* must provide value

In the last 6 months, on a regular basis (ie. more than once per week), have you experienced joint discomfort or stiffness?
* must provide value
Yes
No
reset

In which joints did you experience discomfort or stiffness?
* must provide value

Rate your average discomfort or stiffness on a scale from 1-10 (1=minor, 10=major)
* must provide value
1 (minor) 5 10 (major)
Click bar above and then drag to set response
reset

Reason if known

In the last 6 months have you had any other pain?
* must provide value
Yes
No
reset

Body part affected
* must provide value

Pain Rating ([pain_body_part1])
* must provide value
1 (minor) 5 10 (major)
Click bar above and then drag to set response
reset

Reason if known ([pain_body_part1] pain)

Is this a chronic pain lasting at least 12 weeks?
* must provide value
Yes
No
reset

In the last 6 months have you had any other pain?
* must provide value
Yes
No
reset

Body part affected (2)
* must provide value

Pain Rating ([pain_body_part2])
* must provide value
1 (minor) 5 10 (major)
Click bar above and then drag to set response
reset

Reason if known ([pain_body_part2] pain)

Is this a chronic pain lasting at least 12 weeks?
* must provide value
Yes
No
reset

In the last 6 months have you had any other pain?
* must provide value
Yes
No
reset

Body part affected (3)
* must provide value

Pain Rating ([pain_body_part3])
1 (minor) 5 10 (major)

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* must provide value

Click bar above and then drag to set response

reset

Reason if known ([pain_body_part3] pain)

Is this a chronic pain lasting at least 12 weeks?

* must provide value

- Yes
- No

reset

If you have regularly monitored your blood pressure, have you noticed a change over the last 6 months?

* must provide value

- Clear improvement
- Some improvement
- Unchanged
- Some worsening
- Clear worsening
- Don't know
- I do not regularly monitor my blood pressure

reset

In the last 6 months, have you noticed a change in your cognitive function or memory?

* must provide value

- Clear improvement
- Some improvement
- Unchanged
- Some worsening
- Clear worsening
- Don't know

reset

In the last 6 months, have you noticed a change in your overall mood (depression, anxiety, etc.)?

* must provide value

- Clear improvement
- Some improvement
- Unchanged
- Some worsening
- Clear worsening
- Don't know

reset

In the last 6 months, have you had a menstrual period?

* must provide value

- Yes
- No

reset

Over the last 6 months, have you noticed a change in your:

	clear improvement	some improvement	unchanged	some worsening	clear worsening	don't know
Menstrual Cramping * must provide value	○	○	○	○	○	○
Duration of Menstrual Period * must provide value	○	○	○	○	○	○
Regularity of Menstrual Period * must provide value	○	○	○	○	○	○

reset

reset

reset

Over the last 6 months, what was the average duration of your menstrual period (from the start of menstrual flow to the end)?

* must provide value

days

Over the last 6 months, what was the average duration of your menstrual cycle (from the start of one period to the start of the next)?

* must provide value

days

MEDICATIONS

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Do you currently take, or have you taken within the last month, any of the following medications?

* must provide value

- [ ] **Statins** (such as atorvastatin (Lipitor), fluvastatin (Lescol, Lescol XL), lovastatin (Mevacor, Altoprev), pravastatin (Pravachol), rosuvastatin (Crestor), simvastatin (Zocor), or pitavastatin (Livalo))
- [ ] **Fibrates** (such as gemfibrozil (Lopid), or fenofibrate (Tricor))
- [ ] **Nicotinic acid**
- [ ] I have not taken any of the above medications in the last month

Are you a regular user (ie. more than once per week) of over the counter NSAIDS such as Aspirin, Advil, Motrin, Ibuprofen, Aleve, Anaprox, Naprosyn, etc. (BUT NOT including acetaminophen or Tylenol products)

* must provide value

- ( ) Yes
- ( ) No

reset

Please indicate your average daily dose over the last 3 months

* must provide value

mg/day

Are you currently taking any prescription-only NSAID medication, such as Celebrex, Catafla, Voltaren, Zipsor, Diflunisal, Etodolac, Fenoprofen, Flurbiprofen, Indomethacin, Ketoprofen, Meclofenamate, Ponstel, Mobic, Nabumetone, Daypro, Piroxicam, Feldene, Suldinac, Clinoril, Tolmetin, etc.?

* must provide value

- ( ) Yes
- ( ) No

reset

Please indicate your average daily dose over the last 3 months

* must provide value

mg/day

Over the last 3 months, have you started or stopped taking any type of hormone therapy or birth control pills?

* must provide value

- ( ) Yes
- ( ) No

reset

DIET AND SUPPLEMENTS

During the past 6 months, did you take any vitamin D supplements?

* must provide value

- ( ) Yes
- ( ) No

reset

Brand Name (Vitamin D Supplement #1)

* must provide value

- ( ) Bio-Tech Pharmacal
- ( ) Biotics Research
- ( ) Carlson
- ( ) Country Life
- ( ) Healthy Origins
- ( ) Kirkland
- ( ) Life Extension
- ( ) Mercola
- ( ) Nature Made
- ( ) Nature's Bounty
- ( ) Now
- ( ) Pure Encapsulations
- ( ) Puritans Pride
- ( ) Swanson
- ( ) Vitacost
- ( ) Other
- ( ) Don't Know

reset

Brand Name - Other

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* must provide value

Type of Vitamin D supplement
* must provide value

- Liquid (including drops or sprays)
- Liquid-filled capsule
- Powder or powder-filled capsule
- Pill/tablet
- Gummy
- Sublingual or lozenge
- Topical patch or cream

reset

Typical dose per day when taken (IU/day)
* must provide value

IU - no commas or decimals

How often did you generally take this supplement, in this amount?
* must provide value

- Every day
- Most days (4-6 days/week)
- Some days (2-3 days/week)
- Once a week
- Once every 2 weeks
- Once a month
- Inconsistently (or infrequently)
- Other (specify)

reset

Supplement frequency: Other
* must provide value

Have you taken this vitamin D supplement
* must provide value

- For the entire past 6 months
- More than 4 months, but less than 6
- More than 2 months, but less than 4
- More than 1 month, but less than 2
- Started taking it within the past month

reset

Have you taken any other supplements that included vitamin D during the past 6 months?
* must provide value

- Yes
- No

reset

Brand Name (Supplement #2)
* must provide value

Product Name (Supplement #2)
* must provide value

Type of Supplement
* must provide value

- Liquid (including drops or sprays)
- Liquid-filled capsule
- Powder or powder-filled capsule
- Pill/tablet
- Gummy
- Sublingual or lozenge
- Topical patch or cream

reset

Amount of vitamin D per daily dose when taken (IU/day)
* must provide value

IU - no commas or decimals

How often did you generally take this supplement, in this amount?

- Every day
- Most days (4-6 days/week)
- Some days (2-3 days/week)
- Once a week
- Once every 2 weeks

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* must provide value

- Once a month
- Inconsistently (or infrequently)
- Other (specify)

reset

Supplement frequency: Other

* must provide value

Have you taken this supplement

* must provide value

- For the entire past 6 months
- More than 4 months, but less than 6
- More than 2 months, but less than 4
- More than 1 month, but less than 2
- Started taking it within the past month

reset

Have you taken any other supplements that included vitamin D during the past 6 months?

* must provide value

- Yes
- No

reset

Brand Name (Supplement #3)

* must provide value

Product Name (Supplement #3)

* must provide value

Type of supplement

* must provide value

- Liquid (including drops or sprays)
- Liquid-filled capsule
- Powder or powder-filled capsule
- Pill/tablet
- Gummy
- Sublingual or lozenge
- Topical patch or cream

reset

Amount of vitamin D per daily dose when taken (IU/day)

* must provide value

IU - no commas or decimals

How often did you generally take this supplement, in this amount

* must provide value

- Every day
- Most days (4-6 days/week)
- Some days (2-3 days/week)
- Once a week
- Once every 2 weeks
- Once a month
- Inconsistently (or infrequently)
- Other (specify)

reset

Supplement frequency: Other

* must provide value

Have you taken this supplement

* must provide value

- For the entire past 6 months
- More than 4 months, but less than 6
- More than 2 months, but less than 4
- More than 1 month, but less than 2
- Started taking it within the past month

reset

In the past 2 months, have you taken an extra-large dose of vitamin D?

* must provide value

- Yes
- No

reset

What was the dose? (IU/day)

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* must provide value

IU/day - no commas or decimals

How many days did you take that dose?

* must provide value

days

How long ago did you take it?

* must provide value

- Within the past week
- 1-2 weeks ago
- 2-4 weeks ago
- 4-6 weeks ago
- More than 6 weeks ago

reset

OMEGA 3 SUPPLEMENTATION

Please answer the following questions for any omega 3 supplements taken within the last 6 months. If you took more than one omega 3 supplement, complete each set of questions for your 3 most recent omega 3 products.

During the past 6 months, did you take any supplements containing omega 3 fatty acids? (Please include any supplements containing long chain omega 3 fatty acids, marine omega 3 fatty acids, or other omega 3 fatty acids)

* must provide value

- Yes
- No

reset

***(Omega 3 Supplement #1)* Brand Name**

* must provide value

***(Omega 3 Supplement #1)* Product Name or Title**

* must provide value

***(Omega 3 Supplement #1)* Type of supplement**

* must provide value

- Liquid
- Softgels or liquid-filled capsules
- Powder-filled capsules
- Pills/tablets
- Gummies
- Sublinguals or lozenges
- Topical patch or cream
- Other (specify)

reset

***([o3_brand1] [o3_prod1])* Type of supplement - Specify**

* must provide value

***([o3_brand1] [o3_prod1])* How do you usually measure your liquid supplement when taken?**

* must provide value

- Drops
- Droppers full
- Tablespoons
- teaspoons
- ml
- Ounces
- Sprays
- Other (as specified)

reset

***([o3_brand1] [o3_prod1])* Liquid measurement when taken - Specify**

* must provide value

***([o3_brand1] [o3_prod1])* What was the typical amount taken or used per day? (for example, enter "2" if you usually took 2 softgels, gummies, or teaspoons each day)**

* must provide value

Please enter a number value only

- Every day
- Most days (4-6 days/week)
- Some days (2-3 days/week)

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([o3_brand1] [o3_prod1]) **How often did you generally take this supplement, in this amount?**

* must provide value

- Once a week
- Once every 2 weeks
- Once a month
- Inconsistently (or infrequently)
- Other (specify)

reset

Supplement frequency: Other

* must provide value

([o3_brand1] [o3_prod1]) **Have you taken this supplement**

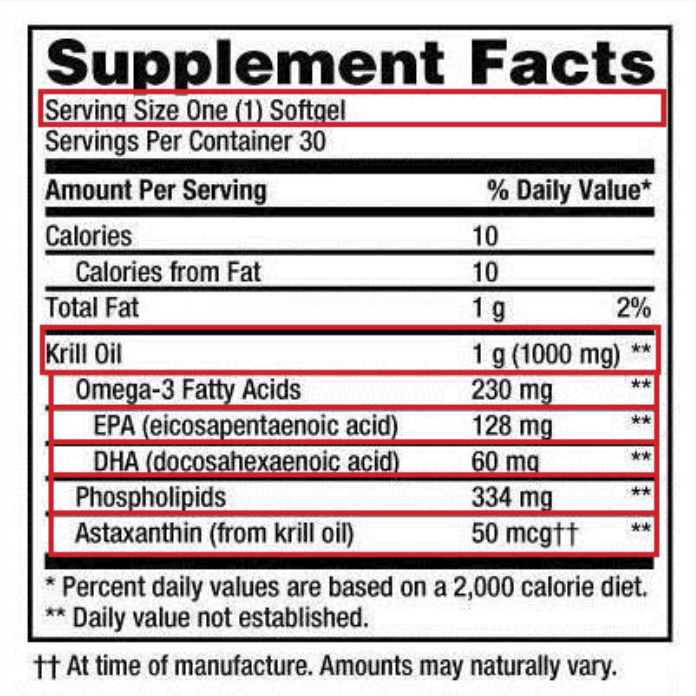
* must provide value

- For the entire past 6 months
- More than 4 months, but less than 6
- More than 2 months, but less than 4
- More than 1 month, but less than 2
- Started taking it within the past month

reset

For the following section, please refer to the label on your [o3_brand1] [o3_prod1] supplement bottle for information (see picture below for example).

Example Image:



Supplement Facts

Serving Size One (1) Softgel	
Servings Per Container 30	
Amount Per Serving	**% Daily Value***
Calories	10
Calories from Fat	10
Total Fat	1 g 2%
Krill Oil	1 g (1000 mg) **
Omega-3 Fatty Acids	230 mg **
EPA (eicosapentaenoic acid)	128 mg **
DHA (docosahexaenoic acid)	60 mg **
Phospholipids	334 mg **
Astaxanthin (from krill oil)	50 mcg†† **

* Percent daily values are based on a 2,000 calorie diet.
** Daily value not established.

†† At time of manufacture. Amounts may naturally vary.

([o3_brand1] [o3_prod1]) **What is the serving size or amount referenced on the supplement's nutrition label? (for example, enter "1" if the serving size is 1 softgel, capsule or other.)**

* must provide value

Please enter a number value only

([o3_brand1] [o3_prod1]) **What is the serving size unit of measure shown on the label for this liquid supplement?**

* must provide value

- Drops
- Droppers full
- Tablespoons
- teaspoons
- ml
- Ounces
- Sprays
- Other (as specified)

reset

([o3_brand1] [o3_prod1]) **Liquid Serving Size Unit of Measure - Other (Specify)**

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Other (Specify)

* must provide value

([o3_brand1] [o3_prod1]) **Type(s) of oil in supplement (as listed on the nutrition label or in the ingredients list)**

* must provide value

- [ ] Fish Oil
- [ ] Fish Oil Concentrate
- [ ] Cod Liver Oil
- [ ] Krill Oil
- [ ] Algal Oil
- [ ] Calamari Oil
- [ ] Flaxseed Oil
- [ ] Other (Specify)
- [ ] None Listed

([o3_brand1] [o3_prod1]) **Type of oil: Specify**

* must provide value

([o3_brand1] [o3_prod1]) **For each of the following, check "Listed" or "Not Listed" to indicate if it is listed on the nutrition fact label of your supplement bottle. If it is listed, enter the per serving amount (exactly as listed on the label).**

Total Supplemental Oil (such as Fish Oil, Krill Oil, Flaxseed Oil, etc.)

* must provide value

- ( ) Listed
- ( ) Not Listed

reset

Amount of Total Supplemental Oil listed on the label

* must provide value

Total Supplemental Oil unit of measure

* must provide value

- ( ) g
- ( ) mg

reset

Omega 3-fatty acids/Total Omega-3s

* must provide value

- ( ) Listed
- ( ) Not Listed

reset

Omega 3-fatty acids/Total Omega-3 amount listed on the label

* must provide value

mg

Total EPA and DHA (if listed together)

* must provide value

- ( ) Listed
- ( ) Not Listed

reset

Total EPA and DHA amount listed on the label

* must provide value

mg

EPA (listed separately from DHA)

* must provide value

- ( ) Listed
- ( ) Not Listed

reset

EPA amount listed on the label

* must provide value

mg

DHA (listed separately from EPA)

* must provide value

- ( ) Listed
- ( ) Not Listed

reset

DHA amount listed on the label

* must provide value

mg

ALA

* must provide value

- ( ) Listed
- ( ) Not Listed

reset

ALA amount listed on the label

* must provide value

mg

SDA

- ( ) Listed

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* must provide value

- Not Listed

reset

SDA amount listed on the label

* must provide value

mg

Phospholipids

* must provide value

- Listed
- Not Listed

reset

Phospholipid amount listed on the label

* must provide value

mg

Astaxanthin

* must provide value

- Listed
- Not Listed

reset

Astaxanthin amount listed on the label

* must provide value

Astaxanthin unit of measure

* must provide value

- mg
- mcg

reset

Other Omega 3 Listed on the Label (Specify Name)

Other Omega 3 amount listed on the label

mg

(Optional) Upload a picture of your label here

Upload document

Have you taken any other supplements that included Omega 3s during the past 6 months?

* must provide value

- Yes
- No

reset

***(Omega 3 Supplement #2)* Brand Name**

* must provide value

***(Omega 3 Supplement #2)* Product Name**

* must provide value

***(Omega 3 Supplement #2)* Type of supplement**

* must provide value

- Liquid
- Softgels or liquid-filled capsules
- Powder-filled capsules
- Pills/tablets
- Gummies
- Sublinguals or lozenges
- Topical patch or cream
- Other (specify)

reset

***([o3_brand2] [o3_prod2])* Type of supplement - Specify**

* must provide value

***([o3_brand2] [o3_prod2])* How do you usually measure your liquid supplement when taken?**

* must provide value

- Drops
- Droppers full
- Tablespoons
- teaspoons
- ml
- Ounces
- Sprays
- Other (as specified)

reset

***([o3_brand2] [o3_prod2])* Liquid measurement when taken - Specify**

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Specify

* must provide value

([o3_brand2] [o3_prod2]) **What was the typical amount taken or used per day? (for example, enter "2" if you usually took 2 softgels, gummies, or teaspoons each day)**

* must provide value

Please enter a number value only.

([o3_brand2] [o3_prod2]) **How often did you generally take this supplement, in this amount?**

* must provide value

- Every day
- Most days (4-6 days/week)
- Some days (2-3 days/week)
- Once a week
- Once every 2 weeks
- Once a month
- Inconsistently (or infrequently)
- Other (specify)

reset

Supplement frequency: Other

* must provide value

([o3_brand2] [o3_prod2]) **Have you taken this supplement**

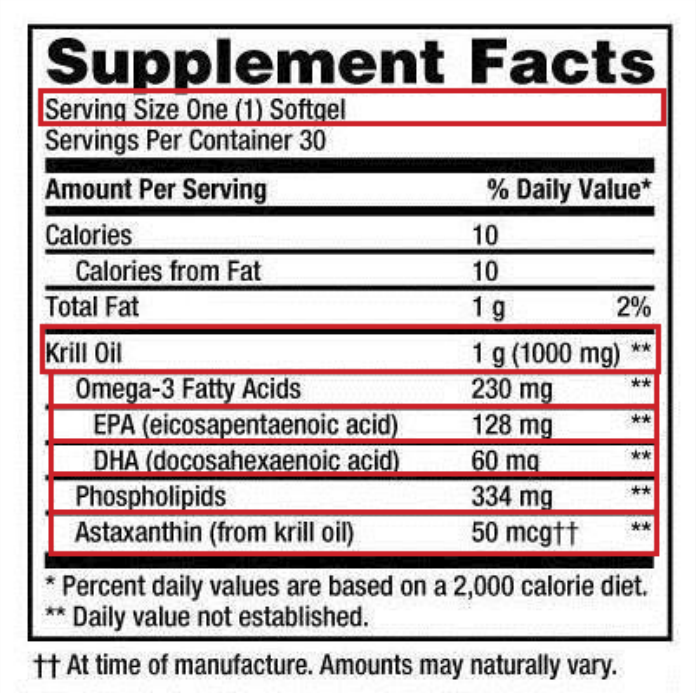
* must provide value

- For the entire past 6 months
- More than 4 months, but less than 6
- More than 2 months, but less than 4
- More than 1 month, but less than 2
- Started taking it within the past month

reset

For the following section, please refer to the label on your [o3_brand2] [o3_prod2] supplement bottle for information.

Example Image:



Supplement Facts

Serving Size One (1) Softgel
Servings Per Container 30

Amount Per Serving		% Daily Value*
Calories	10	
Calories from Fat	10	
Total Fat	1 g	2%
Krill Oil	1 g (1000 mg)	**
Omega-3 Fatty Acids	230 mg	**
EPA (eicosapentaenoic acid)	128 mg	**
DHA (docosahexaenoic acid)	60 mg	**
Phospholipids	334 mg	**
Astaxanthin (from krill oil)	50 mcg††	**

* Percent daily values are based on a 2,000 calorie diet.
** Daily value not established.

†† At time of manufacture. Amounts may naturally vary.

([o3_brand2] [o3_prod2]) **What is the serving size or amount referenced on the supplement's nutrition label? (for example, enter "1" if the serving size is 1 softgel, capsule or other.)**

* must provide value

Please enter a number value only

- Drops
- Droppers full

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([o3_brand2] [o3_prod2]) **What is the serving size unit of measure for this liquid supplement?**

* must provide value

- Tablespoons
- teaspoons
- ml
- Ounces
- Sprays
- Other (as specified)

reset

([o3_brand2] [o3_prod2]) **Liquid Serving Size Unit of Measure - Other (Specify)**

* must provide value

([o3_brand2] [o3_prod2]) **Type(s) of oil in supplement (as listed on the nutrition label)**

* must provide value

- [ ] Fish Oil
- [ ] Fish Oil Concentrate
- [ ] Cod Liver Oil
- [ ] Krill Oil
- [ ] Algal Oil
- [ ] Calamari Oil
- [ ] Flaxseed Oil
- [ ] Other (Specify)
- [ ] None Listed

([o3_brand2] [o3_prod2]) **Type of oil: Specify**

* must provide value

([o3_brand2] [o3_prod2]) **For each of the following, check "Listed" or "Not Listed" to indicate if it is listed on the nutrition fact label of your supplement bottle. If it is listed, enter the per serving amount (exactly as listed on the label).**

Total Supplemental Oil (such as Fish Oil, Krill Oil, Flaxseed Oil, etc.)

* must provide value

- Listed
- Not Listed

reset

Amount Total Supplemental Oil listed on the label

* must provide value

Supplemental Oil unit of measure

* must provide value

- g
- mg

reset

Omega 3-fatty acids/Total Omega-3s

* must provide value

- Listed
- Not Listed

reset

Omega 3-fatty acids/Total Omega-3 amount listed on the label

* must provide value

mg

Total EPA and DHA (if listed together)

* must provide value

- Listed
- Not Listed

reset

Total EPA and DHA amount listed on the label

* must provide value

mg

EPA (listed separately from DHA)

* must provide value

- Listed
- Not Listed

reset

EPA amount listed on the label

* must provide value

mg

DHA (listed separately from EPA)

* must provide value

- Listed
- Not Listed

reset

DHA amount listed on the label

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DHA amount listed on the label
* must provide value
mg

ALA
* must provide value
- Listed
- Not Listed

reset

ALA amount listed on the label
* must provide value
mg

SDA
* must provide value
- Listed
- Not Listed

reset

SDA amount listed on the label
* must provide value
mg

Phospholipids
* must provide value
- Listed
- Not Listed

reset

Phospholipid amount listed on the label
* must provide value
mg

Astaxanthin
* must provide value
- Listed
- Not Listed

reset

Astaxanthin amount listed on the label
* must provide value

Astaxanthin unit of measure
* must provide value
- mg
- mcg

reset

Other Omega 3 Listed on the Label (Specify Name)

Other Omega 3 amount listed on the label
mg

(Optional) Upload a picture of your label here
Upload document

Have you taken any other supplements that included Omega 3s during the past 6 months?
* must provide value
- Yes
- No

reset

***(Omega 3 Supplement #3)* Brand Name**
* must provide value

***(Omega 3 Supplement #3)* Product Name**
* must provide value

***(Omega 3 Supplement #3)* Type of supplement**
* must provide value
- Liquid
- Softgels or liquid-filled capsules
- Powder-filled capsules
- Pills/tablets
- Gummies
- Sublinguals or lozenges
- Topical patch or cream
- Other (specify)

reset

***([o3_brand3] [o3_prod3])* Type of supplement - Specify**
* must provide value

- Drops
- Droppers full

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***([o3_brand3] [o3_prod3])* How do you usually measure your liquid supplement when taken?**

* must provide value

- Tablespoons
- teaspoons
- ml
- Ounces
- Sprays
- Other (as specified)

reset

***([o3_brand3] [o3_prod3])* Liquid measurement when taken - Specify**

* must provide value

***([o3_brand3] [o3_prod3])* What was the typical amount taken or used per dayt? (for example, enter "2" if you usually took 2 softgels, gummies, or teaspoons each day)**

* must provide value

Please enter a number value only.

***([o3_brand3] [o3_prod3])* How often did you generally take this supplement, in this amount?**

* must provide value

- Every day
- Most days (4-6 days/week)
- Some days (2-3 days/week)
- Once a week
- Once every 2 weeks
- Once a month
- Inconsistently (or infrequently)
- Other (specify)

reset

Supplement frequency: Other

* must provide value

***([o3_brand3] [o3_prod3])* Have you taken this supplement**

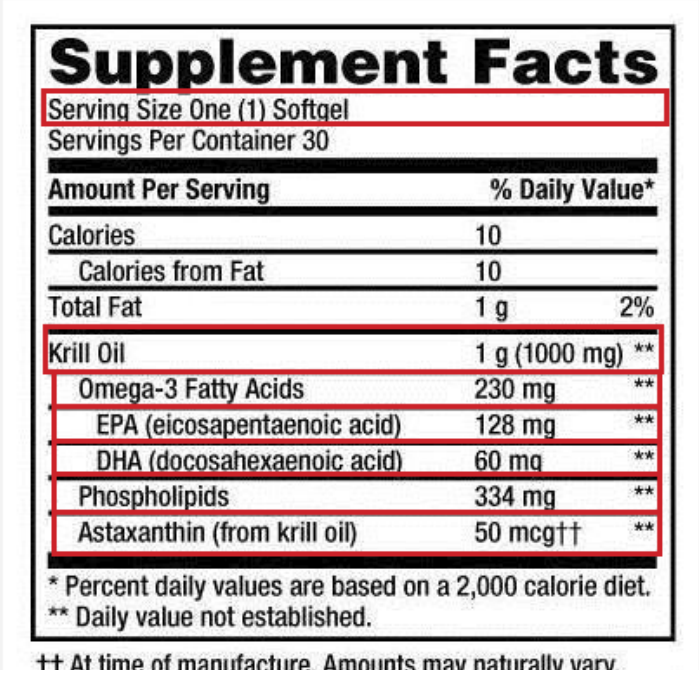
* must provide value

- For the entire past 6 months
- More than 4 months, but less than 6
- More than 2 months, but less than 4
- More than 1 month, but less than 2
- Started taking it within the past month

reset

For the following section, please refer to the label on your [o3_brand3] [o3_prod3] supplement bottle for information.

Example Image:



Supplement Facts

Serving Size One (1) Softgel
Servings Per Container 30

Amount Per Serving		% Daily Value*
Calories	10	
Calories from Fat	10	
Total Fat	1 g	2%
Krill Oil	1 g (1000 mg)	**
Omega-3 Fatty Acids	230 mg	**
EPA (eicosapentaenoic acid)	128 mg	**
DHA (docosahexaenoic acid)	60 mg	**
Phospholipids	334 mg	**
Astaxanthin (from krill oil)	50 mcg††	**

* Percent daily values are based on a 2,000 calorie diet.
** Daily value not established.

†† At time of manufacture. Amounts may naturally vary

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([o3_brand3] [o3_prod3]) **What is the serving size or amount referenced on the supplement's nutrition label? (for example, enter "1" if the serving size is 1 softgel, capsule or other.)**

Please enter a number value only

* must provide value

([o3_brand3] [o3_prod3]) **What is the serving size unit of measure for this liquid supplement?**

- Drops
- Droppers full
- Tablespoons
- teaspoons
- ml
- Ounces
- Sprays
- Other (as specified)

* must provide value

reset

([o3_brand3] [o3_prod3]) **Liquid Serving Size Unit of Measure - Other (Specify)**

* must provide value

([o3_brand3] [o3_prod3]) **Type(s) of oil in supplement (as listed on the nutrition label)**

- Fish Oil
- Fish Oil Concentrate
- Cod Liver Oil
- Krill Oil
- Algal Oil
- Calamari Oil
- Flaxseed Oil
- Other (Specify)
- None Listed

* must provide value

([o3_brand3] [o3_prod3]) **Type of oil: Specify**

* must provide value

([o3_brand3] [o3_prod3]) **For each of the following, check "Listed" or "Not Listed" to indicate if it is listed on the nutrition fact label of your supplement bottle. If it is listed, enter the per serving amount (exactly as listed on the label).**

Total Supplemental Oil (such as Fish Oil, Krill Oil, Flaxseed Oil, etc.)

- Listed
- Not Listed

* must provide value

reset

Amount Total Supplemental Oil listed on the label

* must provide value

Total Supplemental Oil unit of measure

- g
- mg

* must provide value

reset

Omega 3-fatty acids/Total Omega-3s

- Listed
- Not Listed

* must provide value

reset

Omega 3-fatty acids/Total Omega-3 amount listed on the label

mg

* must provide value

Total EPA and DHA (if listed together)

- Listed
- Not Listed

* must provide value

reset

Total EPA and DHA amount listed on the label

mg

* must provide value

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EPA (listed separately from DHA)
* must provide value
○ Listed
○ Not Listed
reset

EPA amount listed on the label
* must provide value
mg

DHA (listed separately from EPA)
* must provide value
○ Listed
○ Not Listed
reset

DHA amount listed on the label
* must provide value
mg

ALA
* must provide value
○ Listed
○ Not Listed
reset

ALA amount listed on the label
* must provide value
mg

SDA
* must provide value
○ Listed
○ Not Listed
reset

SDA amount listed on the label
* must provide value
mg

Phospholipids
* must provide value
○ Listed
○ Not Listed
reset

Phospholipid amount listed on the label
* must provide value
mg

Astaxanthin
* must provide value
○ Listed
○ Not Listed
reset

Astaxanthin amount listed on the label
* must provide value

Astaxanthin unit of measure
* must provide value
○ mg
○ mcg
reset

Other Omega 3 Listed on the Label (Specify Name)

Other Omega 3 amount listed on the label
mg

(Optional) Upload a picture of your label here
Upload document

DIET AND SUPPLEMENTS (CONT.)

DURING THE PAST 6 MONTHS, ON AVERAGE, PLEASE INDICATE YOUR INTAKE OF THE FOLLOWING SUPPLEMENTS:

Vitamin A (as retinol or retinyl palmitate)
* must provide value
IU - no commas or decimals; Enter '0' for none.

Calcium
* must provide value
mg - no commas or decimals; Enter '0' for none.

Vitamin K2
* must provide value
mcg; no commas or decimals; Enter '0' for none.

Vitamin B12
No commas or decimals; Enter '0' for none.
○ mcg
○ mg

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- mcg/mL
- I don't know how much

reset

Vitamin C

No commas or decimals; Enter '0' for none.

- mg
- g
- I don't know how much

reset

Magnesium

mg; no commas or decimals; Enter '0' for none.

- I don't know how much

reset

What form(s) of magnesium did you usually take?

- Magnesium Amino Acid Chelate
- Magnesium Carbonate
- Magnesium Chloride
- Magnesium Citrate
- Magnesium Glycinate
- Magnesium Hydroxide
- Magnesium Lactate
- Magnesium Orotate
- Magnesium Oxide
- Magnesium Sulfate
- Magnesium Taurate
- Magnesium Threonate
- I don't know

During the last 6 months, which of the following additional nutrients did you take on a regular basis? (check all that apply)

* must provide value

- Iron
- Probiotics
- Vitamin A (as beta carotene)
- Vitamin B1/Thiamin
- Vitamin B2/Riboflavin
- Vitamin B3/Niacin
- Vitamin B5/Pantothenic Acid
- Vitamin B9/Folic Acid
- Vitamin E
- Vitamin K1
- Zinc
- All of the Above
- None of the Above
- I don't know

Do you consider yourself to be a

* must provide value

- Strict vegetarian (does not eat meat or some other animal products)
- Lacto/ovo vegetarian (a person who eats vegetables, eggs, and dairy products but who does not eat meat)
- Vegan (a person who does not eat or use any animal products)
- None of the above

reset

- 0

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How many meals containing fatty/oily fish do you normally have per week, such as salmon, mackerel, herring, sardines or tuna?

* must provide value

- 1
- 2
- 3
- 4
- More than 4
- I don't know

reset

Which fish do you normally eat? (Such as salmon, anchovies, tuna, trout, mahi mahi, etc.)

* must provide value

How many meals containing plant-based omega 3s do you normally have per week, such as flaxseed, flaxseed oil, chia seeds or walnuts?

* must provide value

- 0
- 1
- 2
- 3
- 4
- More than 4
- I don't know

reset

On average, during the past 12 months, approximately how many minutes per day have you spent outdoors in the sun between 10:00 am and 2:00 pm?

	None	1-14 minutes	15-29 minutes	30 minutes - 1 hour	1-2 hours	2-4 hours
April - June * must provide value						
July - September * must provide value						
October - December * must provide value						
January - March * must provide value						

reset

Describe your usual clothing when outdoors in the sun between 10:00 am and 2:00 pm during each season during the past 12 months.

	Shorts and no or very brief top with shoulders exposed	Shorts and T-shirt or similar top	Shorts and long sleeves	Long pants and T-shirt or similar top	Long pants and long sleeves
April - June * must provide value					
July - September * must provide value					
October - December * must provide value					
January - March * must provide value					

reset

Excluding your face and neck, describe your usual use of sunscreen when outdoors in the sun between 10:00 AM and 2:00 PM during each season during the past 12 months.

	I almost never	I used it occasionally	I used it somewhat regularly (20-	I used it most of the time	I used it almost all of the time (80-	I used it all

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	used sunscreen	(5-20% of the time)	50% of the time)	(50-80% of the time)	95% of the time)	the time (95-100%)
April - June * must provide value	○	○	○	○	○	○
reset						
July - September * must provide value	○	○	○	○	○	○
reset						
October - December * must provide value	○	○	○	○	○	○
reset						
January - March * must provide value	○	○	○	○	○	○
reset						

Excluding your face and neck, what SPF sunscreen did you usually use during the past 12 months?

* must provide value

○ 4 ○ 8 ○ 10 ○ 15 ○ 20 ○ 30 ○ 40 ○ 50 ○ 60+ ○ None ○ Don't Know

reset

SPF sunscreen level

During the past 6 months

* must provide value

- ○ I have not used indoor tanning equipment
- ○ I have received UV exposure from indoor tanning just a few times (1-5 times in six months)
- ○ I have received UV exposure from indoor tanning regularly (1-3 tanning visits a week on average)

reset

Enter your occupation during the past 6 months below. If you are retired, specify the occupation you were in for most of your life.

* must provide value

☐ I am currently retired.

During the past 2 months, have you been to a place other than where you live today, such as on a vacation or a work assignment, for 7 days or longer?

* must provide value

- ○ Yes, vacation
- ○ Yes, work assignment
- ○ Yes, both
- ○ Yes, other reason
- ○ No

reset

(Location #1) City / Town (or that nearest to location)

* must provide value

(Location #1) State / Province / Region

* must provide value

(Location #1) Country

* must provide value

(Location #1) Number of days

* must provide value

(Location #2) City / Town (or that nearest to location)

(Location #2) State / Province / Region

(Location #2) Country

(Location #2) Number of days

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(Location #3) City / Town

(Location #3) State / Province / Region

(Location #3) Country

(Location 3) Number of days

PHYSICAL ACTIVITY

During the past 6 months, which forms of exercise did you typically engage in for at least 20 minutes per day, 3 or more times per week? (Choose all that apply)

* must provide value

- [ ] Mild physical activity such as gardening, walking or biking
- [ ] Moderate physical activity to the point where you usually break a sweat
- [ ] Strenuous physical activity to the point where you always break a sweat
- [ ] Less than or none of the above
- [ ] Other (specify)
- [ ] Don't know

Physical activity - Other

* must provide value

SMOKING

Have you ever smoked a total of 100 or more cigarettes in your whole lifetime?

* must provide value

- ( ) Yes
- ( ) No
- ( ) Don't Know

reset

How many cigarettes did you usually smoke per day?

* must provide value

cigarettes

What age were you when you started regularly smoking 5 or more cigarettes per day?

* must provide value

(enter "99" for don't know)

Do you currently smoke cigarettes?

* must provide value

- ( ) Yes
- ( ) No
- ( ) Don't Know

reset

If yes, how many cigarettes do you currently smoke per day?

* must provide value

cigarettes

If you no longer smoke cigarettes, what age were you when you finally quit smoking?

* must provide value

(enter "99" for don't know)

Does anyone currently smoke cigarettes in your presence for at least 30 minutes per day on average?

* must provide value

- ( ) Yes
- ( ) No

reset

ALCOHOL

Have you had any drinks containing alcohol during the past 6 months?

* must provide value

- ( ) Yes
- ( ) No
- ( ) Don't Know

reset

If yes, mark the average number of drinks during a typical week (Monday through Sunday); 1 drink is equal to a 5 oz glass of wine, 12 oz bottle of beer, or 1.5 oz shot of liquor:

- ( ) Less than 1
- ( ) 1-5
- ( ) 6-10
- ( ) 11-15

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* must provide value

- 16-20
- 21 or more
- Don't know

reset

AUTHORIZATION FOR STUDY PARTICIPATION

Yes indicates I have read the details in the link below and choose to enroll in this project. This authorization is equivalent to my signature.

- Yes

* must provide value

Click to view study participation details and use of data authorization

Attachment: ConsentInformationSheet-w O3.pdf (0.03 MB)

HOSPITAL INFORMATION

Any hospital or urgent care for your medical care in the last 6 months?

- Yes
- No

* must provide value

reset

Indicate diagnosis

Name of hospital where emergency room is located

Name of urgent care clinic, if applicable

Address of clinic/hospital

City

State

Date(s) of care

AUTHORIZATION FOR RELEASE OF HOSPITAL RECORDS

I authorize the above-named hospital or urgent care clinic to provide a copy of my discharge summary and all pathology reports to Dr. C. Garland, Department of Family and Preventive Medicine, University of California, San Diego, PO Box 800, La Jolla, CA 92093-0800. This authorization is equivalent to my signature.

- Yes
- No

reset

* must provide value

AUTHORIZATION FOR NUTRIENT TESTING AND RELEASE OF TEST RESULTS

"Yes" indicates my request, authorization and/or consent for laboratory testing. I understand that test results are strictly informational. The review of my test results by the study investigator does not represent diagnosis or treatment. I am responsible for contacting my personal health care provider for follow-up and interpretation of my test results. This authorization is equivalent to my signature.

- Yes

reset

* must provide value

AUTHORIZATION FOR USE OF HEALTH DATA

"Yes" indicates my authorization for the research use of my de-identified health data by GrassrootsHealth or its designated researchers. This authorization is equivalent to my signature.

- Yes

reset

* must provide value

AUTHORIZATION TO RECEIVE TEXT MESSAGES

"Yes" indicates my authorization for GrassrootsHealth to send text messages to the phone number listed above regarding important study reminders. I am responsible for

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any text or data fees that may apply based on my carrier and plan. I can opt out of receiving text messages at any time by texting STOP in reply. This authorization is equivalent to my signature.

* must provide value

- Yes
- No

reset

QUESTIONS, COMMENTS OR FEEDBACK?
Enter it here.

Expand

Thank you!

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