ASCEND: Follow-up 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. 26 / 01 / 2015 (Day / Month / Year)

1. Contact and GP Details

Please check that these contact details are still 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.

2. ASCEND Medication

2.1. Please indicate how regularly you have taken ASCEND medication during the last 6 months:

	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*

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2.2 Are you willing to continue taking the **white** (aspirin/placebo) ASCEND tablets?

Yes [ ] No [ ]

If **No**, please tell us why:

2.3 Are you willing to continue taking the **brown** (one or other natural oil) ASCEND capsules?

Yes [ ] No [ ]

If **No**, please tell us why:

3. Other Current Medication

3.1 Do you currently take any of the following **regularly** (i.e. more than one day per week)?

a)	Warfarin (Marevan), apixaban (Eliquis), acenocoumarol (Nicoumalone, Sinthrome), phenindione, dabigatran (Pradaxa) or rivaroxaban (Xarelto)	Yes [ ]	No [ ]
b)	Aspirin, prescribed or over-the-counter (e.g. Anadin, Caprin, Disprin, Imazin, PostMI). *Do not include your ASCEND study tablets.*	Yes [ ]	No [ ]
c)	Clopidogrel (Plavix)	Yes [ ]	No [ ]
d)	Dipyridamole (Persantin, Persantin Retard or Asasantin Retard)	Yes [ ]	No [ ]

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

4. Medical Events

4.1 Since completing your last questionnaire on have you had ANY of the following? (If **Yes**, please give the date and the name and town of the hospital you attended). Please note there is extra space overleaf to list **second occurrences** of any of the medical events listed below.

a) **Heart attack** — Yes ☐ No ☐ — Day / Month / Year

Name and town of hospital attended:

b) **Admission to hospital with angina or any chest pains** — Yes ☐ No ☐ — Day / Month / Year

Name and town of hospital attended:

c) **Stroke** — Yes ☐ No ☐ — Day / Month / Year

Name and town of hospital attended:

d) **Ministroke (sometimes called TIA)** — Yes ☐ No ☐ — Day / Month / Year

Name and town of hospital attended:

e) **Coronary artery bypass operation (CABG or "cabbage")** — Yes ☐ No ☐ — Day / Month / Year

Name and town of hospital attended:

f) **Coronary angioplasty ("balloon", "stent" insertion or PTCA)** — Yes ☐ No ☐ — Day / Month / Year

Name and town of hospital attended:

g) **Other arterial surgery or angioplasty (e.g. leg bypass)** — Yes ☐ No ☐ — Day / Month / Year

Name and town of hospital attended:

h) **Cancer (e.g. skin, breast, lung, bowel etc)** — Yes ☐ No ☐ — Day / Month / Year

Type of cancer:

Name and town of hospital attended:

i) **Bleeding for which you saw a doctor** — Yes ☐ No ☐ — Day / Month / Year
(e.g. serious nose bleed, bleeding in the eye)
Do not include bleeding as a result of an accident.

Site in body of bleeding:

Were you admitted to hospital? Yes ☐ No ☐

Name and town of hospital attended:

5. Other Serious Illnesses or Hospital Admissions

5.1 Since completing your last questionnaire on have you had ANY other serious illness or admission to hospital (e.g. pneumonia, day surgery, laser treatment to the eye)? Please give details of the illness or surgery, the date, and the name and town of the hospital you attended. (Please note you can also record **second occurrences** of any of the medical events listed in Section 4).

Details of illness or admission:

Name and town of hospital attended:

Date: Day / Month / Year

Details of illness or admission:

Name and town of hospital attended:

Date: Day / Month / Year

Details of illness or admission:

Name and town of hospital attended:

Date: Day / Month / Year

Details of illness or admission:

Name and town of hospital attended:

Date: Day / Month / Year

6. Personal Details

6.1 Please reconfirm your date of birth: Day / Month / 1 9 Year

Thank you for completing the questionnaire.
Please SIGN and DATE the form below using blue or black ink.

Signature:

& **PRINTED** name:

Today's date: Day / Month / 2 0 Year

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 for your continued participation in ASCEND

ASCEND

A Study of Cardiovascular Events iN Diabetes

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A cover letter will be inserted on this page