

The University of Iowa
Seniors Together in Aging Research (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:
 Some college Less than high school High school diploma/GED
 Military 2 year college degree (i.e. AA, AS) 4 year college degree (i.e. BA, BS)
 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 - \$150,000 \$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 _____

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 the University of Iowa 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 Disability 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 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	<input type="checkbox"/> Diverticulitis/osis <input type="checkbox"/> Kidney disease <input type="checkbox"/> Ulcer	<input type="checkbox"/> Inflammatory Bowel Disease <input type="checkbox"/> Liver disease <input type="checkbox"/> Other:
Allergies	<input type="checkbox"/> Food allergies <input type="checkbox"/> Other:	<input type="checkbox"/> Seasonal allergies
Behavior/Psychiatric/Mental	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Eating disorder <input type="checkbox"/> Feeling overly occupied with shopping/spending <input type="checkbox"/> Language/Learning Disorder (e.g., dyslexia, ADHD) <input type="checkbox"/> Obsessive Compulsive Disorder OCD <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Social Isolation	<input type="checkbox"/> Drug addiction/substance use disorder (prescription or illegal substances) <input type="checkbox"/> Gambling problems (too much or having trouble quitting) <input type="checkbox"/> Mood Disorder (anxiety, depression, bipolar) <input type="checkbox"/> Post-Traumatic Stress Disorder (PTSD) <input type="checkbox"/> Other:
Bones	<input type="checkbox"/> Arthritis <input type="checkbox"/> Joint Replacement <input type="checkbox"/> Other:	<input type="checkbox"/> Fracture (e.g., hip, spine) <input type="checkbox"/> Osteoporosis
Cancer	<input type="checkbox"/> Bladder <input type="checkbox"/> Colon/Rectum <input type="checkbox"/> Melanomas of the skin <input type="checkbox"/> Other:	<input type="checkbox"/> Breast <input type="checkbox"/> Lung/Bronchus <input type="checkbox"/> Prostate
Endocrine/Metabolism	<input type="checkbox"/> Diabetes <input type="checkbox"/> Weight problems	<input type="checkbox"/> Hyper/Hypothyroid <input type="checkbox"/> Other:
Head/Eyes/Ears/Nose/Throat	<input type="checkbox"/> Cataracts <input type="checkbox"/> Dental conditions (e.g., caries, periodontal disease, tooth loss, dry mouth) <input type="checkbox"/> Diabetic retinopathy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Hearing problems. Hearing aid? One ear <input type="checkbox"/> Both ears <input type="checkbox"/> N/A <input type="checkbox"/> <input type="checkbox"/> Macular degeneration <input type="checkbox"/> Vision correction: <input type="checkbox"/> glasses/contacts <input type="checkbox"/> Lasik surgery <input type="checkbox"/> Other:	
Heart and Blood Vessels	<input type="checkbox"/> Anemia <input type="checkbox"/> High blood pressure <input type="checkbox"/> Other:	<input type="checkbox"/> Heart disease <input type="checkbox"/> High cholesterol
Lungs	<input type="checkbox"/> Asthma <input type="checkbox"/> Other:	<input type="checkbox"/> Lung disease (chronic bronchitis, COPD, emphysema)
Neurological	<input type="checkbox"/> Alzheimer's/Dementia <input type="checkbox"/> Epilepsy/seizures <input type="checkbox"/> Memory problems <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Stroke	<input type="checkbox"/> Difficulty thinking <input type="checkbox"/> Head injury <input type="checkbox"/> Migraine/Severe Headache <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> Other:
Reproductive Health	<input type="checkbox"/> History of infertility (male or female) <input type="checkbox"/> Gestational Diabetes <input type="checkbox"/> Intrauterine growth restriction (baby grown pathologically too small) <input type="checkbox"/> Hormone Replacement Therapy	<input type="checkbox"/> Toxemia or pre-eclampsia <input type="checkbox"/> Preterm birth (<37 weeks gestation) <input type="checkbox"/> Intrauterine fetal demise (baby died in utero after 20 wks of gestation) <input type="checkbox"/> Other:
Skin	<input type="checkbox"/> Bed sores <input type="checkbox"/> Psoriasis <input type="checkbox"/> Other:	<input type="checkbox"/> Eczema <input type="checkbox"/> Seborrheic dermatitis
Urological	<input type="checkbox"/> Bladder or urinary tract infections <input type="checkbox"/> Straining to empty bladder <input type="checkbox"/> Weak/intermittent urine flow	<input type="checkbox"/> Freq. &/or urgent urination AM or PM <input type="checkbox"/> Urinary incontinence <input type="checkbox"/> Other:

Do you experience chronic pain? Yes No

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.): _____

STAR Registry COVID-19 Supplement

1. Have you tried to get tested for the coronavirus disease, also known as COVID-19? Yes No

2. Were you tested for COVID-19? Yes No

2a. If YES: What was the test result? Negative Positive Don't Know

3. On a scale of 1 to 10, where 1 is 'Not at All Stressed' and 10 is 'Completely Stressed', how stressed do you feel right now as a result of COVID-19? (Please circle one)

1 2 3 4 5 6 7 8 9 10

4. On a scale of 1 to 10, where 1 is 'Not at All Lonely' and 10 is 'Completely Lonely', how lonely are you feeling as a result of COVID-19? (Please circle one)

1 2 3 4 5 6 7 8 9 10

Survey source: University of Florida. (2020).

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>.

What happens to my information?

- STAR keeps all your data secure and confidential, according to guidelines established by the University of Iowa Institutional Review Board.
- STAR uses your personal information to match you with research studies.
- Researchers do not get your personal information unless you contact them.
- STAR asks you to update any new information once a year.