The University of Iowa

Seniors **T**ogether in **A**ging **R**esearch (STAR) Volunteer Research Registry

The information below will be used to match you with research studies in Iowa. Only STAR Registry staff has access to this information, and it will not be shared. If we notify you of a study, you are free to participate or to refuse. Please print clearly and mark all that apply.

Today's date: Month: _____ Day: _____ Year: _____

Please select one: ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr. ☐ Other _____

First Name: _____ Middle Name: _____ Last Name: _____

Primary Mailing Address: _____

City: _____ State: _____ Zip: _____ County: _____

Secondary Mailing Address: _____

City: _____ State: _____ Zip: _____ County: _____

Months of the year at secondary address: _____ to _____

Preferred phone: (_____) _____ **Alternate phone**: (_____) _____

Email: _____

Date of birth: Month: _____ Day: _____Year: _____

Sex: ☐ Male ☐ Female ☐ Intersex ☐ Prefer not to answer ☐ Other, please specify: _____

Race/Ethnicity: ☐ American Indian/Alaska Native ☐ Asian or Pacific Islander ☐ Black or African American
☐ Hispanic ☐ White, not Hispanic ☐ Mixed Race ☐ Other, please specify: _____
☐ Prefer not to answer

Marital status: ☐ Married/Partnered ☐ Widowed ☐ Divorced/Separated ☐ Never Married

Highest level of education:
☐ Less than high school ☐ High school diploma/GED
☐ Some college ☐ 2 year college degree (i.e. AA, AS) ☐ 4 year college degree (i.e. BA, BS)
☐ Military ☐ Master's Degree ☐ Prof/Doctorate (i.e. MD, PhD)

Total annual income:
☐ $0 – 24,999 ☐ $25,000 – 49,999
☐ $50,000 – 99,999 ☐ $100,000 - $149,999 ☐ $150,000 +
☐ Prefer not to answer

Are you a military veteran? ☐ Yes ☐ No

Present living situation: ☐ Private residence ☐ Assisted living ☐ Nursing home

☐ Other, please specify _____

How many adults (including yourself) and children live in your household:

_____ Number of Adults (including yourself) _____ Number of Children

Does someone close to you live in a nursing home? ☐ No ☐ Spouse/partner ☐ Parent ☐ Friend

☐ Other, please specify: _____

Do you have a valid driver's license? ☐ Yes ☐ No

If we scheduled a convenient time for you, would you be able to come to UI, in Iowa City, to participate in a study?

☐ I could drive myself or arrange for someone to drive me.
☐ I would be willing to come only if transportation were arranged for me.
☐ I would not be able to come to Iowa City.

Do you use (check all that apply): ☐ Computer ☐ Tablet ☐ Smartphone

Do you have access to the internet at home or another convenient place? ☐ Yes ☐ No

Are you employed? ☐ Yes ☐ No If yes, hours per week _____

Do you volunteer? ☐ Yes ☐ No If yes, hours per week _____

Since last year, did you **provide** care to a family member or friend? Caregiving activities can include: helping with eating, bathing, dressing, walking or personal hygiene, household chores, medication management, financial management, errands, transportation, etc.? ☐ Yes ☐ No

If yes, what type(s) of care did you provide? (check all that apply)

☐ Instrumental Activities of Daily Living (IADL) include: household chores, medication management, financial management, errands, transportation, etc.
☐ Activities of Daily Living (ADL) include: helping with eating, bathing, dressing, walking or personal hygiene.

For whom do you provide care? ☐ Spouse/partner ☐ Parent ☐ Child ☐ Grandchild ☐ Friend

☐ Other: _____

Reason this person needs care: ☐ Cancer ☐ Dementia/AD ☐ Physical limitation ☐ Other:_____

Since last year, have you **received** care or other kinds of help from a family member or friend? ☐ Yes ☐ No

Health-Related Information:

Are you a twin? ☐ Yes ☐ No Height (inches): _____ Weight (pounds): _____

Have you ever been a patient at UIHC? ☐ Yes ☐ No ☐ Prefer not to answer

Do you have access to MyChart? ☐ Yes ☐ No ☐ Prefer not to answer

How many days during the past 30 days was your physical health, which includes which includes physical illness and injury, **not** good? _____ Number of days

How many days during the past 30 days was your mental health, which includes stress, depression, and problems with emotions, **not** good? _____ Number of days

How would you characterize your present state of health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How would you characterize your present **dental** health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How often do you participate in physical activity?

☐ Never ☐ Less than 1 hour/week ☐ 1-2 hours/week ☐ 2-3 hours/week ☐ Over 3 hours/week

Do you have any physical limitations? ☐ Yes ☐ No

If yes, do you use: ☐ Cane ☐ Walker ☐ Brace(s) ☐ Wheelchair ☐ Motorized Scooter ☐ Other _____

Have you ever consumed wine, beer, or other alcoholic beverages? ☐ Yes ☐ No

If yes, what best describes your current alcohol consumption? (1 serving = 1 glass wine, 1 beer, or 1 shot of liquor)

☐ None ☐ <1 per week ☐ 1 per week ☐ 2-5 per week ☐ 1 per day ☐ >1 per day

Are you an active tobacco user? ☐ Yes ☐ No

If yes, which type: ☐ Cigarettes ☐ E-cigarettes ☐ Cigar ☐ Vape ☐ Smokeless Tobacco ☐ Pipe
☐ Other: _____

If yes to cigarettes, how many packs per day? ☐ 1 or fewer ☐ >1 and <3 ☐ 3 or more

Have you smoked in the past? ☐ Yes ☐ No

If yes, how many years did you smoke?	☐ 1-10	☐ 11-20	☐ 21-30	☐ 31+
If yes, how many packs per day?	☐ 1 or fewer	☐ >1 and <3	☐ 3 or more	☐ N/A
If yes, how many years ago did you quit?	☐ 1-10	☐ 11-20	☐ 21-30	☐ 31+

Please select conditions or diseases a healthcare provider has told you that you have. This information is optional, but providing it may help researchers match you with studies that fit you personally:

Abdomen	☐ Diverticulitis/osis ☐ Kidney disease ☐ Ulcer	☐ Inflammatory Bowel Disease ☐ Liver disease ☐ Other:
Allergies	☐ Food allergies ☐ Other:	☐ Seasonal allergies
Behavior/Psychiatric/Mental	☐ Alcoholism ☐ Eating disorder ☐ Feeling overly occupied with shopping/spending ☐ Language/Learning Disorder (e.g., dyslexia, ADHD) ☐ Obsessive Compulsive Disorder OCD ☐ Schizophrenia ☐ Social Isolation	☐ Drug addiction/substance use disorder (prescription or illegal substances) ☐ Gambling problems (too much or having trouble quitting) ☐ Mood Disorder (anxiety, depression, bipolar) ☐ Post-Traumatic Stress Disorder (PTSD) ☐ Other:
Bones	☐ Arthritis ☐ Joint Replacement ☐ Other:	☐ Fracture (e.g., hip, spine) ☐ Osteoporosis
Cancer	☐ Bladder ☐ Colon/Rectum ☐ Melanomas of the skin ☐ Other:	☐ Breast ☐ Lung/Bronchus ☐ Prostate
Endocrine/Metabolism	☐ Diabetes ☐ Weight problems	☐ Hyper/Hypothyroid ☐ Other:
Head/Eyes/Ears/Nose/Throat	☐ Cataracts ☐ Dental conditions (e.g., caries, periodontal disease, tooth loss, dry mouth) ☐ Diabetic retinopathy ☐ Glaucoma ☐ Hearing problems. Hearing aid? One ear ☐ Both ears ☐ N/A ☐ ☐ Macular degeneration ☐ Vision correction: ☐ glasses/contacts ☐ Lasik surgery ☐ Other:	
Heart and Blood Vessels	☐ Anemia ☐ High blood pressure ☐ Chest pain with exertion	☐ Heart disease ☐ High cholesterol ☐ Other:
Lungs	☐ Asthma ☐ Other:	☐ Lung disease (chronic bronchitis, COPD, emphysema)
Neurological	☐ Alzheimer's/Dementia ☐ Epilepsy/seizures ☐ Memory problems ☐ Multiple sclerosis ☐ Stroke	☐ Difficulty thinking ☐ Head injury ☐ Migraine/Severe Headache ☐ Parkinson's disease ☐ Other:

Reproductive Health	☐ History of infertility (male or female) ☐ Gestational Diabetes ☐ Hormone Replacement Therapy	☐ Toxemia or pre-eclampsia ☐ Preterm birth (<37 weeks gestation) ☐ Other:
Skin	☐ Bed sores ☐ Psoriasis ☐ Other:	☐ Eczema ☐ Seborrheic dermatitis
Urological	☐ Bladder or urinary tract infections ☐ Straining to empty bladder ☐ Weak/intermittent urine flow	☐ Freq. &/or urgent urination AM or PM ☐ Urinary incontinence ☐ Other:

Do you experience chronic pain? ☐ Yes ☐ No

In the past 12 months, how many times have you fallen (by a fall, we mean when a person unintentionally comes to rest on the ground or another lower level)? _____ Number of falls ☐ None

Are there any other important medical conditions for which you are now being treated? ☐ Yes ☐ No
Please list: _____

Do you agree to share your longitudinal information? Checking yes will allow STAR collect and keep a record of your responses to the STAR survey each time you complete an annual update. *You do not have to consent to sharing your longitudinal information to participate in the STAR Registry.* ☐ Yes ☐ No

Please indicate your willingness to receive information about the following types of studies (check for yes):

☐ Mail Questionnaires ☐ Telephone Interviews ☐ Face-to-Face Interviews

☐ Studies of Memory ☐ Studies requiring physical exam

☐ Studies requiring blood or other body products ☐ Studies requiring use of medications

Where did you hear about the STAR Volunteer Research Registry? Please be specific (e.g. a particular newspaper, a friend, a doctor's office, etc.): _____

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1. **On average, how many hours of sleep do you get in a 24-hour period?**
   ☐ 5 Hours or Less ☐ More than 5 Hours, but Less than 7 Hours ☐ 7 Hours or More
   ☐ Don't Know/Not sure
2. **How often do you have trouble falling asleep?**
   ☐ Rarely or never ☐ Sometimes ☐ Most of the time ☐ Don't Know/Not sure
3. **How often do you have trouble with waking up during the night?**
   ☐ Rarely or never ☐ Sometimes ☐ Most of the time ☐ Don't Know/Not sure
4. **How often do you have trouble with waking up too early and not being able to fall asleep again?**
   ☐ Rarely or never ☐ Sometimes ☐ Most of the time ☐ Don't Know/Not sure
5. **How often do you feel really rested when you wake up in the morning?**
   ☐ Rarely or never ☐ Sometimes ☐ Most of the time ☐ Don't Know/Not sure

Thank you for participating! Please mail this completed form in the enclosed self-addressed stamped envelope to: UI ICTS, STAR Volunteer Research Registry, C44 GH, Iowa City, IA 52242. Return of this form indicates your agreement to place your information in the registry. If you would like more information, contact the STAR Registry Coordinator at 319-335-7569 or by email coa-star@uiowa.edu, or visit our website: http://icts.uiowa.edu/star.