

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 No

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

OR write clearly in the appropriate boxes, e.g.

2	6
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 /

0	1
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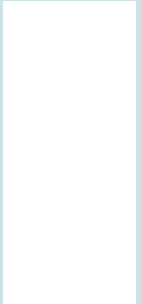
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2	0	1	5
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Day Month Year

1. Contact and GP Details

Please check that these contact details are still correct. If not, then please call Freephone 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	<input type="checkbox"/>	Every day	<input type="checkbox"/>	<i>Please cross ONE box only in EACH column</i>
Most days	<input type="checkbox"/>	Most days	<input type="checkbox"/>	
Only occasionally	<input type="checkbox"/>	Only occasionally	<input type="checkbox"/>	
Never	<input type="checkbox"/>	Never	<input type="checkbox"/>	

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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, Sintrome), phenindione, dabigatran (Pradaxa) or rivaroxaban (Xarelto) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | <i>Please cross ONE box only for EACH question</i> |
| b) Aspirin, prescribed or over-the-counter (e.g. Anadin, Caprin, Disprin, Imazin, PostMI). Do not include your ASCEND study tablets. | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| c) Clopidogrel (Plavix) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| d) Dipyridamole (Persantin, Persantin Retard or Asasantin Retard) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |

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 (e.g. serious nose bleed, bleeding in the eye)** Yes No / /
Day Month Year

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 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 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*

