



MILLENNIUM COHORT STUDY

You may also complete this questionnaire online at:
www.MillenniumCohort.org

PRIVACY ACT STATEMENT: You have rights under the Privacy Act. The following statement describes how that Act applies to this study:

Authority: Authority to request this information is granted under Title 5, U.S. Code 136, the Department of Defense Regulations, Executive Order 9396, and DoD RGS#DD-HA(AR)2106 (expires 11-01-03). Personal identifiers will be used to link survey data with medical and other military records.

Purpose: Medical research information will be collected in a research project titled "Prospective Studies of U.S. Military Forces: The Millennium Cohort Study." The project objective is to enhance basic medical knowledge and to improve the treatment and prevention of illnesses that may be related to military service.

Routine Uses: The information provided in this questionnaire will be maintained in data files at the DoD Center for Deployment Health Research at the Naval Health Research Center and used only for medical research purposes. Use of these data may be granted to other federal and non-federal medical research agencies as approved by the Naval Health Research Center's Institutional Review Board. However, your personal identifiers will be protected. By signing the enclosed consent form, you are volunteering to disclose your information as identified above. If you do not agree to this disclosure, your failure will make the research less useful. The "Blanket Routine Uses" that appears at the beginning of the Department of Defense's compilation of medical data bases also applies to this system.

Anonymity: All responses will be held in confidence by the DoD Center for Deployment Health Research. Information you provide will be considered only when statistically summarized with the responses of others. Your personal identifiers (name, etc) will only be used to link data sets and then the identifiers will be stripped from study data such that medical researchers cannot identify you individually.

Voluntary Disclosure: Completion of the questionnaire is voluntary. Failure to respond to any of the questions will NOT result in any penalties except possible lack of representation of your views in the final results and outcomes.



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MARKING INSTRUCTIONS

- > Use BLACK or BLUE ink.
- > Shade circles like this: ● Not like this: ⊗ ⊙
- > Mistakes must be crossed out with an "X."
- > Print in CAPITAL LETTERS and avoid contact with the edge of the box. EXAMPLE:

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

- > Answer every question to the best of your ability.
- > It will take approximately 30 minutes to complete the questionnaire.

1. What is your current mailing address?

Address Line 1:

Address Line 2 (optional):

City (or FPO/APO):

State/Province/Region (or AA/AE/AP):

ZIP/Postal Code:

Country:

2. Please provide your daytime phone number:

3. Please provide your email address:

If any of your contact information changes, please log on to www.MillenniumCohort.org or call our toll-free number at (888) 942-5222 to provide an update.

4. What is today's date?

M M / D D / Y Y Y Y

/ / 2 0 0

5. What are the last four digits of your social security number?

6. What is your **CURRENT** marital status?
Choose the single best answer:

- Single, never married
- Now married
- Separated
- Divorced
- Widowed

7. What is the highest level of education that you have **COMPLETED**? Choose the single best answer:

- Less than high school completion/diploma
- High school degree/GED/or equivalent
- Some college, no degree
- Associate's degree
- Bachelor's degree
- Master's, doctorate, or professional degree

8. Approximately how much do you weigh (in pounds)?

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pounds

9. How tall are you? For example, a person who is 5'8" tall would write 5 feet 08 inches.

	feet			inches
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10. Has your doctor or other health professional **EVER** told you that you have any of the following conditions?

		No	Yes	If YES, what year did the problem begin?
a. Hypertension (high blood pressure)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
b. Coronary heart disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
c. Heart attack	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
d. Angina (chest pain)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
e. Any other heart condition please specify <input style="width: 150px;" type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
f. Sinusitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
g. Chronic bronchitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
h. Emphysema	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
i. Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
j. Kidney failure requiring dialysis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
k. Bladder infection	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
l. Pancreatitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
m. Diabetes or sugar diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
n. Gallstones	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
o. Hepatitis B	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
p. Hepatitis C	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
q. Any other hepatitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
r. Cirrhosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
s. Rheumatoid arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
t. Lupus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
u. Multiple sclerosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
v. Crohn's disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
w. Stomach, duodenal, or peptic ulcer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

Question 10 continued...

If YES, what year did
the problem begin?

	No	Yes				
x. Ulcerative colitis or proctitis	<input type="radio"/>	<input type="radio"/>				
y. Significant hearing loss	<input type="radio"/>	<input type="radio"/>				
z. Migraine headaches	<input type="radio"/>	<input type="radio"/>				
aa. Stroke	<input type="radio"/>	<input type="radio"/>				
bb. Neuropathy-caused reduced sensation in hands or feet	<input type="radio"/>	<input type="radio"/>				
cc. Seizures	<input type="radio"/>	<input type="radio"/>				
dd. Sleep apnea	<input type="radio"/>	<input type="radio"/>				
ee. Anemia	<input type="radio"/>	<input type="radio"/>				
ff. Thyroid condition other than cancer	<input type="radio"/>	<input type="radio"/>				
gg. Cancer please specify <input type="text"/>	<input type="radio"/>	<input type="radio"/>				
hh. Chronic fatigue syndrome	<input type="radio"/>	<input type="radio"/>				
ii. Depression	<input type="radio"/>	<input type="radio"/>				
jj. Schizophrenia or psychosis	<input type="radio"/>	<input type="radio"/>				
kk. Manic-depressive disorder	<input type="radio"/>	<input type="radio"/>				
ll. Posttraumatic stress disorder	<input type="radio"/>	<input type="radio"/>				
mm. Other please specify <input type="text"/>	<input type="radio"/>	<input type="radio"/>				

11. **DURING THE LAST 3 YEARS**, have you had persistent or recurring
problems with any of the following conditions?If YES, what year did
the problem begin?

	No	Yes				
a. Severe headache	<input type="radio"/>	<input type="radio"/>	2	0	0	
b. Diarrhea	<input type="radio"/>	<input type="radio"/>	2	0	0	
c. Rash or skin ulcer	<input type="radio"/>	<input type="radio"/>	2	0	0	
d. Sore throat	<input type="radio"/>	<input type="radio"/>	2	0	0	
e. Frequent bladder infections	<input type="radio"/>	<input type="radio"/>	2	0	0	
f. Cough	<input type="radio"/>	<input type="radio"/>	2	0	0	
g. Fever	<input type="radio"/>	<input type="radio"/>	2	0	0	
h. Sudden unexplained hair loss	<input type="radio"/>	<input type="radio"/>	2	0	0	
i. Earlobe pain	<input type="radio"/>	<input type="radio"/>	2	0	0	
j. Sleepy all the time	<input type="radio"/>	<input type="radio"/>	2	0	0	
k. Night sweats	<input type="radio"/>	<input type="radio"/>	2	0	0	
l. Chest pain	<input type="radio"/>	<input type="radio"/>	2	0	0	
m. Unusual muscle pains	<input type="radio"/>	<input type="radio"/>	2	0	0	
n. Shortness of breath	<input type="radio"/>	<input type="radio"/>	2	0	0	
o. Trouble sleeping	<input type="radio"/>	<input type="radio"/>	2	0	0	
p. Unusual fatigue	<input type="radio"/>	<input type="radio"/>	2	0	0	
q. Forgetfulness	<input type="radio"/>	<input type="radio"/>	2	0	0	
r. Confusion	<input type="radio"/>	<input type="radio"/>	2	0	0	
s. Other please specify <input type="text"/>	<input type="radio"/>	<input type="radio"/>	2	0	0	

12. **DURING THE LAST 4 WEEKS**, how much have you been bothered by any of the following problems?

	Not bothered	Bothered a little	Bothered a lot
a. Stomach pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Back pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Pain in your arms, legs, or joints (knees, hips, etc)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Pain or problems during sexual intercourse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Headaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Chest pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Dizziness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Fainting spells	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Feeling your heart pound or race	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Shortness of breath	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. Constipation, loose bowels, or diarrhea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l. Nausea, gas, or indigestion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
m. Women only: menstrual cramps or other problems with your periods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

13. **OVER THE LAST 2 WEEKS**, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Feeling down, depressed, or hopeless	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Trouble falling or staying asleep or sleeping too much	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Feeling tired or having little energy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Poor appetite or overeating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Moving or speaking so slowly that other people could have noticed, or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Thoughts that you would be better off dead or of hurting yourself in some way	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If you have been frequently bothered by several of the items listed above, you may want to seek help from a health professional in your area.

No Yes

14. a. **IN THE LAST 4 WEEKS**, have you had an anxiety attack - suddenly feeling fear or panic?

If you checked "NO," please go to question 16.

- b. Has this ever happened to you before?
- c. Do some of these attacks come **suddenly out of the blue** - that is, in situations where you don't expect to be nervous or uncomfortable?
- d. Do these attacks bother you a lot, or are you worried about having another attack?

15. Think about your last bad anxiety attack. No Yes

- a. Were you short of breath?
- b. Did your heart race, pound, or skip?
- c. Did you have chest pain or pressure?
- d. Did you sweat?
- e. Did you feel as if you were choking?
- f. Did you have hot flashes or chills?
- g. Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea?
- h. Did you feel dizzy, unsteady, or faint?
- i. Did you have tingling or numbness in parts of your body?
- j. Did you tremble or shake?
- k. Were you afraid you were dying?

16. **OVER THE LAST 4 WEEKS**, how often have you been bothered by any of the following problems?

- | | Not at all | Several days | More than half the days |
|--------------------------------------------------------------------------------|-----------------------|-----------------------|-------------------------|
| a. Feeling nervous, anxious, on edge, or worrying a lot about different things | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

If you checked "NOT AT ALL," go to question 17.

- | | | | |
|---------------------------------------------------------------------------|-----------------------|-----------------------|-----------------------|
| b. Feeling restless so that it is hard to sit still | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| c. Getting tired very easily | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| d. Muscle tension, aches, or soreness | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| e. Trouble falling asleep or staying asleep | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| f. Trouble concentrating on things, such as reading a book or watching TV | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| g. Becoming easily annoyed or irritable | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

17. For each question, mark the column indicating how often **on average** you have eaten the item(s) **during the past year.**

	Less than once per week	Once per week	2-4 times per week	Nearly daily or daily	Twice or more per day
a. Beef, Pork, or Lamb as a Main Dish	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Processed Meats (sausages, salami, bologna, hot dogs, bacon)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Whole eggs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Whole Milk Dairy Foods (whole milk, hard cheese, butter, ice cream)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Deep Fried Foods (deep fried chicken, fish, or seafood; French fries, onion rings)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Baked Products (donuts, cookies, muffins, crackers, cakes, sweet rolls, pastries)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Stick Margarine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Dark Green Leafy Vegetables (spinach, romaine lettuce, kale, turnip greens, bok choy)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Broccoli, Cauliflower, Cabbage, Brussel Sprouts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Carrots	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. Other vegetables (peas, corn, green beans, tomatoes, squash, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l. Citrus Fruits (orange juice or grapefruit juice, oranges, grapefruit, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
m. Other Fruits (fresh apples or pears, bananas, berries, grapes, melons, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
n. Whole Grain Foods (whole grain breads, brown rice, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
o. Do you add salt to food at the table?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
p. Do you currently take a multi-vitamin?	<input type="radio"/> No <input type="radio"/> Yes		If YES, how many per week? <input type="text"/> <input type="text"/>		

18. On an average day, about how many cups, bottles, or cans of drink with caffeine do you drink (like coffee, tea, or coke/soda/pop)?

- None 1 2 3 4 to 5 6 or more

19. About how many times each week do you eat from a fast food restaurant (like hamburgers, tacos, or pizza)?

- None 1 2 to 3 4 to 7 8 to 14 15 or more times

- | | | No | Yes |
|--------|--------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-----------------------|
| 20. a. | Do you often feel that you can't control <u>what</u> or <u>how much</u> you eat? | <input type="radio"/> | <input type="radio"/> |
| b. | Do you often eat, <u>within any 2 hour period</u> , what most people would regard as an unusually <u>large</u> amount of food? | <input type="radio"/> | <input type="radio"/> |

If you checked "NO," to either question 20a or 20b, go to question 23.

- | | | | |
|----|----------------------------------------------------------------------------------|-----------------------|-----------------------|
| c. | Has this been as often, on average, as twice a week for the last 3 months? | <input type="radio"/> | <input type="radio"/> |
|----|----------------------------------------------------------------------------------|-----------------------|-----------------------|

21. **IN THE LAST 3 MONTHS**, have you done any of the following in order to avoid gaining weight?

- | | | No | Yes |
|----|------------------------------------------------------------------------------------------------|-----------------------|-----------------------|
| a. | Made yourself vomit? | <input type="radio"/> | <input type="radio"/> |
| b. | Took more than twice the recommended dose of laxatives? | <input type="radio"/> | <input type="radio"/> |
| c. | Fasted - not eaten anything at all for at least 24 hours? | <input type="radio"/> | <input type="radio"/> |
| d. | Exercised for more than an hour specifically to avoid gaining weight after binge eating? | <input type="radio"/> | <input type="radio"/> |

22. If you checked "YES" to any of these ways of avoiding gaining weight, were any as often, on average, as twice a week?

No Yes

23. If you checked any problems on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all Somewhat difficult Very difficult Extremely difficult

24. **IN THE LAST 4 WEEKS**, how much have you been bothered by any of the following problems?

- | | Not
bothered | Bothered
a little | Bothered
a lot |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-----------------------|-----------------------|
| a. Worrying about your health | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| b. Your weight or how you look | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| c. Little or no sexual desire or pleasure during sex | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| d. Difficulties with husband/wife, partner/lover, or boyfriend/girlfriend | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| e. The stress of taking care of children, parents, or other family members | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| f. Stress at work outside of the home or at school | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| g. Financial problems or worries | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| h. Having no one to turn to when you have a problem | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| i. Something bad that happened <u>recently</u> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| j. Thinking or dreaming about something terrible that happened to you in the past - like your house being destroyed, a severe accident, being hit or assaulted, or being forced to commit a sexual act | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

25. **IN THE LAST YEAR**, have you been hit, slapped, kicked, or otherwise physically hurt by someone, or has anyone forced you to have an unwanted sexual act? No Yes

26. Are you **CURRENTLY** taking any medicine for anxiety, depression, or stress? No Yes

27. **OVER THE PAST MONTH**, how many hours of sleep did you get in an average 24-hour period? hours

If you are **MALE**, please go to question 29.
If you are **FEMALE**, please go to question 28.

28. **FOR WOMEN ONLY: Questions about menstruation, pregnancy, and childbirth.**

- a. Which best describes your menstrual periods?
- No periods because pregnant or recently gave birth
 - No periods for over a year and unrelated to pregnancy or childbirth
 - Periods regulated by hormone replacement (estrogen) therapy or oral contraceptives
 - Periods unregulated and unchanged for over a year
 - Periods have become irregular or changed in frequency, duration, and/or amount in last year

- | | No | Yes | Does not apply |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-----------------------|-----------------------|
| b. During the week before your period starts, do you have a <u>serious</u> problem with your mood - like depression, anxiety, irritability, anger, or mood swings? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| c. If YES : Do these problems go away by the end of your period? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| d. Have you given birth within the last 3 years? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| e. Have you had a miscarriage within the last 3 years? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| f. During the last 3 years have you tried and been unable to become pregnant? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

29. **IN THE PAST MONTH** have you had?

- | | Not at all | A little bit | Moderately | Quite a bit | Extremely |
|----------------------------------------------------------------------------------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| a. Repeated, disturbing memories of stressful experiences from the past | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| b. Repeated, disturbing dreams of stressful experiences from the past | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| c. Suddenly acting or feeling as if stressful experiences were happening again | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| d. Feeling very upset when something happened that reminds you of stressful experiences from the past .. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| e. Trouble remembering important parts of stressful experiences from the past | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Question 29 continued on page 10

Question 29 continued.....

	Not at all	A little bit	Moderately	Quite a bit	Extremely
f. Loss of interest in activities that you used to enjoy ..	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Feeling distant or cut off from other people	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Feeling emotionally numb, or being unable to have loving feelings for those close to you	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Feeling as if your future will somehow be cut short ..	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Trouble falling asleep or staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. Feeling irritable or having angry outbursts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l. Having difficulty concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
m. Being "super-alert" or watchful or on guard	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
n. Feeling jumpy or easily startled	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
o. Having physical reactions when something reminds you of stressful experiences from the past	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
p. Avoid thinking about your stressful experiences from the past or avoid having feelings about them ..	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
q. Avoid activities or situations because they remind you of stressful experiences from the past	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

30. What is your normal walking speed?

- Easy (<2 mph) Normal, average (2 to 2.9 mph) Brisk pace (3 to 3.9 mph) Very brisk, striding (4 mph or faster)

31. Do you have difficulty with your balance? No Yes

32. How many flights of stairs (**not steps**) do you climb daily?

- No flights 1-2 flights 3-4 flights 5-9 flights 10-14 flights 15 or more flights

33. During the past year, what was your average total time per week at each activity?

	None	<2 Hrs.	2-3 Hrs.	4-6 Hrs	7-10 Hrs.	11-20 Hrs.	21-30 Hrs.	31-40 Hrs.	40+ Hrs.
a. Sitting at work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Sitting or driving in a car, bus, or train	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Sitting or laying watching TV or VCR	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Sitting at home reading	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Other sitting at home (e.g., at desk or eating)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

34. During the past year, what was your average total time per week at each activity?

	None	1-20 Mins.	20-40 Mins.	40-120 Mins.	2-3 Hrs.	4-6 Hrs.	7-10 Hrs.	>10 Hrs.
a. Walking or hiking outdoors (including walking at golf)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Jogging (slower than 10 minutes/mile)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Running (10 minutes/mile or faster)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Bicycling (including stationary machine)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Lap swimming	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Tennis or other racquet sports	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Basketball, Volleyball, or other active team sports	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Calisthenics, Rowing or other Aerobics	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Weightlifting or Nautilus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Heavy outdoor work (e.g. digging, chopping)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

35. In general, would you say your health is: (Please check only one.)

Excellent

Very good

Good

Fair

Poor

36. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
a. Vigorous activities , such as running, lifting heavy objects, or participating in strenuous sports?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Moderate activities , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Lifting or carrying groceries?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Climbing several flights of stairs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Climbing one flight of stairs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Bending, kneeling, or stooping?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Walking more than a mile ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Walking several blocks?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Walking one block?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Bathing or dressing yourself?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

37. **DURING THE PAST 4 WEEKS**, have you had any of the following problems with your work or other regular daily activities as a result of your **physical health**?

	No, none of the time	Yes, a little of the time	Yes, some of the time	Yes, most of the time	Yes, all of the time
a. Cut down the amount of time you spent on work or other activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Accomplished less than you would like	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Were limited in the kind of work or other activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Had difficulty performing the work or other activities (for example, it took extra effort)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

38. **DURING THE PAST 4 WEEKS**, have you had any of the following problems with your work or other regular daily activities as a result of any **emotional problems** (such as feeling depressed or anxious)?

	No, none of the time	Yes, a little of the time	Yes, some of the time	Yes, most of the time	Yes, all of the time
a. Cut down the amount of time you spent on work or other activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Accomplished less than you would like	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Didn't do work or other activities as carefully as usual	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

39. **DURING THE PAST 4 WEEKS**, to what extent has your **physical health or emotional problems** interfered with your normal social activities with family, friends, neighbors, or groups?

- Not at all
 Slightly
 Moderately
 Quite a bit
 Extremely

40. **DURING THE PAST 4 WEEKS**, how much bodily pain have you had?

- None
 Very mild
 Mild
 Moderate
 Severe
 Very severe

41. **DURING THE PAST 4 WEEKS**, how much did **pain** interfere with your normal work (including both work outside the home and housework)?

- Not at all
 A little bit
 Moderately
 Quite a bit
 Extremely

42. **DURING THE PAST 4 WEEKS**, how much of the time:
(Please select the **single best** answer for each question.)

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
a. Did you feel full of pep ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Have you been a very nervous person ? ..	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Have you felt so down in the dumps that nothing could cheer you up ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Have you felt calm and peaceful ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Did you have a lot of energy ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Have you felt downhearted and blue ? ...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Did you feel worn out ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Have you been a happy person ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Did you feel tired ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

43. **DURING THE PAST 4 WEEKS**, how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives)?

All of the time Most of the time Some of the time A little of the time None of the time

44. Please choose the answer that best describes how true or false **EACH** of the following statements is for you.

	Definitely true	Mostly true	Not sure	Mostly false	Definitely false
a. I seem to get sick a little easier than other people ...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. I am as healthy as anybody I know	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. I expect my health to get worse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. My health is excellent	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

45. **COMPARED TO 3 YEARS AGO**, how would you rate your **physical health** in general now?

Much better Somewhat better About the same Somewhat worse Much worse

46. **COMPARED TO 3 YEARS AGO**, how would you rate your *emotional health or well-being* (such as feeling anxious, depressed, or irritable) *now*?

- Much better Somewhat better About the same Somewhat worse Much worse

47. Other than conventional medicine, what other health treatments have you used **IN THE LAST 12 MONTHS**?

	No	Yes		No	Yes
a. Acupuncture	<input type="radio"/>	<input type="radio"/>	g. High dose/megavitamin therapy	<input type="radio"/>	<input type="radio"/>
b. Biofeedback	<input type="radio"/>	<input type="radio"/>	h. Homeopathy	<input type="radio"/>	<input type="radio"/>
c. Chiropractic care	<input type="radio"/>	<input type="radio"/>	i. Hypnosis	<input type="radio"/>	<input type="radio"/>
d. Energy healing	<input type="radio"/>	<input type="radio"/>	j. Massage	<input type="radio"/>	<input type="radio"/>
e. Folk remedies	<input type="radio"/>	<input type="radio"/>	k. Relaxation	<input type="radio"/>	<input type="radio"/>
f. Herbal therapy	<input type="radio"/>	<input type="radio"/>	l. Spiritual healing	<input type="radio"/>	<input type="radio"/>

48. Have you ever received anthrax vaccine? No Yes

If **YES**, how many shots of the anthrax vaccine have you received?

49. In the **PAST 3 YEARS**, have you received smallpox vaccine? No Yes

These next few questions are about drinking alcoholic beverages. Alcoholic beverages include liquor such as whiskey, gin, beer, wine, wine coolers, and any other type of alcoholic beverage. For the purpose of this questionnaire:

One drink = one 12-ounce beer, one 4-ounce glass of wine, or one 1.5 ounce shot of liquor

50. **IN ANY ONE YEAR**, have you had a total of 12 drinks of any type of alcoholic beverage (including beer and wine)? No Yes

51. **IN YOUR ENTIRE LIFE**, have you had at least 12 drinks of any type of alcoholic beverage (including beer and wine)? No Yes

If you checked "YES," go to question 52.
If you checked "NO," go to question 60.

52. **IN THE PAST YEAR**, have you had at least 12 drinks of any type of alcoholic beverage? ---- No Yes

If you checked "YES," go to question 53.
If you checked "NO," go to question 60.

53. **IN THE PAST YEAR**, how **OFTEN** did you typically drink any type of alcoholic beverage?

Never Rarely Monthly Weekly Daily

54. **IN THE PAST YEAR**, on those days that you drank alcoholic beverages, on average, how many drinks did you have? ----- drinks

55. **IN A TYPICAL WEEK**, how many drinks do you have? ----- drinks

56. **LAST WEEK**, how many drinks of alcoholic beverages did you have?

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday

Sunday

57. **IN THE PAST YEAR**, on how many **DAYS** did you have 5 or more drinks of any alcoholic beverage? ----- days

58. **IN THE LAST 12 MONTHS**, have any of the following happened to you **MORE THAN ONCE**?

No Yes

- | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-----------------------|
| a. You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health ----- | <input type="radio"/> | <input type="radio"/> |
| b. You drank alcohol, were high from alcohol, or hung over while you were working, going to school, or taking care of children or other responsibilities ----- | <input type="radio"/> | <input type="radio"/> |
| c. You missed or were late for work, school, or other activities because you were drinking or hung over ----- | <input type="radio"/> | <input type="radio"/> |
| d. You had a problem getting along with people while you were drinking ----- | <input type="radio"/> | <input type="radio"/> |
| e. You drove a car after having several drinks or after drinking too much ----- | <input type="radio"/> | <input type="radio"/> |

59. Have you **EVER** felt any of the following?

No Yes

- | | | |
|-----------------------------------------------------------------------------|-----------------------|-----------------------|
| a. Felt you needed to cut back on your drinking ----- | <input type="radio"/> | <input type="radio"/> |
| b. Felt annoyed at anyone who suggested you cut back on your drinking ----- | <input type="radio"/> | <input type="radio"/> |
| c. Felt you needed an "eye-opener," or early morning drink ----- | <input type="radio"/> | <input type="radio"/> |
| d. Felt guilty about your drinking ----- | <input type="radio"/> | <input type="radio"/> |

60. In the **PAST YEAR**, have you used any of the following tobacco products?

- | | No | Yes |
|-----------------------------------------------|-----------------------|-----------------------|
| a. Cigarettes | <input type="radio"/> | <input type="radio"/> |
| b. Cigars | <input type="radio"/> | <input type="radio"/> |
| c. Pipes | <input type="radio"/> | <input type="radio"/> |
| d. Smokeless tobacco (chew, dip, snuff) | <input type="radio"/> | <input type="radio"/> |

61. **IN YOUR LIFETIME**, have you smoked at least 100 cigarettes (5 packs)? No Yes

If you checked "YES," go to question 62.
If you checked "NO," go to question 66.

62. At what age did you start smoking? years old

63. How many years have or did you smoke an average of at least 3 cigarettes per day
(or one pack per week)? years

64. When smoking, how many packs per day did you or do you smoke?

- Less than half a pack per day
- 1/2 to 1 pack per day
- 1 to 2 packs per day
- More than 2 packs per day

65. Have you ever tried to quit smoking?

- Yes, and succeeded
- Yes, but not successfully
- No

66. In the **PAST 3 YEARS**, have you had any of the following life events happen to you?

	No	Yes	If YES, list most recent year			
a. You were divorced or separated	<input type="radio"/>	<input type="radio"/>	2	0	0	<input type="text"/>
b. Suffered major financial problems (such as bankruptcy)	<input type="radio"/>	<input type="radio"/>	2	0	0	<input type="text"/>
c. Suffered forced sexual relations or sexual assault	<input type="radio"/>	<input type="radio"/>	2	0	0	<input type="text"/>
d. Experienced sexual harassment	<input type="radio"/>	<input type="radio"/>	2	0	0	<input type="text"/>
e. Suffered a violent assault	<input type="radio"/>	<input type="radio"/>	2	0	0	<input type="text"/>
f. Had a family member or loved one become severely ill or die	<input type="radio"/>	<input type="radio"/>	2	0	0	<input type="text"/>
g. Suffered a disabling illness or injury	<input type="radio"/>	<input type="radio"/>	2	0	0	<input type="text"/>

67. During the **PAST 3 YEARS**, have you been **PERSONALLY** exposed to any of the following?
(do not include television or video exposure)

	No	Yes, 1 time	Yes, more than 1 time	If YES, list most recent year of exposure
a. Witnessing a person's death due to war, disaster, or tragic event	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2 0 0
b. Witnessing instances of physical abuse (torture, beating, rape)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2 0 0
c. Seeing dead and/or decomposing bodies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2 0 0
d. Seeing maimed soldiers/civilians	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2 0 0
e. Seeing prisoners of war/refugees	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2 0 0
f. Chemical or biological warfare agents	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2 0 0
g. Other medical countermeasures for chemical or biological warfare agent exposure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2 0 0
h. Alarms necessitating wearing of chemical/biological warfare protective gear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2 0 0

68. **DURING THE PAST 3 YEARS**, were you **PERSONALLY** exposed to any of the following?

	No	Don't know	Yes	If YES, list most recent year of exposure
a. Occupational hazards requiring protective equipment, such as respirators or hearing protection	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2 0 0
b. Routine skin contact with paint and/or solvent and/or substances	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2 0 0
c. Depleted uranium (DU)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2 0 0
d. Microwaves (excluding small microwave ovens)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2 0 0
e. Pesticides, including creams, sprays, or uniform treatments	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2 0 0
f. Pesticides applied in the environment or around living facilities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2 0 0
g. Any exposure, physical or psychological, during a military deployment that had a significant impact on your health?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2 0 0
please specify <input type="text"/>				

Theaters of Operation

Location
Number

- 1 South Central Asia (example: Afghanistan, Pakistan, India, Uzbekistan, Tajikistan, Kazakhstan)
- 2 South West Asia (example: Iraq, Iran, Kuwait, Saudi Arabia, Israel, Qatar, Jordan, Yemen, Turkey)
- 3 Other Asian Countries (example: Japan, Korea, Guam, Phillipines, Indonesia, Malaysia)
- 4 Balkans (example: Kosovo, Macedonia, Albania, Bosnia, Yugoslavia/Serbia, Croatia)
- 5 Africa
- 6 South or Central America
- 7 Other (please specify)

69. Please review the list above. Have you been to any of these Theaters of Operation for more than **30 consecutive days** in the **PAST 3 YEARS**? No Yes

If you marked "YES," go to question 70
 If you marked "NO," go to question 72

70. If yes, use the numbers assigned to each Theater of Operation above to fill in the following table for each location where you spent more than **30 consecutive days** in the **PAST 3 YEARS**:

	Location Number	Date Arrived						TO	Date Departed						
		M	M	/	Y	Y	Y		Y	M	M	/	Y	Y	Y
a.	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	/	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	/	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>
b.	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	/	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	/	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>
c.	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	/	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	/	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>
d.	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	/	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	/	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>
e.	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	/	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	/	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>
f.	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	/	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	/	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>
g.	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	/	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	/	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>
h.	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	/	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	/	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>
i.	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	/	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	/	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>
j.	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	/	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	/	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>

71. Have you been to more Theaters of Operation than the space allowed in the past 3 years? ... No Yes

72. Were any of these deployments part of Operation Enduring Freedom? No Yes

Please answer question 73 ONLY if you are ENLISTED (Active Duty, Reserve, or National Guard).
All others please skip to question 74.

73. Review the list of military occupational categories below. Select the **TWO** categories that **BEST MATCH** your military job and fill in the two-digit code for your **PRIMARY** job code and your **SECONDARY** job code.

PRIMARY JOB CODE

SECONDARY JOB CODE

<p>INFANTRY, GUN CREWS & SEAMANSHIP SPECIALISTS</p> <p>01 Infantry</p> <p>02 Armor & Amphibious</p> <p>03 Combat Engineering</p> <p>04 Artillery/Gunnery, Rockets & Missiles</p> <p>05 Air Crew</p> <p>06 Seamanship</p> <p>07 Installation Security</p>	<p>COMMUNICATIONS & INTELLIGENCE SPECIALISTS</p> <p>20 Radio & Radio Code</p> <p>21 Sonar</p> <p>22 Radar & Air Traffic Control</p> <p>23 Signal Intel/Electronic Warfare</p> <p>24 Intelligence</p> <p>25 Combat Operations Control</p> <p>26 Communications Center Operations</p>	<p>CRAFTWORKERS</p> <p>70 Metalworking</p> <p>71 Construction</p> <p>72 Utilities</p> <p>74 Lithography</p> <p>75 Industrial Gas & Fuel Production</p> <p>76 Fabric, Leather & Rubber</p> <p>79 Other Craftworker</p>	<p>SERVICE & SUPPLY HANDLERS</p> <p>80 Food Service</p> <p>81 Motor Transport</p> <p>82 Material Receipt, Storage & Issue</p> <p>83 Law Enforcement</p> <p>84 Personnel Service</p> <p>85 Auxiliary Labor</p> <p>86 Forward Area Equipment Support</p> <p>87 Other Services</p>
<p>ELECTRONIC EQUIPMENT REPAIRERS</p> <p>10 Radio/Radar</p> <p>11 Fire Control Electric Systems (Non-Missile)</p> <p>12 Missile Guidance, Control & Check-out</p> <p>13 Sonar Equipment</p> <p>14 Nuclear Weapons Equipment</p> <p>15 ADP Computers</p> <p>16 Teletype & Cryptographic Equipment</p> <p>19 Other Electronic Equipment</p>	<p>HEALTH CARE SPECIALISTS</p> <p>30 Medical Care</p> <p>31 Ancillary Medical Support</p> <p>32 Biomedical Sciences & Allied Health</p> <p>33 Dental Care</p> <p>34 Medical Admin & Logistics</p> <p>35 Other Technical & Allied Specialists</p>	<p>ELECTRICAL /MECHANICAL EQUIPMENT REPAIRERS</p> <p>60 Aircraft & Aircraft-Related</p> <p>61 Automotive</p> <p>62 Wire Communications</p> <p>63 Missile Mechanical & Electrical</p> <p>64 Armament & Munitions</p> <p>65 Shipboard Propulsion</p> <p>66 Power Generating Equipment</p> <p>67 Precision Equipment</p> <p>69 Other Mechanical & Electrical Equipment</p>	<p>FUNCTIONAL SUPPORT & ADMINISTRATION</p> <p>50 Personnel</p> <p>51 Administration</p> <p>52 Clerical/Personnel</p> <p>53 Data Processing</p> <p>54 Accounting, Finance & Disbursing</p> <p>55 Other Functional Support</p> <p>56 Religious, Morale & Welfare</p> <p>57 Information & Education</p>
<p>PHOTOGRAPHY</p> <p>41 Mapping, Surveying, Drafting & Illustrating</p> <p>42 Weather</p> <p>43 Ordnance Disposal & Diving</p> <p>45 Musician</p> <p>49 Technical Specialist</p>		<p>NON-OCCUPATIONAL</p> <p>90 Patients & Prisoners</p> <p>91 Officer Candidate & Student</p> <p>92 Undesignated Occupations</p> <p>95 Not Occupationally Qualified</p>	

Please answer question 74 **ONLY** if you are an **OFFICER** (Active Duty, Reserve, or National Guard).
All others please skip to question 75.

74. Review the list of military occupational categories below. Select the **TWO** that **BEST MATCH** your military job and fill in the two-digit code for your **PRIMARY** job code and your **SECONDARY** job code.

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PRIMARY JOB CODE

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SECONDARY JOB CODE

ENGINEERING & MAINTENANCE OFFICERS

4A Construction & Utilities
4B Electrical/Electronic
4C Communications & Radar
4D Aviation Maintenance & Allied
4E Ordnance
4F Missile Maintenance
4G Ship Construction & Maintenance
4H Ship Machinery
4J Safety
4K Chemical
4L Automotive & Allied
4M Surveying & Mapping
4N Other

NON-OCCUPATIONAL

9A Patient
9B Student
9E Other

GENERAL OFFICERS & EXECUTIVES

1A General & Flag
1B Executive

SCIENTISTS & PROFESSIONALS

5A Physical Scientist
5B Meteorologist
5C Biological Scientist
5D Social Scientist
5E Psychologist
5F Legal
5G Chaplain
5J Mathematician & Statistician
5K Educator & Instructor
5L Research & Development Coordinator
5M Community Activities Officers
5N Scientist & Professional

INTELLIGENCE OFFICERS

3A Intelligence, General
3B Communications Intelligence
3C Counter-Intelligence

ADMINISTRATORS

7A Administrator, General
7B Training Administrator
7C Manpower & Personnel
7D Comptroller & Fiscal
7E Data Processing
7F Pictorial
7G Information
7H Police
7L Inspection
7N Morale & Welfare

TACTICAL OPERATIONS OFFICERS

2A Fixed-Wing Fighter & Bomber Pilot
2C Helicopter Pilot
2D Aircraft Crew
2E Ground & Naval Arms
2F Missiles
2G Operations Staff
2H Civilian Pilot

SUPPLY, PROCUREMENT & ALLIED OFFICERS

8A Logistics, General
8B Supply
8C Transportation
8D Procurement & Production
8E Food Service
8F Exchange & Commissary
8G Other

HEALTH CARE OFFICERS

6A Physician
6C Dentist
6E Nurse
6G Veterinarian
6H Biomedical Sciences & Allied Health
6I Health Service Administration

76. Do you have a civilian job at this time?

- YES Go to question 76
 NO civilian employment at this time Go to question 77
 Homemaker Go to question 77

Please answer question 76 **ONLY** if you answered "YES" to question 75.
All others please skip to question 77.

76. Review the list of **CIVILIAN** occupational categories on this page and the next page. Select the **TWO** categories that **BEST MATCH** your civilian job and fill in the three-digit code for your **PRIMARY** and your **SECONDARY** job codes.

PRIMARY JOB CODE

SECONDARY JOB CODE

OFFICE & ADMINISTRATION SUPPORT

- 431 Supervisors, Office & Administrative Support
- 432 Communications Equipment Operator
- 433 Financial Clerk
- 434 Information & Record Clerk
- 435 Material Recording, Scheduling, Dispatching & Distributing Worker
- 436 Secretaries & Admin Assistants
- 439 Other Office & Admin Support

PRODUCTION OCCUPATIONS

- 511 Supervisor, Production Worker
- 512 Assembler, Fabricator
- 513 Food Processing Worker
- 514 Metal & Plastic Worker
- 515 Printing Worker
- 516 Textile, Apparel & Furnishing Worker
- 517 Woodworker
- 518 Plant & Systems Operator
- 519 Other Production Occupation

PERSONAL CARE SERVICE

- 391 Supervisor, Personal Care & Service
- 392 Animal Care & Service
- 393 Entertainment Attendant & Related Worker
- 394 Funeral Worker
- 395 Personal Appearance
- 396 Transportation, Tourism & Lodging Attendant
- 399 Other Personal Care & Service Worker

INSTALLATION, REPAIR & MAINTENANCE OCCUPATIONS

- 491 Supervisor of Installation, Maintenance & Repair Worker
- 492 Electrical & Electric Equipment Mechanic, Installer & Repairer
- 493 Vehicle & Mobile Equipment Mechanic, Installer, & Repairer
- 499 Other Installation, Maintenance & Repair

FARMING, FISHING & FORESTRY WORKERS

- 451 Supervisor, Farming, Fishing & Forestry Worker
- 452 Agricultural Worker
- 453 Fishing & Hunting Worker
- 454 Forest, Conservation & Logging Worker
- 459 Other Farming, Fishing & Forestry

EDUCATION, TRAINING & LIBRARY

- 251 Postsecondary Teacher
- 252 Primary, Secondary & Special Education School Teacher
- 253 Other Teacher & Instructor
- 254 Librarian, Curator & Archivist
- 259 Other Education, Training & Library Occupations

COMPUTER & MATHEMATICAL

- 151 Computer Specialist
- 152 Mathematical Specialist
- 153 Mathematical Tech

BUSINESS & FINANCIAL OPERATIONS

- 131 Business Operations Specialist
- 132 Financial Specialist

LEGAL

- 231 Lawyer, Judge & Related Worker
- 232 Legal Support Worker

ARTS, DESIGN, MEDIA, ENTERTAINMENT & SPORTS

- 271 Art & Design
- 272 Entertainer & Performer Sports & Related Worker
- 273 Media Communication Worker
- 274 Media Communication Equipment Worker

ARCHITECTURE & ENGINEERING

- 171 Architect, Surveyor & Cartographer
- 172 Engineer
- 173 Drafters, Engineering & Mapping Technician

COMMUNITY & SOCIAL SERVICES

- 211 Counselor, Social Worker & Other Community & Social Service Specialist
- 212 Religious Worker

Question 76 continued, Civilian Occupational categories...

CONSTRUCTION & EXTRACTION

- 471 Supervisor, Construction & Extraction Worker
- 472 Construction Trades Worker
- 473 Helper, Construction Trades
- 474 Other Construction & Related Worker
- 475 Extraction Worker

FOOD PREPARATION & SERVING RELATED

- 351 Supervisor, Food Preparation & Serving
- 352 Cook & Food Preparation Worker
- 353 Food and Beverage Worker
- 359 Other Food Preparation & Serving Related Worker

BUILDING & GROUNDS CLEANING & MAINTENANCE

- 371 Supervisor, Building & Grounds & Cleaning & Maintenance Worker
- 372 Building Cleaning & Pest Control
- 373 Ground Maintenance

TRANSPORTATION & MATERIAL MOVING

- 531 Supervisor, Transportation & Material Moving
- 533 Motor Vehicle Operator
- 534 Rail Transportation Worker
- 535 Water Transportation
- 536 Other Transportation
- 537 Material Moving Worker

HEALTH CARE

- 295 Physician
- 311 Nursing, Psychiatric & Home Health Aid
- 312 Occupational & Physical Therapist Assistant and Aid
- 319 Other Health Care Occupations

SALES-RELATED OCCUPATIONS

- 411 Supervisor, Sales
- 412 Retail Sales Worker
- 413 Sales Rep, Services
- 414 Sales Rep, Wholesale & Manufacturing
- 415 Counter & Rental Clerks & Parts Salesperson
- 419 Other Sales & Related Worker

LIFE, PHYSICAL & SOCIAL SCIENCES

- 191 Life Scientist
- 192 Physical Scientist
- 193 Social Scientist & Related Worker
- 194 Life, Physical & Social Sciences Technician

PROTECTIVE SERVICES

- 331 First Line Supervisor/ Manager, Protective Services
- 332 Firefighting & Prevention Worker
- 333 Law Enforcement Worker
- 339 Other Protective Service Worker

MANAGEMENT

- 111 Top Executive
- 112 Advertising, Marketing, Promotions, PR & Sales Manager
- 113 Operations Specialties Manager
- 119 Other Management Occupations

77. Do you have any concerns about your health that are not covered in this survey that you would like to share?
(Continue on a separate sheet if necessary.)
