The University of Iowa   
**S**eniors **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 - $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 | Diverticulitis/osis  Inflammatory Bowel Disease  Kidney disease  Liver disease  Ulcer  Other: |
| Allergies | Food allergies  Seasonal allergies  Other: |
| Behavior/Psychiatric/Mental | Alcoholism  Drug addiction/substance use disorder  Eating disorder        (prescription or illegal substances)  Feeling overly occupied with  Gambling problems (too much or having          shopping/spending trouble quitting)  Language/Learning Disorder  Mood Disorder (anxiety, depression,  (e.g., dyslexia, ADHD) bipolar)  Obsessive Compulsive Disorder OCD  Post-Traumatic Stress Disorder (PTSD)  Schizophrenia  Social Isolation  Other: |
| Bones | Arthritis  Fracture (e.g., hip, spine)  Joint Replacement  Osteoporosis  Other: |
| Cancer | Bladder  Breast  Colon/Rectum  Lung/Bronchus  Melanomas of the skin  Prostate  Other: |
| Endocrine/Metabolism | Diabetes  Hyper/Hypothyroid  Weight problems  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  Heart disease  High blood pressure  High cholesterol  Other: |
| Lungs | Asthma  Lung disease (chronic bronchitis, COPD,  Other: emphysema) |
| Neurological | Alzheimer’s/Dementia  Difficulty thinking  Epilepsy/seizures  Head injury  Memory problems  Migraine/Severe Headache  Multiple sclerosis  Parkinson’s disease  Stroke  Other: |
| Reproductive Health | History of infertility (male or female)  Toxemia or pre-eclampsia  Gestational Diabetes  Preterm birth (<37 weeks gestation)   Intrauterine growth restriction  Intrauterine fetal demise (baby died in  (baby grown pathologically too small) utero after 20 wks of gestation)  Hormone Replacement Therapy  Other: |
| Skin | Bed sores  Eczema  Psoriasis  Seborrheic dermatitis  Other: |
| Urological | Bladder or urinary tract infections  Freq. &/or urgent urination AM or PM   Straining to empty bladder  Urinary incontinence   Weak/intermittent urine flow  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 (see accompanying letter)?** *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.):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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](mailto:coa-star@uiowa.edu), or visit our website: <http://icts.uiowa.edu/star>.

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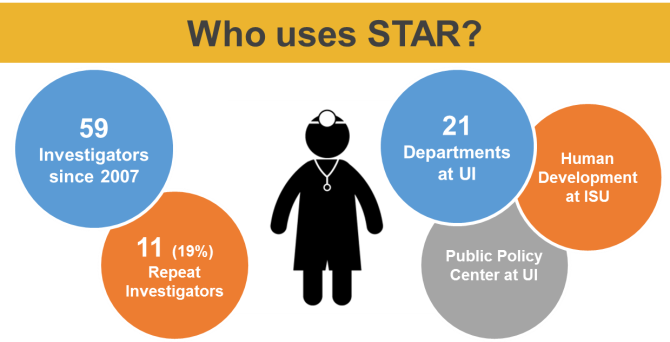
**How does it work?**

You complete a 4-page form about health, demographics, and behavior. STAR matches you with research studies for which you may be eligible. You decide if you are interested, and you contact the research team.

**What kinds of research?**

YOU CHOOSE which studies you’re interested in. Many kinds of research studies are looking for eligible participants.

* Some studies look for healthy volunteers.
* Some are health-related; some are not.
* Participation can range from phone calls to medical tests or drug trials, among others.



*Breakdown of researchers who have used STAR Registry to help recruit research participants.*

**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.

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**Why STAR?**

Researchers often have difficulty recruiting older adults. If you’re over 50, join over 1700 other community members who are willing to participate in research studies! By registering, you can help UI increase diversity in research studies by including more adults over age 50 AND help make research results more helpful to the scientific community and inform the general public.