# ASCEND: Randomisation Questionnaire

**INSTRUCTIONS FOR COMPLETION**:

Please complete the questionnaire in BLOCK CAPITALS using blue or black ink.

Please place a cross in the appropriate box, e.g. Yes [X] No [ ]

(If you make a mistake, fill the entire box and mark the correct box, e.g. Yes [■] No [X] )

**OR** write clearly in the appropriate boxes, e.g. 2 6 / 0 1 / 2 0 1 0 (Day / Month / Year)

## 1. Contact and GP Details

**Please check that the contact details for you and your GP are correct. If not, then please call Freefone 0800 585323 and provide the correct information. Please quote the reference number from the covering letter on the front of this questionnaire.**

***Your details:*** ***GP details:***

## 2. Continuing in ASCEND

**Are you willing to continue taking study tablets and capsules in ASCEND for the next 5 years?** Yes [ ] No [ ]

If you answered **YES**, then please complete **ALL** the remaining sections of this questionnaire, sign and date the form, and return it in the FREEPOST envelope provided.

If you answered **NO**, then return the questionnaire in the FREEPOST envelope provided (but do not complete the remaining sections).

## 3. About Your ASCEND Medication

Please indicate how regularly you have taken your ASCEND medication since you received it:

| | **White Tablets** (aspirin/placebo) | **Brown Capsules** (one or other natural oil) |
|---|---|---|
| Every day | [ ] | [ ] |
| Most days | [ ] | [ ] |
| Only occasionally | [ ] | [ ] |
| Never | [ ] | [ ] |

*Please cross **ONE** box only in **EACH** column*

## 4. About Your Diabetes

**4.1** What **year** was your diabetes diagnosed? [ ][ ][ ][ ]

**4.2** Do you use INSULIN (injections or via pump) for your diabetes? Yes [ ] No [ ]

**4.3** If **Yes**, did you start insulin within one year of having diabetes? Yes [ ] No [ ]

**4.4** Are you known to have diabetes changes at the back of the eye? Yes [ ] No [ ]

**4.5** If **Yes**, have you ever had laser treatment to the eye for this? Yes [ ] No [ ]

**4.6** Do you take treatment for high blood pressure or hypertension? Yes [ ] No [ ]

## 5. Confirming Your Medical History

**5.1 Has a doctor ever told you that you had any of the following?**

*Please cross **ONE** box only for each question*

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| | | | |
|---|---|---|---|
| a) | Heart attack | Yes ☐ | No ☐ |
| b) | Angina (chest pain from the heart) | Yes ☐ | No ☐ |
| c) | Stroke or ministroke (sometimes called TIA) | Yes ☐ | No ☐ |
| d) | Coronary artery bypass operation (CABG or "cabbage") | Yes ☐ | No ☐ |
| e) | Coronary angioplasty ("balloon", "stent" insertion or PTCA) | Yes ☐ | No ☐ |
| f) | Other arterial surgery or angioplasty (e.g. leg bypass) (Do not include angiogram) | Yes ☐ | No ☐ |

If **Yes**, please specify:

| | | | |
|---|---|---|---|
| g) | Liver disease (active or chronic, or cirrhosis) | Yes ☐ | No ☐ |

If **Yes**, please specify:

| | | | |
|---|---|---|---|
| h) | Cancer **within the last 5 years** (e.g. skin, breast, lung, bowel etc) | Yes ☐ | No ☐ |

If **Yes**, please give the type of cancer:

| | | | |
|---|---|---|---|
| i) | Other serious illness | Yes ☐ | No ☐ |

If **Yes**, please specify:

**5.2 In the last 6 months have you been in hospital with, or has a doctor said you have:**

| | | | |
|---|---|---|---|
| a) | Active peptic (stomach or duodenal) ulcer? | Yes ☐ | No ☐ |
| b) | Bleeding from the stomach or bowel? | Yes ☐ | No ☐ |

## 6. About You

**6.1** Please give your date of birth: Day ☐☐ / Month ☐☐ / Year 1 9 ☐☐

**6.2** Which best describes your ethnic origin?

*Please cross **ONE** box only*

| | | | |
|---|---|---|---|
| White | ☐ | Black: African/Caribbean | ☐ |
| Indian, Pakistani or Bangladeshi | ☐ | Other | ☐ |

**6.3** Please provide your **weight** in light indoor clothes without shoes (round to nearest whole number): ☐☐☐ kgs **OR** ☐☐ stones & ☐☐ lbs

**6.4** Please provide your standing **height** without shoes (round to nearest whole number): ☐☐☐ cms **OR** ☐ feet & ☐☐ inches

**6.5** Do you smoke cigarettes regularly (i.e. on most days)? Yes ☐ No ☐ If **Yes**, give approximate number smoked per day: ☐☐

**6.6** If **No**, have you **ever** smoked regularly? Yes ☐ No ☐ If **Yes**, give the age you stopped: ☐☐ years

**Need help completing this form? Please call Freefone 0800 585323**

## 7. Current Medication

**7.1** Please list your current medication as **prescribed by your doctor** (names only, doses not required). Please **do not** list any medication (e.g. aspirin) you have stopped to enter ASCEND.

**7.2** Please list any other treatments you take regularly (i.e. more than twice a week), for example, pain killers, vitamins, supplements, over-the-counter tablets or capsules.

## 8. Alternative Contact

It would be very helpful for us if you could provide the details of a relative, friend or neighbour living at a **different address** who we could contact if for any reason we were unable to get hold of you. **Please indicate their relationship to you and write their contact details clearly in the boxes provided.**

Relationship: ☐ **Relative** ☐ **Friend** ☐ **Neighbour** ☐ **Other**

Title: Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other

First name(s):

Surname:

Address:

Postcode:

Telephone number (inc. code):

## 9. Continuing in ASCEND

Thank you for completing the questionnaire. If you are happy to continue taking the ASCEND tablets and capsules for the next 5 years, then please SIGN and DATE the form below using blue or black ink, and return it in the FREEPOST envelope provided. Within about 2 weeks of us receiving your questionnaire, if eligible, you will receive a new box of ASCEND medication and will be asked to take one tablet and one capsule daily.

### I am happy to take part in ASCEND:

(Please use blue or black ink)

Signature:

& **PRINTED** name:

Today's date: Day / Month / Year (20__)

Please check that you have answered **every** question, and **signed and dated** the form.
Return the completed questionnaire in the **Freepost** envelope provided **(no stamps needed)** to:-

**Freepost RLUJ-TKES-SURB, ASCEND, Richard Doll Building, University of Oxford, Old Road Campus, Headington, Oxford, OX3 7LF**

If you have any questions about the study, please contact the coordinating centre in Oxford on **FREEFONE: 0800 585323** (preferably during office hours 9 am - 5 pm, Monday to Friday)

**Thank you very much**

# ASCEND

**A S**tudy of **C**ardiovascular **E**vents i**N** **D**iabetes

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*A cover letter will be inserted on this page*