BIOMETRICS

What is your current weight without clothing, measured in
* must provide value

- Pounds (lbs)
- Killograms (kg)

reset

* must provide value

Whole number only

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

- feet and inches
- centimeters

reset

Enter values below

* must provide value

ft

* must provide value

in

* must provide value

cm

Do you know your average blood pressure over the last 6 months?
* must provide value

- Yes
- No

reset

What was your average systolic blood pressure for the past 6 months?
* must provide value

XXX

(the top number of your blood pressure reading)

What was your average diastolic blood pressure for the past 6 months?
* must provide value

XXX

(the bottom number of your blood pressure reading)

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

- Yes
- No
- I don't know

reset

Year of most recent blood cholesterol results or diagnosis (or best estimate)
* must provide value

YYYY

Year as YYYY

Month of most recent blood cholesterol results or diagnosis (or best estimate)
* must provide value

MM

Month as MM

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

- Desirable (< 200 mg/dL or < 5.2 nmol/L)
- Borderline High (200-240 mg/dL or 5.2-6.2 nmol/L)
- High (>240 mg/dL or >6.2 nmol/L)
- Don't Know

reset

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

- Desirable (< 130 mg/dL or < 3.4 nmol/L)
- Borderline High (130-159 mg/dL or 3.4-4.1 nmol/L)
- High (>160 mg/dL or >4.1 nmol/L)
- Don't Know

reset

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

- Good (>50 mg/dL or >1.3 nmol/L)
- Intermediate (35-50 mg/dL or 0.9-1.3 nmol/L)
- At Risk (< 35 mg/dL or < 0.9 nmol/L)
- Don't Know

reset

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

- Desirable (< 150 mg/dL or < 1.7 nmol/L)
- Borderline High (150-199 mg/dL or 1.7-2.2 nmol/L)
- High (200-499 mg/dL or 2.3-5.6 nmol/L)
- Very High (>=500 mg/dL or >5.6 nmol/L)
- 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

Breast Cancer: Year of Diagnosis (or best estimate) YYYY
Year as YYYY
* must provide value

Breast Cancer: Month of Diagnosis (or best estimate) MM
Month as MM
* must provide value

Breast Cancer: Year of Recurrence (or best estimate) YYYY
Year as YYYY

Breast Cancer: Month of Recurrence (or best estimate) MM
Month as MM

Colon Cancer ☐ Yes

Colon Cancer: Year of Diagnosis (or best estimate) YYYY
Year as YYYY
* must provide value

Colon Cancer: Month of Diagnosis (or best estimate) MM
Month as MM
* must provide value

Colon Cancer: Year of Recurrence (or best estimate) YYYY
Year as YYYY

Colon Cancer: Month of Recurrence (or best estimate) MM
Month as MM

Melanoma ☐ Yes

Melanoma Cancer: Year of Diagnosis (or best estimate) YYYY
Year as YYYY
* must provide value

Melanoma Cancer: Month of Diagnosis (or best estimate) MM
Month as MM
* must provide value

Melanoma Cancer: Year of Recurrence (or best estimate) YYYY
Year as YYYY

Melanoma Cancer: Month of Recurrence (or best estimate) MM
Month as MM

Ovarian Cancer ☐ Yes

Ovarian Cancer: Year of Diagnosis (or best estimate) YYYY
Year as YYYY
* must provide value

Ovarian Cancer: Month of Diagnosis (or best estimate) MM
Month as MM
* must provide value

Ovarian Cancer: Year of Recurrence (or best estimate) YYYY
Year as YYYY

Ovarian Cancer: Month of Recurrence (or best estimate) MM
Month as MM

Prostate Cancer ☐ Yes

Prostate Cancer: Year of Diagnosis (or best estimate) YYYY
Year as YYYY
* must provide value

Prostate Cancer: Month of Diagnosis (or best estimate) MM
Month as MM
* must provide value

Prostate Cancer: Year of Recurrence (or best estimate) YYYY
Year as YYYY

Prostate Cancer: Month of Recurrence (or best estimate) MM
Month as MM

Other Cancer ☐ Yes

Other Cancer (Specify)

Other Cancer: Year of Diagnosis (or best estimate) YYYY
Year as YYYY
* must provide value

Other Cancer: Month of Diagnosis (or best estimate) MM
Month as MM
* must provide value

Other Cancer: Year of Recurrence (or best estimate) YYYY
Year as YYYY

Other Cancer: Month of Recurrence (or best estimate) MM
Month as MM

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

Alzheimer's (and other dementias) ☐ Yes

Alzheimer's: Year of Diagnosis (or best estimate) YYYY
Year as YYYY
* must provide value

Alzheimer's: Month of Diagnosis (or best estimate) MM
Month as MM
* must provide value

Angina Pectoris ☐ Yes

Angina Pectoris: Year of Diagnosis (or best estimate) YYYY
Year as YYYY
* must provide value

Angina Pectoris: Month of Diagnosis (or best estimate) MM
Month as MM
* must provide value

Celiac Disease ☐ Yes

Celiac Disease: Year of Diagnosis (or best estimate) YYYY
Year as YYYY
* must provide value

Celiac Disease: Month of Diagnosis (or best estimate) MM
Month as MM
* must provide value

Chronic Fatigue ☐ Yes

Chronic Fatigue: Year of Diagnosis (or best estimate) YYYY
Year as YYYY
* must provide value

Chronic Fatigue: Month of Diagnosis (or best estimate) MM
Month as MM
* must provide value

Eczema or Serious Rash ☐ Yes

Eczema or Serious Rash: Year of Diagnosis (or best estimate) YYYY
Year as YYYY
* must provide value

Eczema or Serious Rash: Month of Diagnosis (or best estimate) MM
Month as MM
* must provide value

Fibromyalgia ☐ Yes

Fibromyalgia: Year of Diagnosis (or best estimate) YYYY
Year as YYYY
* must provide value

Fibromyalgia: Month of Diagnosis (or best estimate) MM
Month as MM
* must provide value

Gluten Intolerance ☐ Yes

Gluten Intolerance: Year of Diagnosis (or best estimate) YYYY
Year as YYYY
* must provide value

Gluten Intolerance: Month of Diagnosis (or best estimate) MM
Month as MM
* must provide value

Heart Attack ☐ Yes

Heart Attack: Year of Diagnosis (or best estimate) YYYY
Year as YYYY
* must provide value

Heart Attack: Month of Diagnosis (or best estimate) MM
Month as MM
* must provide value

Hypertension ☐ Yes

Hypertension: Year of Diagnosis (or best estimate) YYYY
Year as YYYY
* must provide value

Hypertension: Month of Diagnosis (or best estimate) MM
Month as MM
* must provide value

Kidney Failure ☐ Yes

Kidney Failure: Year of Diagnosis (or best estimate) YYYY
Year as YYYY
* must provide value

Kidney Failure: Month of Diagnosis (or best estimate) MM
Month as MM
* must provide value

Kidney Stones ☐ Yes

Kidney Stones: Year of Diagnosis (or best estimate) YYYY
Year as YYYY
* must provide value

Kidney Stones: Month of Diagnosis (or best estimate) MM
Month as MM
* must provide value

Lactose Intolerance ☐ Yes

Lactose Intolerance: Year of Diagnosis (or best estimate) YYYY
Year as YYYY
* must provide value

Lactose Intolerance: Month of Diagnosis (or best estimate) MM
Month as MM
* must provide value

Multiple Sclerosis ☐ Yes

Multiple Sclerosis: Year of Diagnosis (or best estimate) YYYY
Year as YYYY
* must provide value

Multiple Sclerosis: Month of Diagnosis (or best estimate) MM
Month as MM
* must provide value

Myasthenia Gravis ☐ Yes

Myasthenia Gravis: Year of Diagnosis (or best estimate) YYYY
Year as YYYY
* must provide value

Myasthenia Gravis: Month of Diagnosis (or best estimate) MM
Month as MM
* must provide value

Non-alcoholic Fatty Liver Disease ☐ Yes

Non-alcoholic Fatty Liver Disease: Year of Diagnosis (or best estimate) YYYY
Year as YYYY
* must provide value

Non-alcoholic Fatty Liver Disease: Month of Diagnosis (or best estimate) MM
Month as MM
* must provide value

Parkinsons ☐ Yes

Parkinsons: Year of Diagnosis (or best estimate) YYYY
Year as YYYY
* must provide value

Parkinsons: Month of Diagnosis (or best estimate) MM
Month as MM
* must provide value

Pneumonia ☐ Yes

Pneumonia: Year of Diagnosis (or best estimate) YYYY
Year as YYYY
* must provide value

Pneumonia: Month of Diagnosis (or best estimate) MM
Month as MM
* must provide value

Stroke ☐ Yes

Stroke: Year of Diagnosis (or best estimate) YYYY
Year as YYYY
* must provide value

Stroke: Month of Diagnosis (or best estimate) MM
Month as MM
* must provide value

Type 1 Diabetes ☐ Yes

Type 1 Diabetes: Year of Diagnosis (or best estimate) YYYY
Year as YYYY
* must provide value

Type 1 Diabetes: Month of Diagnosis (or best estimate) MM
Month as MM
* must provide value

Type 2 Diabetes ☐ Yes

Type 2 Diabetes: Year of Diagnosis (or best estimate) YYYY
Year as YYYY
* must provide value

Type 2 Diabetes: Month of Diagnosis (or best estimate) MM
Month as MM
* must provide value

Other Disease ☐ Yes

Other Disease (Specify)
* must provide value

Other Disease: Year of Diagnosis (or best estimate) YYYY
Year as YYYY
* must provide value

Other Disease: Month of Diagnosis (or best estimate) MM
Month as MM
* must provide value

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

MM-DD-YYYY Today M-D-Y

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: Year of Diagnosis (or best estimate)
* must provide value

YYYY
Year as YYYY

Gestational Diabetes: Month of Diagnosis (or best estimate)
* must provide value

MM
Month as MM

Pregnancy-induced Hypertension
- Yes

Pregnancy-induced Hypertension: Year of Diagnosis (or best estimate)
* must provide value

YYYY
Year as YYYY

Pregnancy-induced Hypertension: Month of Diagnosis (or best estimate)
* must provide value

MM
Month as MM

Pre-eclampsia
- Yes

Pre-eclampsia: Year of Diagnosis (or best estimate)
* must provide value

YYYY
Year as YYYY

Pre-eclampsia: Month of Diagnosis (or best estimate)
* must provide value

MM
Month as MM

Eclampsia
- Yes

Eclampsia: Year of Diagnosis (or best estimate)
* must provide value

YYYY
Year as YYYY

Eclampsia: Month of Diagnosis (or best estimate)
* must provide value

MM
Month as MM

HELLP Syndrome
- Yes

HELLP Syndrome: Year of Diagnosis (or best estimate)
* must provide value

YYYY
Year as YYYY

HELLP Syndrome: Month of Diagnosis (or best estimate)
* must provide value

MM
Month as MM

Pre-term Labor
- Yes

Pre-term Labor: Year of Diagnosis (or best estimate)
* must provide value

YYYY
Year as YYYY

Pre-term Labor: Month of Diagnosis (or best estimate)
* must provide value

MM
Month as MM

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

MM-DD-YYYY Today M-D-Y

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

Gestational Diabetes
- Yes

Gestational Diabetes: Year of Diagnosis (or best estimate)
* must provide value

YYYY
Year as YYYY

Gestational Diabetes: Month of Diagnosis (or best estimate)
* must provide value

MM
Month as MM

Pregnancy-induced Hypertension
- Yes

Pregnancy-induced Hypertension: Year of Diagnosis (or best estimate)
* must provide value

YYYY
Year as YYYY

Pregnancy-induced Hypertension: Month of Diagnosis (or best estimate)
* must provide value

MM
Month as MM

Pre-eclampsia
- Yes

Pre-eclampsia: Year of Diagnosis (or best estimate)
* must provide value

YYYY
Year as YYYY

Pre-eclampsia: Month of Diagnosis (or best estimate)
* must provide value

MM
Month as MM

Eclampsia
- Yes

Eclampsia: Year of Diagnosis (or best estimate)
* must provide value

YYYY
Year as YYYY

Eclampsia: Month of Diagnosis (or best estimate)
* must provide value

MM
Month as MM

HELLP Syndrome
- Yes

HELLP Syndrome: Year of Diagnosis (or best estimate)
* must provide value

YYYY
Year as YYYY

HELLP Syndrome: Month of Diagnosis (or best estimate)
* must provide value

MM
Month as MM

Pre-term Labor
- Yes

Pre-term Labor: Year of Diagnosis (or best estimate)
* must provide value

YYYY
Year as YYYY

Pre-term Labor: Month of Diagnosis (or best estimate)
* must provide value

MM
Month as MM

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

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 2 3 4 5 6 7 8 9 10

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]) on a scale from 1-10 (1=minor, 10=major)
* must provide value
1 2 3 4 5 6 7 8 9 10

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]) on a scale from 1-10 (1=minor, 10=major)
* must provide value
1 2 3 4 5 6 7 8 9 10

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]) on a scale from 1-10 (1=minor, 10=major)
* must provide value
1 2 3 4 5 6 7 8 9 10

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

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

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

Do you regularly use (ie. more than once per week) any of the following over the counter NSAIDS (NOT including acetaminophen or Tylenol products)? *Check all that apply.*
* must provide value
- Advil
- Aleve
- Anaprox
- Aspirin
- Ibuprofen
- Motrin
- Naprosyn
- Other
- I do not regularly use over the counter NSAIDS

Other over the counter NSAID (Please Specify)
* must provide value

Please indicate your average daily dose of [nsaid_other] over the last 3 months
* must provide value
mg/day

Please indicate your average daily dose of Advil over the last 3 months
* must provide value
mg/day

Please indicate your average daily dose of Aleve over the last 3 months
* must provide value
mg/day

Please indicate your average daily dose of Anaprox over the last 3 months
* must provide value
mg/day

Please indicate your average daily dose of Aspirin over the last 3 months
* must provide value
mg/day

Please indicate your average daily dose of Ibuprofen over the last 3 months
* must provide value
mg/day

Please indicate your average daily dose of Motrin over the last 3 months
* must provide value
mg/day

Please indicate your average daily dose of Naprosyn over the last 3 months
* must provide value
mg/day

Do you regularly use (ie. more than once per week) any of the following prescription-only NSAID medications? *Check all that apply.*
* must provide value
- Catafla
- Celebrex
- Clinoril
- Dayro
- Diflunisal
- Etodolac
- Feldene
- Fenoprofen
- Flurbiprofen
- Indomethacin
- Ketoprofen
- Meclofenamate
- Mobic
- Nabumetone
- Piroxicam
- Ponstel
- Sulclinac
- Tolmetin
- Voltaren
- Zipsor
- Other
- I do not regularly use prescription NSAIDS

Other prescription NSAID (Please Specify)
* must provide value

Please indicate your average daily dose of [rx_nsaid_other] over the last 3 months
* must provide value
mg/day

Please indicate your average daily dose of Catafla over the last 3 months
* must provide value
mg/day

Please indicate your average daily dose of Celebrex over the last 3 months
* must provide value
mg/day

Please indicate your average daily dose of Clinoril over the last 3 months
* must provide value
mg/day

Please indicate your average daily dose of Dayro over the last 3 months
* must provide value
mg/day

Please indicate your average daily dose of Diflunisal over the last 3 months
* must provide value
mg/day

Please indicate your average daily dose of Etodolac over the last 3 months
* must provide value
mg/day

Please indicate your average daily dose of Feldene over the last 3 months
* must provide value
mg/day

Please indicate your average daily dose of Fenoprofen over the last 3 months
* must provide value
mg/day

Please indicate your average daily dose of Flurbiprofen over the last 3 months
* must provide value
mg/day

Please indicate your average daily dose of Indomethacin over the last 3 months
* must provide value
mg/day

Please indicate your average daily dose of Ketoprofen over the last 3 months
* must provide value
mg/day

Please indicate your average daily dose of Meclofenamate over the last 3 months
* must provide value
mg/day

Please indicate your average daily dose of Mobic over the last 3 months
* must provide value
mg/day

Please indicate your average daily dose of Nabumetone over the last 3 months
* must provide value
mg/day

Please indicate your average daily dose of Piroxicam over the last 3 months
* must provide value
mg/day

Please indicate your average daily dose of Ponstel over the last 3 months
* must provide value
mg/day

Please indicate your average daily dose of Sulclinac over the last 3 months
* must provide value
mg/day

Please indicate your average daily dose of Tolmetin over the last 3 months
* must provide value
mg/day

Please indicate your average daily dose of Voltaren over the last 3 months
* must provide value
mg/day

Please indicate your average daily dose of Zipsor 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

Sorting the search results by average, most recent, most popular, most helpful, most expensive, most cheap, most relevant, most recent, most popular, most helpful, most expensive, most cheap, most relevant

Product Name (Relevance) ⓘ

Product Name (Relevance) ⓘ

Product Name (Relevance) ⓘ

DIET AND SUPPLEMENTS (CONT.)

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

Vitamin A (as retinol or retinyl palmitate)
* must provide value
IU - no commas or decimals; Enter '0' for None and '9999' for Don't Know

Calcium
* must provide value
mg - no commas or decimals; Enter '0' for None and '9999' for Don't Know

Vitamin K2 (Menaquinone) Total
* must provide value
mcg - no commas or decimals; Enter '0' for None and '9999' for Don't Know

Vitamin K2 (as MK-4)
* must provide value
mcg - no commas or decimals; Enter '0' for None and '9999' for Don't Know

Vitamin K2 (as MK-7)
* must provide value
mcg - no commas or decimals; Enter '0' for None and '9999' for Don't Know

Vitamin B12
* must provide value
No commas or decimals; Enter '0' for None and '9999' for Don't Know

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

reset

Vitamin C
* must provide value
No commas or decimals; Enter '0' for None and '9999' for Don't Know

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

reset

Magnesium
* must provide value
mg - no commas or decimals; Enter '0' for None and '9999' for Don't Know

- 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 Malate
- 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

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

- 0
- 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

Additional comments about your diet and other supplements taken:

Expand

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 never or almost never used sunscreen	I used it occasionally (5-20% of the time)	I used it somewhat regularly (20-50% of the time)	I used it most of the time (50-80% of the time)	I used it almost all of the time (80-95% of the time)	I used it all the time (95-100%)
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, 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

SPF sunscreen level

reset

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

(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)

Do you currently use an electronic cigarette?
* must provide value

- Yes
- No

reset

How many times per day do you usually use an electronic cigarette? (assume that one "time" consists of around 15 puffs or lasts around 10 minutes)
* must provide value

- Less than 1
- 1-4 times/day,
- 5-9
- 10-14
- 15-19
- 20-29
- 30+

reset

How long have you been using an electronic cigarette?
* must provide value

- Less than one month
- 1-2 months
- 3-4 months
- Longer than 4 months

reset

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:
* must provide value

- Less than 1
- 1-5
- 6-10
- 11-15
- 16-20
- 21 or more
- Don't know

reset

AUTHORIZATION FOR STUDY PARTICIPATION

Yes indicates I have read the details in the "Research Subject Information Sheet" 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 ☐ View "Research Subject Information Sheet"

Sponsor: GrassrootsHealth

Protocol Title: 25-hydroxyvitamin D [25(OH)D] serum levels and associated health outcomes in the population resulting from a program of education and testing

Investigator: Dr. Cedric Garland

The purpose of this population study is to offer testing and/or feedback about results and education to make necessary lifestyle changes to effect serum level concentrations. In this study you will create an account with GrassrootsHealth (GRH), fill out a health questionnaire and receive vitamin D test results either from a home blood spot test provided by GRH or from a participating GRH Certified physician and lab (available only to participants of qualifying GRH projects). You may also choose to include additional nutrient tests by enrolling in a sub-project. For the home blood spot test(s), you will provide drops of blood on the blood spot card and return it to GRH. The results of the test(s) will be made available to you through the account created on the GRH website along with information about target levels. The test results are strictly informational. The review of your test results by the study investigator does not represent diagnosis and treatment. The health questionnaire will be filled out and testing will occur at regular intervals. It is an international study which is expected to involve over 100,000 participants. You may not receive a direct benefit if you agree to participate. However, people in the future may benefit from the information obtained from this research.

There is minimal risk to obtaining blood drops for testing 25(OH)D and other nutrient tests available by home blood spot test kits. The test generally will be done in your home, using a sterile self-loaded lancet to puncture the fingertip. This will be done after a thorough washing of hands with soap and warm water and the use of an alcohol swab where the blood drops will be obtained. We are aware of no reports of harm other than short term pain with using the test. You are advised that if any complications develop you should consult your healthcare provider. You will be advised if there is any new information that would influence your decision about participation.

Your alternative to participating in this study includes requesting your own physician to order the 25(OH)D or other test(s). Results from physician ordered tests can only be used by participants of a qualifying GRH project and if the physician and lab are contracted with GRH. You can use the free educational pieces on the website without participating in the study. Contact Jen Aliano at (760) 710-9305 for questions about the research or if you think you have been harmed as a result of joining this research. Contact the Western Institutional Review Board (WIRB) if you have questions about your rights as a research subject: 1-800-562-4789. WIRB is a group of people who perform independent review of research.

If you use certain electronic health applications (apps), you may opt to have data from that application securely shared with GrassrootsHealth. Third-party data, such as that from the health application, is de-identified and transmitted with a unique identification code that will link health data from each application with information in your GrassrootsHealth account, and will allow for expanded analysis.

Your individual health data will be kept confidential except for where required by law. The accumulated data will be stored in a secured, encrypted database operating behind a firewall, and password protected. The only person that will have access to the identified data will be our primary data biostatistician. This will be for purposes of accessing hospital records as indicated and released by participants, or for clarification of entries in the health questionnaire. The de-identified health information is shared so the research can be conducted, properly monitored and published. The Principal Investigator and other researchers will access the data in a de-identified form. For all analyses only an arbitrary number will identify the participant.

If you are under 18 years of age, parental consent must be provided to participate in this study. This permission will not end unless you cancel it. You may cancel it by sending written notice to the study leader at: *GrassrootsHealth, 315 S Coast Hwy 101, Suite U-87, Encinitas, CA 92024.*

Your decision to be in this study is voluntary. You will not be penalized or lose benefits if you decide not to participate or if you decide to stop participating. There may be a sponsorship fee associated with participation in this study. Sponsorship supports the efforts of documenting serum levels and health outcomes, feedback of the information, as well as the tests and laboratory fees.

END OF DOCUMENT

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 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. ○ Yes ○ No

reset

* must provide value

QUESTIONS, COMMENTS OR FEEDBACK?
Enter it here.

Expand

Thank you!

*****REMINDER*****

You indicated that you would like to return to the questionnaire to add your Omega-3 supplement label information. DO NOT SUBMIT this questionnaire if you plan on returning to provide those answers, select "Save and Return Later" below.

PLEASE NOTE: All participants in this project will be subscribed to GrassrootsHealth news and updates emails. You may unsubscribe at any time by clicking the "SafeUnsubscribe" link at the bottom of each email.