

From: The Sister Study <update@sisterstudy.org>
To: <PARTICIPANT EMAIL ADDRESS>
Subject: Sister Study Follow-Up

Dear Ms. <LAST NAME>,

Thank you for your continued participation in the Sister Study. We want to keep in touch with you about your health and contact information. You can help us do that by taking a minute to complete the Health and Contact Information Updates.

Beginning this year, we are making update forms available online. [You can complete these updates now by clicking here](#) **Please complete these updates even if you have no changes to report.** Information you share will be kept confidential. Your participation in the Sister Study is completely voluntary and you may choose to skip questions or stop at any time. For security purposes, after you log in, you will need to answer a few brief questions to verify your identity. Your responses will be secured during Internet transmission. If you are having trouble accessing the link, or have questions, please check [here for the frequently asked questions \(FAQs/Help\)](#).

Within the next few weeks we will send you the current issue of the Sister Study Newsletter (PDF). If we haven't heard from you online, we will include the Health and Contact Information Updates in the packet. We will send you updates like this every year. Every other year, we will also include a short questionnaire with more detailed questions about your health and new questions about your environment.

Please keep in touch. You can always visit our website at www.sisterstudy.org for more news about the Sister Study. You can also update your health and contact information by sending an email to update@sisterstudy.org or by calling the Sister Study helpdesk toll-free at 1-877-4SISTER (1-877-474-7837). Thank you again for your ongoing contribution to this important research.

Woman by woman, sister by sister, we can make a difference.

Sincerely,

Dale P. Sandler, PhD
Principal Investigator

[Click here to complete the updates now.](#)



Date

First Name Last Name
Address1
Address2
City, State Zip

Dear Ms. Last Name:

Thank you for your continued participation in the Sister Study. We want to keep in touch with you about your health and contact information. You can help us do that by taking a minute to complete and mail back the Health Update Form and the Contact Information Update Form.

Beginning this year, we are making forms available online. You can complete these updates now at **[www.sisterstudy.org/200- AnnualUpdate.htm](http://www.sisterstudy.org/200-AnnualUpdate.htm)**. To access the web-based forms, you will need your Sister Study ID number, which is printed at the bottom of this letter. Information you share will be kept confidential. Your participation in the Sister Study is completely voluntary and you may choose to skip questions or stop at any time. For security purposes, after you log in, you will need to answer a few brief questions to verify your identity. Your responses will be secured during Internet transmission.

Even if you have no changes to report, please complete the online forms or the enclosed paper forms. We have included a postage-paid envelope for your convenience - The Sister Study, 1009 Slater Road, Suite 120, Durham, NC 27703. We will send you forms like this every year. Every other year, we will also include a short questionnaire with more detailed questions about your health and new questions about your environment.

You can also update your health and contact information by sending an email to **update@sisterstudy.org** or by calling the Sister Study helpdesk toll-free at 1-877-4SISTER (1-877-474-7837). When you call or email us, it will be helpful to give your Sister Study ID number, which is printed at the bottom of this letter.

Please keep in touch. I hope you find the newsletter we've included interesting. You can always visit our website at **www.sisterstudy.org** for more news about the Sister Study. Thank you again for your ongoing contribution to this important research.

Woman by woman, sister by sister, we can make a difference.

Sincerely,

A handwritten signature in black ink that reads "Dale P. Sandler".

Dale P. Sandler, PhD
Principal Investigator

<SIS STUDY ID>



Sister Study Health Update: Year 1

Please return this form even if there are no changes to report.

*It is important to the Sister Study that we stay updated on your health. Please take a few minutes to fill out this form and let us know if you have been diagnosed with any of the following conditions **since August 2007.***

1. Since August 2007, has a doctor or other health professional told you that you had any of the following conditions?

	NO	YES	Month and year of diagnosis:
a. Breast cancer	<input type="checkbox"/> N	<input type="checkbox"/> Y	→ <input type="text"/> / <input type="text"/> 2 0 0 <input type="text"/>
a1. Ductal (breast) carcinoma in situ (DCIS)	<input type="checkbox"/> N	<input type="checkbox"/> Y	→ <input type="text"/> / <input type="text"/> 2 0 0 <input type="text"/>
a2. Lobular (breast) carcinoma in situ (LCIS)	<input type="checkbox"/> N	<input type="checkbox"/> Y	→ <input type="text"/> / <input type="text"/> 2 0 0 <input type="text"/>
b. Lung cancer	<input type="checkbox"/> N	<input type="checkbox"/> Y	→ <input type="text"/> / <input type="text"/> 2 0 0 <input type="text"/>
c. Ovarian cancer	<input type="checkbox"/> N	<input type="checkbox"/> Y	→ <input type="text"/> 2 0 0 <input type="text"/>
d. Cancer of the colon or rectum	<input type="checkbox"/> N	<input type="checkbox"/> Y	→ <input type="text"/> 2 0 0 <input type="text"/>
e. Malignant melanoma	<input type="checkbox"/> N	<input type="checkbox"/> Y	→ <input type="text"/> 2 0 0 <input type="text"/>
f. Skin cancer (not malignant melanoma)	<input type="checkbox"/> N	<input type="checkbox"/> Y	→ <input type="text"/> 2 0 0 <input type="text"/>
g. Any other type of cancer	<input type="checkbox"/> N	<input type="checkbox"/> Y	→ { <input type="text"/> / <input type="text"/> 2 0 0 <input type="text"/> } What kind: _____ }
h. Heart attack (myocardial infarction)	<input type="checkbox"/> N	<input type="checkbox"/> Y	→ { <input type="text"/> / <input type="text"/> 2 0 0 <input type="text"/> } Were you a patient in a hospital overnight? NO <input type="checkbox"/> N YES <input type="checkbox"/> Y }
i. Stroke	<input type="checkbox"/> N	<input type="checkbox"/> Y	→ <input type="text"/> 2 0 0 <input type="text"/>
j. Asthma	<input type="checkbox"/> N	<input type="checkbox"/> Y	→ <input type="text"/> 2 0 0 <input type="text"/>
k. Hypertension	<input type="checkbox"/> N	<input type="checkbox"/> Y	→ <input type="text"/> 2 0 0 <input type="text"/>
l. Diabetes	<input type="checkbox"/> N	<input type="checkbox"/> Y	→ <input type="text"/> / <input type="text"/> 2 0 0 <input type="text"/>
m. Hip fracture	<input type="checkbox"/> N	<input type="checkbox"/> Y	→ <input type="text"/> 2 0 0 <input type="text"/>
n. Wrist fracture	<input type="checkbox"/> N	<input type="checkbox"/> Y	→ <input type="text"/> 2 0 0 <input type="text"/>
o. Any other major illness	<input type="checkbox"/> N	<input type="checkbox"/> Y	→ { <input type="text"/> / <input type="text"/> 2 0 0 <input type="text"/> } What kind: _____ }

2. Have you had surgery since Aug. 2007?

N Y → { / 2 | 0 | 0 | }
What kind: _____ }
 / 2 | 0 | 0 | }
What kind: _____ }

3. Today's date:

/ / 2 | 0 | 0 |
(month) (day) (year)

Thank you for your continued participation in the Sister Study. Please mail this form to us at the address below. A postage-paid envelope is provided.

The Sister Study, 1009 Slater Road, Suite 120, Durham, NC 27703
phone: 1-877-4SISTER (1-877-474-7837); email: update@sisterstudy.org





Contact Information Update Form

Please return this form even if there are no changes to report.

Help us keep in touch with you by reporting changes to your contact information. If you've moved, are about to move, or changed your phone number or email address, please provide your updated information.

Today's date: / / 20
(month) (day) (year)

There have been no changes to any of my contact information. (Check box and go to next page.)

Name and Primary Address

Name: «FirstName»

«MiddleInitial»

«LastName»

Update or Correction

If you have more than one residence, provide information for your primary address, where you live most of the year.

Street Address: «Address1»

«Address2»

«City», «State»

«Zip»

,

-

If you have moved, what was the date of your move? OR,
If you are moving in 2-3 months, what date will you move?

/ / 20
(month) (day) (year)

Mailing Address:

«Address1»

«Address2»

«City», «State»

«Zip»

Same as street address

,

-

Telephone Numbers We Can Use to Reach You:

Home phone: «HomePhoneNumber»

() -

Work phone: «WorkPhoneNumber» «WorkPhoneExt»

() - ext.

Cell phone: «OtherPhoneNumber»

() -

Email Address We Can Use to Reach You:

Email: «Email1»

@ .

PAGE ONE - PLEASE CONTINUE TO NEXT PAGE

ID#: SIS





Please return this form even if there are no changes to report.

We request the names of two people who do not live with you, but who will always know how to reach you. Please be sure their information is up to date. You may replace a contact person with someone else by filling in the new information. If we do not have two contacts for you, please provide the information below.

There have been no changes to any of the information for my contact people. (Check box and return form.)

First Contact

Update/Correction/New Contact

Name: «FirstName»
«LastName»

Relationship to you: «Relationship»

Address: «StreetNumber» «StreetName»
«ApartmentNumber»
«City», «State»
«Zip»

_____, _____
_____ - _____

Phone Number: «PhoneNumber»

(_____) _____ - _____

What is the reason for the changes you made?

updating old or outdated information
 correcting errors in current information
 replacing old contact with a new contact person

Second Contact

Update/Correction/New Contact

Name: «FirstName»
«LastName»

Relationship to you: «Relationship»

Address: «StreetNumber» «StreetName»
«ApartmentNumber»
«City», «State»
«Zip»

_____, _____
_____ - _____

Phone Number: «PhoneNumber»

(_____) _____ - _____

What is the reason for the changes you made?

updating old or outdated information
 correcting errors in current information
 replacing old contact with a new contact person

After completing both pages of this form, please mail it to the address below. A postage-paid envelope is provided. Thank you!

*The Sister Study, 1009 Slater Road, Suite 120, Durham, NC 27703
phone: 1-877-4SISTER (1-877-474-7837); email: update@sisterstudy.org*

Date

FirstName LastName
Address 1
Address 2
City, ST ZIP

Dear Ms. LastName:

Thank you for your continued participation in the Sister Study and for completing your Annual Health and Contact Information Update forms. In order to keep you updated on the study's progress, the most recent Sister Study Newsletter is enclosed. It is one of the many ways we will communicate with you throughout the study so I hope you find it interesting and informative. In addition, I invite you to visit our beautiful web site at www.sisterstudy.org for more news about the Sister Study.

We look forward to contacting you again in the spring of 2010 when it is time to complete your next update. To report any health or contact information changes in the meantime, please call toll-free at 1-877-4SISTER (1-877-474-7837) or email info@sisterstudy.org.

With your participation in the Sister Study you are making a powerful contribution in helping find the causes of breast cancer so that future generation don't have to face this disease. Again, thank you for your participation in this important research.

Woman by woman, sister by sister, we can make a difference.

Sincerely,



Dale P. Sandler, PhD
Principal Investigator

SISID



Date

First Name Last Name

Address1

Address2

City, State Zip

Dear Ms. Last Name:

We still need your Sister Study Annual Update – we recently sent you a Health Update Form and Contact Information Update Form. Please take a few minutes to complete and return your Annual Update today **even if you have no changes to report**. The success of the study depends on our ability to track changes in your health and stay in touch over the years.

If you prefer, you can complete these forms online at **[www.sisterstudy.org/200- AnnualUpdate.htm](http://www.sisterstudy.org/200-AnnualUpdate.htm)**. To access the web-based forms, you will need your Sister Study ID Number which is printed at the bottom of this letter. For security purposes, after you log in, you will need to answer a few brief questions to verify your identity. Your responses will be secured during Internet transmission.

You can also complete these questionnaires over the telephone by calling the Sister Study helpdesk toll-free at 1-877-4SISTER (1-877-474-7837) or by emailing us at **update@sisterstudy.org**.

Information you share will be kept confidential. Your participation in the Sister Study is completely voluntary and you may choose to skip questions or stop at any time. If you have already returned your forms, please accept our thanks for your continued participation in the Sister Study.

Woman by woman, sister by sister, we can make a difference.

Sincerely,

A handwritten signature in black ink that reads "Dale P. Sandler".

Dale P. Sandler, Ph.D.
Principal Investigator

<SIS STUDY ID>

1. Hello, my name is... and I am calling on behalf of the Sister Study. I'd like to speak with [PARTICIPANT NAME]. Is that you?

- ₁ YES → GO TO 6
- ₂ NO → GO TO 2
- ₃ POSSIBLE WRONG NUMBER → GO TO 3

2. May I speak with [PARTICIPANT NAME]?

- ₁ R AVAILABLE → GO TO 6
- ₂ R NOT AVAILABLE → DETERMINE CALLBACK TIME, RECORD IN COMMENTS AND FLAG FRONT OF THIS FORM
- ₃ POSSIBLE WRONG # → GO TO 3

3. Did I reach [PHONE NUMBER]?

- ₁ YES → GO TO 4
- ₂ NO → I'm sorry to have disturbed you. REDIAL THE TELEPHONE NUMBER.

4. IF NECESSARY: Is this the number for [PARTICIPANT NAME]?

- ₁ YES, RIGHT NUMBER FOR R. → GO TO 2
- ₂ NO, NOT THEIR NUMBER → GO TO 5

5. IF APPROPRIATE: Could you give me the address or phone number for [PARTICIPANT NAME]?

- ₁ YES → Thank you for your help. Good-bye. UPDATE NUMBER ON LABEL AND ATTEMPT CONTACT AT NEW #
- ₂ NO → Thank you for your help. Good-bye. BE SURE TO RECORD ANYTHING YOU LEARNED ABOUT HOW TO LOCATE R. CODE AS WRNG.

6. REINTRODUCE SELF IF NECESSARY: I am calling on behalf of the Sister Study. We recently sent you a packet containing a newsletter and a brief questionnaire about your health. We have not yet received the questionnaire back so we are calling to ask if you would help by taking a few minutes to answer these questions with us now over the phone.

- ₁ YES → PROCEED TO HEALTH UPDATE QUESTION 1, THEN GO TO 7 ON NEXT PAGE OF THIS FORM
- ₂ NOT A GOOD TIME NOW → DETERMINE CALLBACK TIME, RECORD IN COMMENTS AND FLAG FRONT OF THIS FORM
- ₃ ALREADY RETURNED → Thank you very much. We'll hope to receive your questionnaire in the next week or so. We may call you in a couple of weeks if it still hasn't arrived. Good-bye. CODE AS MAIL.

7. Thank you. We will send you an update like this every year. Every other year, we will also include a questionnaire with more detailed questions about your health and new questions about your environment.

We would also like to update your contact information.

REFER TO THE CONTACT UPDATE FORM AND PROMPT:

Have there been any changes to your:

- Name
- Mailing address
- Street address
- Any of your phone numbers
- Any email address

Also, have there been any changes to the information for the contact people you provided?

PROMPT FOR NAME, RELATIONSHIP, ADDRESS, PHONE NUMBER

FILL IN TODAY'S DATE ON BOTH FORMS AND THE STUDY ID IN THE SPACES PROVIDED. ENTER THE HEALTH UPDATE "YEAR" ON THE PURPLE FORM.

Thank you for your help. You can update us with your contact information at any time by sending an email to **update@sisterstudy.org** or by calling the Sister Study helpdesk toll-free at 1-877-4SISTER (1-877-474-7837). When you call or email us, it will be helpful to give your Sister Study ID number, which is (REFER TO ID ON PAGE 1).

You can always visit our website at **www.sisterstudy.org** for more news about the Sister Study. Thank you again for contributing to this important research.

CODE AS COMP.

COMMENTS:

Biennial Follow-up
Cover Letter

Date

FirstName LastName
Mailing Address 1
Mailing Address 2
City, State Zip

Dear Ms. Last Name:

It is once again time to update your health and contact information. As you may remember, every two to three years we will be asking detailed questions to collect updated and new information about your environment and health. Information about changes in your health and exposures will allow us to learn how environmental and lifestyle factors contribute to developing breast cancer and other conditions. This year, we ask you to complete updates about your Health and Medical History, Lifestyle and Environment, and Stress and Coping.

You can help by completing and mailing back the enclosed forms as soon as possible. Information you share will be kept confidential. Your participation in the Sister Study is completely voluntary and you may choose to skip questions or stop at any time. **Y g'j cxg'lpemf gf 'è'r quwi g/r ckf 'gpxgnr g'ht' '{ qwt 'èqpxgplepeg'// Vj g'Uungt 'Uwf { .'322; 'Urvgt 'Tqcf . 'Uwkg'342. F wtj co . 'PE'499250**

Enclosed you will also find a Contact Information Update Form displaying information currently in our records. *Even if you have no changes to report*, please complete this update by returning the form in the enclosed postage-paid envelope.

Please keep in touch. I hope you find the newsletter we've included interesting. You can always visit our website at www.sisterstudy.org for more news about the Sister Study. If you have any questions, please email us at update@sisterstudy.org or call us at our toll-free number 1-877-4SISTER (1-877-474-7837).

Woman by woman, sister by sister, we can make a difference.

Sincerely,



Dale P. Sandler, Ph.D.
Principal Investigator

Enclosures (7)

<SIS STUDY ID>



The Sister Study

Health and Medical History

Version 4



Instructions:

- Please use **DARK BLUE OR BLACK BALLPOINT PEN.**
- Mark only one answer for each question unless otherwise indicated.
- Follow the arrow from your response to find the next question.
- Do not write comments on the form.
- Please keep this questionnaire clean, flat, and dry.
- Do not fold or tear any of the pages.

Fill in the bubbles **COMPLETELY** for each of the questions in this form.

Like this: ●

Not like this: ⊗ ⊙

If you must change an answer, please mark a single horizontal line through it and bubble in the correct answer completely.

Like this: ● ~~YES~~

Not like this: ⊗ ~~YES~~

Please write responses in all capital letters and numbers without touching the sides of the boxes.

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
---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---

1	2	3	4	5	6	7	8	9	0
---	---	---	---	---	---	---	---	---	---

When writing dates, please follow this example.

EXAMPLE: June 7, 2004 =

0	6
---	---

 /

0	7
---	---

 /

2	0	0	4
---	---	---	---

(month) (day) (year)

Public reporting burden for this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0522). Do not return the completed form to this address.





Your continued participation in the Sister Study is completely voluntary and greatly appreciated. If you are not comfortable answering a question, just skip it and go to the next one. All information you share will be kept confidential.

Today's Date: / / 2 0
(month) (day) (year)

GENERAL HEALTH

1. In the past 24 months, would you say your health has generally been...

- Excellent
- Very good
- Good
- Fair
- Poor

2. In the past 24 months, have you...

	No	Yes
a. had a routine physical exam?	<input type="radio"/>	<input type="radio"/>
b. been to a dentist for a routine check-up or cleaning?	<input type="radio"/>	<input type="radio"/>
c. had a Pap smear?	<input type="radio"/>	<input type="radio"/>
d. had a breast exam by a doctor or other health professional?	<input type="radio"/>	<input type="radio"/>
e. had a screening mammogram?	<input type="radio"/>	<input type="radio"/>
f. had a screening ultrasound of the breast?	<input type="radio"/>	<input type="radio"/>
g. had a screening MRI of the breast?	<input type="radio"/>	<input type="radio"/>
h. had a bone density scan or osteoporosis screening?	<input type="radio"/>	<input type="radio"/>
i. had a screening colonoscopy or sigmoidoscopy exam?	<input type="radio"/>	<input type="radio"/>
j. had an ultrasound of the uterus?	<input type="radio"/>	<input type="radio"/>

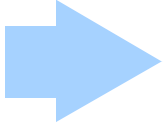
Please use a ballpoint pen for this form



3. Do you have any form of general health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare or Medicaid?

No → GO TO QUESTION 4

Yes



3a. Does your health care insurance cover all or some of the cost of breast screening exams such as mammograms, digital mammography, breast ultrasound, or breast MRI?

No
 Yes

4. Was there a time in the past 12 months when you needed to see a doctor but did not because of the cost?

No
 Yes

5. What is your current weight (in pounds)?

--	--	--

POUNDS

6. What is your current height?

--

FEET

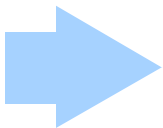
--	--

INCHES

7. In the past 12 months, did you have a flu shot? A flu shot is usually given in the fall and protects against influenza for the flu season.

No → GO TO THE NEXT PAGE, QUESTION 8

Yes



7a. In what month and year did you have a flu shot?

--	--

MONTH

/

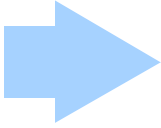
2	0		
---	---	--	--

YEAR

8. In the past 12 months, did you have a flu vaccine sprayed in your nose by a doctor or other health professional? This vaccine is often called FluMist. A health professional may let you spray it yourself. This flu vaccine is usually given in the fall and protects against influenza for the flu season.

No → GO TO QUESTION 9

Yes

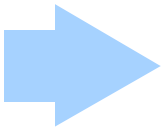


8a. In what month and year did you receive the flu vaccine by nasal spray?	<input type="text"/> / <input type="text"/>
	MONTH YEAR

9. In the past 12 months, did you have the flu? The flu is a respiratory illness with fever. Other symptoms include weakness, fatigue, and muscle aches.

No → GO TO QUESTION 10

Yes



9a. Did a doctor confirm that this was the flu?	<input type="radio"/> No <input type="radio"/> Yes
9b. In what month and year did you have the flu?	<input type="text"/> / <input type="text"/>
	MONTH YEAR

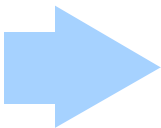
Please use a ballpoint pen for this form

FAMILY MEDICAL HISTORY

10. Since August 1, 2006, were *any* of your sisters diagnosed with breast cancer *for the first time*?

No → GO TO THE NEXT PAGE, QUESTION 11

Yes



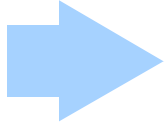
10a. In all, how many sisters who share at least one biological parent with you have <i>ever</i> been diagnosed with breast cancer?	<input type="text"/>
	# SISTERS



11. Since August 1, 2006, have any *other* close blood relatives of yours been diagnosed with breast cancer?

No → GO TO QUESTION 12

Yes



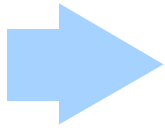
11a. What is/are the relative(s)' relationship to you?
(Please mark all that apply.)

- Mother
- Father
- Brother
- Daughter
- Son
- Grandmother
- Grandfather
- Other relative related to you by blood

12. Since August 1, 2006, have *any* close blood relatives of yours been diagnosed with ovarian cancer?

No → GO TO QUESTION 13

Yes



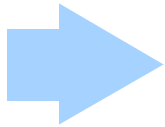
12a. What is/are the relative(s)' relationship to you?
(Please mark all that apply.)

- Sister
- Mother
- Daughter
- Grandmother
- Other relative related to you by blood

13. Have *any* close blood relatives of yours *ever* been diagnosed with asthma?

No → GO TO THE NEXT PAGE, QUESTION 14

Yes



13a. What is/are the relative(s)' relationship to you?
(Please mark all that apply.)

- Mother
- Father
- Sister
- Brother
- Daughter
- Son
- Other relative related to you by blood



PERSONAL MEDICAL HISTORY

We are interested in changes to your health in the few years since you joined the study. Please think about your medical history since **August 1, 2006**.

Has a doctor or other health professional told you that you had...	NEVER OR BEFORE 8/1/2006	DIAGNOSED 8/1/2006 OR LATER	a. If diagnosed August 1, 2006 or later, what month and year were you diagnosed?
14. breast cancer? Please do not include in situ cancer.	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	<input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
15. ductal (breast) carcinoma in situ (DCIS)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	<input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
16. lobular (breast) carcinoma in situ (LCIS)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	<input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
17. lung cancer?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	<input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
18. ovarian cancer?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	<input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
19. cancer of the uterus or endometrium?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	<input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
20. cancer of the colon or rectum?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	<input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
21. malignant melanoma?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	<input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
22. skin cancer (<i>not</i> malignant melanoma)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	<input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
23. leukemia?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	<input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
24. Hodgkin's disease or Hodgkin's lymphoma?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	<input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
25. non-Hodgkin's lymphoma?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	<input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR

Please use a ballpoint pen for this form



Has a doctor or other health professional told you that you had...	NEVER OR BEFORE 8/1/2006	DIAGNOSED 8/1/2006 OR LATER	a. If diagnosed August 1, 2006 or later, what month and year were you diagnosed?
26. any other type of cancer not already listed?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	a. MONTH/YEAR DIAGNOSED <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> MONTH YEAR </div> b. Please specify what type of cancer: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> c. If you were diagnosed with a second other type of cancer August 1, 2006 or later, what month and year were you diagnosed? <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> MONTH YEAR </div> d. Please specify what type of cancer: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
27. a heart attack or myocardial infarction?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> MONTH YEAR </div>



Has a doctor or other health professional <i>ever</i> told you that you had...	NO	YES	b. Do you still have this condition?														
28. hypertension or high blood pressure?	<input type="radio"/> No	<input type="radio"/> Yes, first diagnosed <u>before</u> August 1, 2006 <input type="radio"/> Yes, first diagnosed August 1, 2006 or later → a. What month and year were you diagnosed? <div style="border: 1px solid black; padding: 5px; display: inline-block;"> <table style="border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: none; padding: 0 5px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">2</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center; font-size: 8px;">MONTH</td> <td></td> <td colspan="4" style="text-align: center; font-size: 8px;">YEAR</td> </tr> </table> </div>			/	2	0			MONTH			YEAR				<input type="radio"/> No <input type="radio"/> Yes
		/	2	0													
MONTH			YEAR														
29. angina?	<input type="radio"/> No	<input type="radio"/> Yes, first diagnosed <u>before</u> August 1, 2006 <input type="radio"/> Yes, first diagnosed August 1, 2006 or later → a. What month and year were you diagnosed? <div style="border: 1px solid black; padding: 5px; display: inline-block;"> <table style="border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: none; padding: 0 5px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">2</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center; font-size: 8px;">MONTH</td> <td></td> <td colspan="4" style="text-align: center; font-size: 8px;">YEAR</td> </tr> </table> </div>			/	2	0			MONTH			YEAR				<input type="radio"/> No <input type="radio"/> Yes
		/	2	0													
MONTH			YEAR														
30. cardiac arrhythmia (irregular heartbeat)?	<input type="radio"/> No	<input type="radio"/> Yes, first diagnosed <u>before</u> August 1, 2006 <input type="radio"/> Yes, first diagnosed August 1, 2006 or later → a. What month and year were you diagnosed? <div style="border: 1px solid black; padding: 5px; display: inline-block;"> <table style="border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: none; padding: 0 5px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">2</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center; font-size: 8px;">MONTH</td> <td></td> <td colspan="4" style="text-align: center; font-size: 8px;">YEAR</td> </tr> </table> </div>			/	2	0			MONTH			YEAR				<input type="radio"/> No <input type="radio"/> Yes
		/	2	0													
MONTH			YEAR														
31. congestive heart failure?	<input type="radio"/> No	<input type="radio"/> Yes, first diagnosed <u>before</u> August 1, 2006 <input type="radio"/> Yes, first diagnosed August 1, 2006 or later → a. What month and year were you diagnosed? <div style="border: 1px solid black; padding: 5px; display: inline-block;"> <table style="border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: none; padding: 0 5px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">2</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center; font-size: 8px;">MONTH</td> <td></td> <td colspan="4" style="text-align: center; font-size: 8px;">YEAR</td> </tr> </table> </div>			/	2	0			MONTH			YEAR				<input type="radio"/> No <input type="radio"/> Yes
		/	2	0													
MONTH			YEAR														



Has a doctor or other health professional told you that you had...	NEVER OR BEFORE 8/1/2006	DIAGNOSED 8/1/2006 OR LATER	a. If diagnosed August 1, 2006 or later, what month and year were you diagnosed?
32. a stroke (this does not include TIA or "mini-stroke")?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
33. a mini-stroke or TIA (transient ischemic attack)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR

Have you had...	NEVER OR BEFORE 8/1/2006	8/1/2006 OR LATER	a. How many times has this happened since August 1, 2006?	b. What was the month and year that this <i>first</i> happened since August 1, 2006?
34. a hip fracture?	<input type="radio"/> Never <input type="radio"/> <u>Before</u> August 1, 2006	<input type="radio"/> Occurred August 1, 2006 or later	<input type="text"/> # TIMES	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
35. a wrist fracture?	<input type="radio"/> Never <input type="radio"/> <u>Before</u> August 1, 2006	<input type="radio"/> Occurred August 1, 2006 or later	<input type="text"/> # TIMES	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR

	NO	YES	a. If yes, how many hip replacements have you <i>ever</i> had?	b. What was the month and year of your <i>first</i> hip replacement surgery?
36. Have you <i>ever</i> had hip replacement surgery?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> one hip <input type="radio"/> both hips	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR



	NO	YES																												
37. Has a doctor or other health professional <i>ever</i> told you that you had diabetes?	<input type="radio"/> No	<input type="radio"/> Yes, first diagnosed <u>before</u> August 1, 2006 <input type="radio"/> Yes, first diagnosed August 1, 2006 or later → <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"> a. What month and year were you diagnosed? <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: none; padding: 0 5px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">2</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center; font-size: 8px;">MONTH</td> <td></td> <td colspan="2" style="text-align: center; font-size: 8px;">YEAR</td> <td colspan="2"></td> </tr> </table> </div> <p>b. Do you still have this condition? <input type="radio"/> No <input type="radio"/> Yes</p> <p>c. Do you currently take insulin for diabetes? <input type="radio"/> No → GO TO QUESTION 38 <input type="radio"/> Yes</p> <p>d. If yes, when did you first use insulin? <table style="margin-left: 20px;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: none; padding: 0 5px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center; font-size: 8px;">MONTH</td> <td></td> <td colspan="4" style="text-align: center; font-size: 8px;">YEAR</td> </tr> </table> </p>			/	2	0			MONTH			YEAR						/					MONTH			YEAR			
		/	2	0																										
MONTH			YEAR																											
		/																												
MONTH			YEAR																											

	NO	YES															
Has a doctor or other health professional <i>ever</i> told you that you had...			b. Have you experienced any symptoms in the <i>past 12 months</i> ?														
38. allergic rhinitis, hay fever, or seasonal allergies?	<input type="radio"/> No	<input type="radio"/> Yes, first diagnosed <u>before</u> August 1, 2006 <input type="radio"/> Yes, first diagnosed August 1, 2006 or later → <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"> a. What month and year were you diagnosed? <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: none; padding: 0 5px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">2</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center; font-size: 8px;">MONTH</td> <td></td> <td colspan="2" style="text-align: center; font-size: 8px;">YEAR</td> <td colspan="2"></td> </tr> </table> </div>			/	2	0			MONTH			YEAR				<input type="radio"/> No <input type="radio"/> Yes
		/	2	0													
MONTH			YEAR														
39. asthma?	<input type="radio"/> No	<input type="radio"/> Yes, first diagnosed <u>before</u> August 1, 2006 <input type="radio"/> Yes, first diagnosed August 1, 2006 or later → <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"> a. What month and year were you diagnosed? <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: none; padding: 0 5px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">2</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center; font-size: 8px;">MONTH</td> <td></td> <td colspan="2" style="text-align: center; font-size: 8px;">YEAR</td> <td colspan="2"></td> </tr> </table> </div>			/	2	0			MONTH			YEAR				<input type="radio"/> No <input type="radio"/> Yes
		/	2	0													
MONTH			YEAR														



Has a doctor or other health professional told you that you had...	NEVER OR BEFORE 8/1/2006	DIAGNOSED 8/1/2006 OR LATER	a. If diagnosed August 1, 2006 or later, what month and year were you diagnosed?
40. chronic bronchitis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	<input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> MONTH YEAR
41. emphysema?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	<input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> MONTH YEAR
42. chronic obstructive pulmonary disease (COPD)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	<input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> MONTH YEAR
43. Graves' disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	<input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> MONTH YEAR
44. other hyperthyroidism (overactive thyroid)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	<input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> MONTH YEAR
45. Hashimoto's thyroiditis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	<input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> MONTH YEAR
46. other hypothyroidism (underactive thyroid)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	<input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> MONTH YEAR



Has a doctor or other health professional told you that you had...	NEVER OR BEFORE 8/1/2006	DIAGNOSED 8/1/2006 OR LATER	a. If diagnosed August 1, 2006 or later, what month and year were you diagnosed?
47. an enlarged thyroid or goiter?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
48. thyroid nodules?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
49. another thyroid problem? Please do <i>not</i> include thyroid cancer.	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	a. MONTH/YEAR DIAGNOSED <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR b. Please specify the problem: <input type="text"/>
50. osteoporosis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
51. osteopenia, or low bone density?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
52. rheumatoid arthritis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
53. other arthritis (for example, age or injury related)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
54. multiple sclerosis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
55. scleroderma or systemic sclerosis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
56. systemic lupus erythematosus (SLE)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
57. discoid lupus?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
58. Crohn's disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR

Please use a ballpoint pen for this form

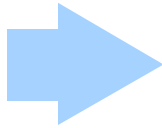


Has a doctor or other health professional told you that you had...	NEVER OR BEFORE 8/1/2006	DIAGNOSED 8/1/2006 OR LATER	a. If diagnosed August 1, 2006 or later, what month and year were you diagnosed?
59. ulcerative colitis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed before August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	<input type="text"/> / <input type="text"/> MONTH YEAR
60. shingles?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed before August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	<input type="text"/> / <input type="text"/> MONTH YEAR

61. Has a doctor or other health professional *ever* told you that you had migraine headaches?

No → GO TO THE NEXT PAGE, QUESTION 62

Yes



61a. Were you diagnosed with migraine headaches <i>before</i> August 1, 2006?	<input type="radio"/> No <input type="radio"/> Yes
61b. Were you [also] diagnosed with migraines August 1, 2006 or <i>later</i> ?	<input type="radio"/> No → GO TO 61d <input type="radio"/> Yes
61c. If you were diagnosed August 1, 2006 or later, what month and year were you diagnosed?	<input type="text"/> / <input type="text"/> MONTH YEAR
61d. Was the diagnosis of migraine made by a... (Please mark all that apply.)	<input type="radio"/> Headache specialist <input type="radio"/> Neurologist <input type="radio"/> Other physician <input type="radio"/> Other health professional
61e. Before a migraine attacks, do you usually have aura symptoms?	<input type="radio"/> No <input type="radio"/> Yes
61f. <i>During the past 12 months</i> , how often have you had a migraine?	<input type="radio"/> Never <input type="radio"/> 1-2 times <input type="radio"/> 3-5 times <input type="radio"/> 6-11 times <input type="radio"/> Once per month <input type="radio"/> 2-3 times per month <input type="radio"/> Once per week <input type="radio"/> 2-4 times per week <input type="radio"/> 5 or more times per week



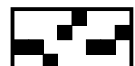
Has a doctor or other health professional <i>ever</i> told you that you had...	NO	YES	b. Do you still have this condition?														
62. depression?	<input type="radio"/> No	<input type="radio"/> Yes, first diagnosed <u>before</u> August 1, 2006 <input type="radio"/> Yes, first diagnosed August 1, 2006 or later → a. What month and year were you diagnosed? <div style="border: 1px solid black; padding: 5px; display: inline-block;"> <table style="border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: none; padding: 0 5px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">2</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center; font-size: 8px;">MONTH</td> <td></td> <td colspan="4" style="text-align: center; font-size: 8px;">YEAR</td> </tr> </table> </div>			/	2	0			MONTH			YEAR				<input type="radio"/> No <input type="radio"/> Yes
		/	2	0													
MONTH			YEAR														
63. periodontal or gum disease?	<input type="radio"/> No	<input type="radio"/> Yes, first diagnosed <u>before</u> August 1, 2006 <input type="radio"/> Yes, first diagnosed August 1, 2006 or later → a. What month and year were you diagnosed? <div style="border: 1px solid black; padding: 5px; display: inline-block;"> <table style="border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: none; padding: 0 5px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">2</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center; font-size: 8px;">MONTH</td> <td></td> <td colspan="4" style="text-align: center; font-size: 8px;">YEAR</td> </tr> </table> </div>			/	2	0			MONTH			YEAR				<input type="radio"/> No <input type="radio"/> Yes
		/	2	0													
MONTH			YEAR														

Has a doctor or other health professional told you that you had...	NEVER OR BEFORE 8/1/2006	DIAGNOSED 8/1/2006 OR LATER	a. If diagnosed August 1, 2006 or later, what month and year were you diagnosed?														
64. polyps in the colon or rectum?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	<div style="border: 1px solid black; padding: 5px; display: inline-block;"> <table style="border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: none; padding: 0 5px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">2</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center; font-size: 8px;">MONTH</td> <td></td> <td colspan="4" style="text-align: center; font-size: 8px;">YEAR</td> </tr> </table> </div>			/	2	0			MONTH			YEAR			
		/	2	0													
MONTH			YEAR														
65. polycystic ovaries or PCOS?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	<div style="border: 1px solid black; padding: 5px; display: inline-block;"> <table style="border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: none; padding: 0 5px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">2</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center; font-size: 8px;">MONTH</td> <td></td> <td colspan="4" style="text-align: center; font-size: 8px;">YEAR</td> </tr> </table> </div>			/	2	0			MONTH			YEAR			
		/	2	0													
MONTH			YEAR														
66. endometriosis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	<div style="border: 1px solid black; padding: 5px; display: inline-block;"> <table style="border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: none; padding: 0 5px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">2</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center; font-size: 8px;">MONTH</td> <td></td> <td colspan="4" style="text-align: center; font-size: 8px;">YEAR</td> </tr> </table> </div>			/	2	0			MONTH			YEAR			
		/	2	0													
MONTH			YEAR														
67. uterine fibroids or fibroid tumors?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	<div style="border: 1px solid black; padding: 5px; display: inline-block;"> <table style="border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: none; padding: 0 5px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">2</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center; font-size: 8px;">MONTH</td> <td></td> <td colspan="4" style="text-align: center; font-size: 8px;">YEAR</td> </tr> </table> </div>			/	2	0			MONTH			YEAR			
		/	2	0													
MONTH			YEAR														
68. gallstones or gallbladder disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2006	<input type="radio"/> Diagnosed August 1, 2006 or later	<div style="border: 1px solid black; padding: 5px; display: inline-block;"> <table style="border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: none; padding: 0 5px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">2</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center; font-size: 8px;">MONTH</td> <td></td> <td colspan="4" style="text-align: center; font-size: 8px;">YEAR</td> </tr> </table> </div>			/	2	0			MONTH			YEAR			
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MONTH			YEAR														



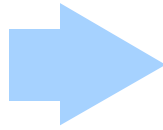
The following are some conditions we have not asked about in the past. Please tell us if you have ever been diagnosed with any of these conditions and when you were first diagnosed.

Has a doctor or other health professional ever told you that you had...	NO	YES	a. If yes, what year were you <i>first</i> diagnosed?								
69. Sjögren's syndrome?	<input type="radio"/> No	<input type="radio"/> Yes	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 25px; height: 20px;"> </td> <td style="width: 25px; height: 20px;"> </td> <td style="width: 25px; height: 20px;"> </td> <td style="width: 25px; height: 20px;"> </td> </tr> <tr> <td colspan="4">YEAR</td> </tr> </table>					YEAR			
YEAR											
70. Parkinson's disease?	<input type="radio"/> No	<input type="radio"/> Yes	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 25px; height: 20px;"> </td> <td style="width: 25px; height: 20px;"> </td> <td style="width: 25px; height: 20px;"> </td> <td style="width: 25px; height: 20px;"> </td> </tr> <tr> <td colspan="4">YEAR</td> </tr> </table>					YEAR			
YEAR											
71. Alzheimer's disease?	<input type="radio"/> No	<input type="radio"/> Yes	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 25px; height: 20px;"> </td> <td style="width: 25px; height: 20px;"> </td> <td style="width: 25px; height: 20px;"> </td> <td style="width: 25px; height: 20px;"> </td> </tr> <tr> <td colspan="4">YEAR</td> </tr> </table>					YEAR			
YEAR											
72. kidney failure requiring dialysis or transplant?	<input type="radio"/> No	<input type="radio"/> Yes	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 25px; height: 20px;"> </td> <td style="width: 25px; height: 20px;"> </td> <td style="width: 25px; height: 20px;"> </td> <td style="width: 25px; height: 20px;"> </td> </tr> <tr> <td colspan="4">YEAR</td> </tr> </table>					YEAR			
YEAR											
73. kidney stones?	<input type="radio"/> No	<input type="radio"/> Yes	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 25px; height: 20px;"> </td> <td style="width: 25px; height: 20px;"> </td> <td style="width: 25px; height: 20px;"> </td> <td style="width: 25px; height: 20px;"> </td> </tr> <tr> <td colspan="4">YEAR</td> </tr> </table>					YEAR			
YEAR											
74. other kidney disease?	<input type="radio"/> No	<input type="radio"/> Yes	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 25px; height: 20px;"> </td> <td style="width: 25px; height: 20px;"> </td> <td style="width: 25px; height: 20px;"> </td> <td style="width: 25px; height: 20px;"> </td> </tr> <tr> <td colspan="4">YEAR</td> </tr> </table>					YEAR			
YEAR											
75. cataracts?	<input type="radio"/> No	<input type="radio"/> Yes	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 25px; height: 20px;"> </td> <td style="width: 25px; height: 20px;"> </td> <td style="width: 25px; height: 20px;"> </td> <td style="width: 25px; height: 20px;"> </td> </tr> <tr> <td colspan="4">YEAR</td> </tr> </table>					YEAR			
YEAR											
76. glaucoma?	<input type="radio"/> No	<input type="radio"/> Yes	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 25px; height: 20px;"> </td> <td style="width: 25px; height: 20px;"> </td> <td style="width: 25px; height: 20px;"> </td> <td style="width: 25px; height: 20px;"> </td> </tr> <tr> <td colspan="4">YEAR</td> </tr> </table>					YEAR			
YEAR											
77. macular degeneration?	<input type="radio"/> No	<input type="radio"/> Yes	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 25px; height: 20px;"> </td> <td style="width: 25px; height: 20px;"> </td> <td style="width: 25px; height: 20px;"> </td> <td style="width: 25px; height: 20px;"> </td> </tr> <tr> <td colspan="4">YEAR</td> </tr> </table>					YEAR			
YEAR											
78. doctor-diagnosed hearing loss?	<input type="radio"/> No	<input type="radio"/> Yes	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 25px; height: 20px;"> </td> <td style="width: 25px; height: 20px;"> </td> <td style="width: 25px; height: 20px;"> </td> <td style="width: 25px; height: 20px;"> </td> </tr> <tr> <td colspan="4">YEAR</td> </tr> </table>					YEAR			
YEAR											
78x. gout?	<input type="radio"/> No	<input type="radio"/> Yes	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 25px; height: 20px;"> </td> <td style="width: 25px; height: 20px;"> </td> <td style="width: 25px; height: 20px;"> </td> <td style="width: 25px; height: 20px;"> </td> </tr> <tr> <td colspan="4">YEAR</td> </tr> </table>					YEAR			
YEAR											



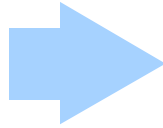
79. Since August 1, 2006, has a doctor or other health professional told you that you had any other major illness?

- Never diagnosed
- Diagnosed before August 1, 2006



GO TO QUESTION 80

- Diagnosed August 1, 2006 or later



79a. If you were diagnosed August 1, 2006 or later, what month and year were you diagnosed? / 2 0
MONTH YEAR

79b. Please specify the problem:
FIRST OTHER MAJOR ILLNESS

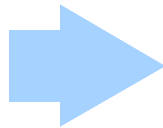
79c. If you were diagnosed with a second *other* major illness August 1, 2006 or later, what month and year were you diagnosed? / 2 0
MONTH YEAR

79d. Please specify the problem:
SECOND OTHER MAJOR ILLNESS

Please use a ballpoint pen for this form

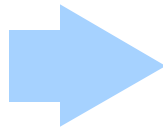
80. Since August 1, 2006, have you had any other major injury?

- Never had a major injury
- Injured before August 1, 2006



GO TO THE NEXT PAGE, QUESTION 81

- Injured August 1, 2006 or later



80a. If you were injured August 1, 2006 or later, what month and year were you injured? / 2 0
MONTH YEAR

80b. Please specify what type of injury:
FIRST OTHER MAJOR INJURY

80c. If you were injured with a second *other* major injury August 1, 2006 or later, what month and year were you injured? / 2 0
MONTH YEAR

80d. Please specify what type of injury:
SECOND OTHER MAJOR INJURY



81. Since August 1, 2006, have you experienced any of the following *medical symptoms*?
Please mark a response for each item below.

	No	Yes
a. swelling in your wrist, finger, elbow, or knee joints <i>lasting six or more weeks</i> ?	<input type="radio"/>	<input type="radio"/>
b. joint stiffness in the mornings, lasting at least one hour, and for more than six weeks (do not include stiffness related or due to an injury or surgery)?	<input type="radio"/>	<input type="radio"/>
c. daily, persistent, troublesome dry eyes, or a recurrent feeling of sand or gravel in your eyes, or use of tear substitutes more than 3 times a day for at least 3 months?	<input type="radio"/>	<input type="radio"/>
d. a daily feeling of dry mouth, or frequent drinking of liquids to aid in swallowing dry foods, or recurrently or persistently swollen salivary glands for more than 3 months?	<input type="radio"/>	<input type="radio"/>
e. a tremor or trembling in either of your hands that is worse when you are not using the hand compared to when you are using it?	<input type="radio"/>	<input type="radio"/>
f. walking or other movements getting noticeably slower?	<input type="radio"/>	<input type="radio"/>
g. handwriting getting noticeably smaller?	<input type="radio"/>	<input type="radio"/>
h. difficulty getting started when walking or making other movements?	<input type="radio"/>	<input type="radio"/>
i. wheezing or whistling in your chest?	<input type="radio"/>	<input type="radio"/>
j. shortness of breath when hurrying on level ground, or when walking up a slight hill, or when climbing a flight of stairs at your usual pace?	<input type="radio"/>	<input type="radio"/>

82. Have you experienced the following *at least once a week in the past year*?

	No	Yes
a. heartburn (a burning discomfort behind the breast bone in your chest)?	<input type="radio"/>	<input type="radio"/>
b. acid regurgitation (a bitter or sour tasting fluid coming into your throat or mouth)?	<input type="radio"/>	<input type="radio"/>

	NO	YES	a. If yes, for how many years have you had this symptom?
83. Since August 1, 2006, have you experienced coughing on most days for three months or more out of a year?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> 1 year <input type="radio"/> 2 or more years
84. Since August 1, 2006, have you brought up phlegm on most days for three months or more out of a year (do not count phlegm from the nose)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> 1 year <input type="radio"/> 2 or more years

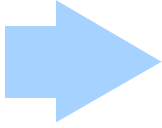


For the next few questions, please think about your breast health over your lifetime.

85. Have you *ever* been told you had abnormal findings on your mammogram, breast ultrasound, or breast MRI?

No → GO TO THE NEXT PAGE, QUESTION 86

Yes



85a. On how many occasions did this happen?	<input type="text"/> <input type="text"/> # OCCASIONS
85b. How old were you when you had your first abnormal mammogram, breast ultrasound, or breast MRI?	<input type="text"/> <input type="text"/> AGE
85c. What was the month and year of your most recent test with abnormal findings?	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
85d. Which breast showed abnormal findings at the most recent test?	<input type="radio"/> Left breast <input type="radio"/> Right breast <input type="radio"/> Both breasts
85e. After completing the work-up for this abnormal test, what was the doctors' recommendation? Did they tell you to...	<input type="radio"/> Come back in 12 months or more for usual follow-up <input type="radio"/> Come back in 6-11 months <input type="radio"/> Come back in 3-5 months <input type="radio"/> Come back in less than 3 months <input type="radio"/> Have a breast biopsy, surgery, or other treatment <input type="radio"/> Don't know
85f. Were you told this test showed any of the following? (Please mark all that apply.)	<input type="radio"/> Breast cysts <input type="radio"/> Fibrocystic breasts <input type="radio"/> Breast calcifications <input type="radio"/> Dense breasts <input type="radio"/> Uneven or one-sided densities <input type="radio"/> Fibroadenoma <input type="radio"/> Other <input type="radio"/> Don't know

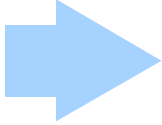
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86. Have you *ever* had a breast cyst or cysts drained (aspirated) or removed?

No → GO TO THE NEXT PAGE, QUESTION 87

Yes



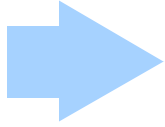
86a. On how many occasions have you had this?	<input type="text"/> <input type="text"/>	# OCCASIONS
86b. How old were you the first time you had this?	<input type="text"/> <input type="text"/>	AGE
86c. What was the month and year of your most recent procedure?	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	MONTH / YEAR
86d. On which breast was the most recent cyst aspiration or removal performed?	<input type="radio"/> Left breast <input type="radio"/> Right breast <input type="radio"/> Both breasts	
86e. Following the most recent procedure, what was the doctors' recommendation? Did they tell you to...	<input type="radio"/> Come back in 12 months or more for usual follow-up <input type="radio"/> Come back in 6-11 months <input type="radio"/> Come back in 3-5 months <input type="radio"/> Come back in less than 3 months <input type="radio"/> Have a breast biopsy, surgery, or other treatment <input type="radio"/> Don't know	



87. Have you *ever* had a needle biopsy to diagnose or rule out a breast condition?

No → GO TO THE NEXT PAGE, QUESTION 88

Yes



87a. On how many occasions have you had this?	<input type="text"/> <input type="text"/> # OCCASIONS
87b. How old were you the first time you had this?	<input type="text"/> <input type="text"/> AGE
87c. What was the month and year of your most recent procedure?	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
87d. On which breast was the most recent needle biopsy performed?	<input type="radio"/> Left breast <input type="radio"/> Right breast <input type="radio"/> Both breasts
87e. Following the most recent procedure, what was the doctors' recommendation? Did they tell you to...	<input type="radio"/> Come back in 12 months or more for usual follow-up <input type="radio"/> Come back in 6-11 months <input type="radio"/> Come back in 3-5 months <input type="radio"/> Come back in less than 3 months <input type="radio"/> Have a different type of breast biopsy, surgery, or other treatment <input type="radio"/> Don't know

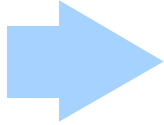
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88. Have you *ever* had a surgical biopsy or a biopsy other than a needle biopsy to diagnose or rule out a breast condition?

No → GO TO THE NEXT PAGE, QUESTION 89

Yes



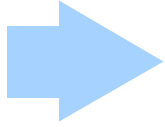
88a. On how many occasions have you had this?	<input type="text"/> <input type="text"/> # OCCASIONS
88b. How old were you the first time you had this?	<input type="text"/> <input type="text"/> AGE
88c. What was the month and year of your most recent procedure?	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
88d. On which breast was the most recent biopsy performed?	<input type="radio"/> Left breast <input type="radio"/> Right breast <input type="radio"/> Both breasts
88e. Following the most recent procedure, what was the doctors' recommendation? Did they tell you to...	<input type="radio"/> Come back in 12 months or more for usual follow-up <input type="radio"/> Come back in 6-11 months <input type="radio"/> Come back in 3-5 months <input type="radio"/> Come back in less than 3 months <input type="radio"/> Have a different type of breast biopsy, surgery, or other treatment <input type="radio"/> Don't know



89. Have you ever had a breast lump or lumps removed (lumpectomy)?

No → GO TO THE NEXT PAGE, QUESTION 90

Yes



89a. On how many occasions have you had this?	<input type="text"/> <input type="text"/>	# OCCASIONS
89b. How old were you the first time you had this?	<input type="text"/> <input type="text"/>	AGE
89c. What was the month and year of your most recent procedure?	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	MONTH YEAR
89d. On which breast was the most recent lumpectomy performed?	<input type="radio"/> Left breast <input type="radio"/> Right breast <input type="radio"/> Both breasts	
89e. Following the most recent procedure, what was the doctors' recommendation? Did they tell you to...	<input type="radio"/> Come back in 12 months or more for usual follow-up <input type="radio"/> Come back in 6-11 months <input type="radio"/> Come back in 3-5 months <input type="radio"/> Come back in less than 3 months <input type="radio"/> Have a different type of biopsy, surgery, or other treatment <input type="radio"/> Don't know	

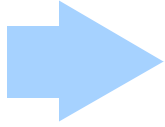
Please use a ballpoint pen for this form



90. Have you *ever* had a mastectomy of your *left* breast?

No → GO TO QUESTION 91

Yes

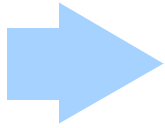


90a. Why was this done?	<input type="radio"/> To treat breast cancer <input type="radio"/> To prevent breast cancer <input type="radio"/> Both														
90b. When was this done?	<input type="radio"/> Before August 1, 2006 → GO TO 91 <input type="radio"/> August 1, 2006 or later														
90c. If you had this procedure August 1, 2006 or later, what was the month and year?	<table border="1"><tr><td></td><td></td><td>/</td><td>2</td><td>0</td><td></td><td></td></tr><tr><td colspan="3">MONTH</td><td colspan="4">YEAR</td></tr></table>			/	2	0			MONTH			YEAR			
		/	2	0											
MONTH			YEAR												

91. Have you *ever* had a mastectomy of your *right* breast?

No → GO TO THE NEXT PAGE, QUESTION 92

Yes



91a. Why was this done?	<input type="radio"/> To treat breast cancer <input type="radio"/> To prevent breast cancer <input type="radio"/> Both														
91b. When was this done?	<input type="radio"/> Before August 1, 2006 → GO TO 92 <input type="radio"/> August 1, 2006 or later														
91c. If you had this procedure August 1, 2006 or later, what was the month and year?	<table border="1"><tr><td></td><td></td><td>/</td><td>2</td><td>0</td><td></td><td></td></tr><tr><td colspan="3">MONTH</td><td colspan="4">YEAR</td></tr></table>			/	2	0			MONTH			YEAR			
		/	2	0											
MONTH			YEAR												



Were you *ever* told you had any of the following after a cyst aspiration, cyst removal, biopsy, lumpectomy, or mastectomy?

	NO	YES	a. IF YES, how old were you when you were <i>first</i> told you had this?
92. fibrocystic or benign changes (within normal range)	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> AGE
93. fibroadenoma	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> AGE
94. proliferative changes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> AGE
95. ductal hyperplasia	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> AGE
96. lobular hyperplasia	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> AGE
97. ductal carcinoma in situ (DCIS)	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> AGE
98. lobular carcinoma in situ (LCIS)	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> AGE
99. breast cancer	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> AGE
100. other changes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> AGE

Please use a ballpoint pen for this form

101. Did you keep a copy of the pathology report(s) from the cyst aspiration, cyst removal, biopsy, lumpectomy, or mastectomy that you are willing to share with us?

- No
- Yes → PLEASE INCLUDE A COPY WITH YOUR COMPLETED QUESTIONNAIRE.
- Not applicable



Have you <i>ever</i> had...	NEVER OR BEFORE 8/1/2006	8/1/2006 OR LATER	a. If you had this procedure August 1, 2006 or later, what was the month and year?
102. breast reduction surgery of your <i>left</i> breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> August 1, 2006	<input type="radio"/> Yes, August 1, 2006 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> MONTH YEAR </div>
103. breast reduction surgery of your <i>right</i> breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> August 1, 2006	<input type="radio"/> Yes, August 1, 2006 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> MONTH YEAR </div>

Have you <i>ever</i> had...	NEVER OR BEFORE 8/1/2006	8/1/2006 OR LATER	a. If you had this procedure August 1, 2006 or later, what was the month and year?	b. Did you have a silicone gel implant?
104. breast reconstruction surgery of your <i>left</i> breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> August 1, 2006	<input type="radio"/> Yes, August 1, 2006 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> MONTH YEAR </div>	<input type="radio"/> No <input type="radio"/> Yes
105. breast reconstruction surgery of your <i>right</i> breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> August 1, 2006	<input type="radio"/> Yes, August 1, 2006 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> MONTH YEAR </div>	<input type="radio"/> No <input type="radio"/> Yes
106. breast enlargement surgery of your <i>left</i> breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> August 1, 2006	<input type="radio"/> Yes, August 1, 2006 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> MONTH YEAR </div>	<input type="radio"/> No <input type="radio"/> Yes
107. breast enlargement surgery of your <i>right</i> breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> August 1, 2006	<input type="radio"/> Yes, August 1, 2006 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> MONTH YEAR </div>	<input type="radio"/> No <input type="radio"/> Yes



Have you ever had...	NEVER OR BEFORE 8/1/2006	8/1/2006 OR LATER	a. If you had this procedure August 1, 2006 or later, what was the month and year?	b. Was this a silicone gel implant?
108. a breast implant surgically removed from your <i>left</i> breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> August 1, 2006	<input type="radio"/> Yes, August 1, 2006 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center; margin-right: 5px;">0</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%;"> MONTH YEAR </div>	<input type="radio"/> No <input type="radio"/> Yes
109. a breast implant surgically removed from your <i>right</i> breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> August 1, 2006	<input type="radio"/> Yes, August 1, 2006 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center; margin-right: 5px;">0</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%;"> MONTH YEAR </div>	<input type="radio"/> No <input type="radio"/> Yes

Please use a ballpoint pen for this form



110. Are you currently pregnant or breastfeeding?

No → GO TO NEXT QUESTION, 110a

Yes → GO TO PAGE 30, QUESTION 111

110a. Have you had a menstrual period in the past 12 months?

No → ANSWER BOX A BELOW

Yes → ANSWER BOX B ON THE NEXT PAGE

BOX A

FOR WOMEN WHO HAVE NOT HAD A MENSTRUAL PERIOD IN THE PAST 12 MONTHS. ALL OTHERS GO TO QUESTION 110d.

110b. Why did your periods stop?

- My periods stopped on their own (naturally).
- My periods stopped on their own but I began taking hormone replacement therapy before my periods fully stopped.
- My periods stopped after my uterus or ovaries were removed (be sure to answer questions 151 and 152).
- My periods stopped due to radiation or chemotherapy.
- My periods stopped due to medicine that suppresses ovarian function.
- My periods stopped because I am taking the kind of birth control pills that eliminate periods.
- My periods stopped for some other reason, please describe:

110c. What month and year did you have your last menstrual period or how old were you when you had your last menstrual period?

	/				OR		
MONTH			YEAR			AGE	

GO TO PAGE 30, QUESTION 111



BOX B

FOR WOMEN WHO HAVE HAD A MENSTRUAL PERIOD IN THE PAST 12 MONTHS.

110d. When was your last menstrual period?

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
MONTH			DAY			YEAR			

110e. What statement best describes you?

- My periods have not stopped and I am not taking hormones.
- My periods have not stopped but I am taking hormones.
- My periods stopped temporarily, but restarted when I began hormone replacement therapy.



GO TO PAGE 30,
QUESTION 111

OR

- My periods stopped sometime in the last 12 months. → GO TO QUESTION 110f

110f. Why did your periods stop?

- My periods stopped on their own (naturally).
- My periods stopped on their own but I began taking hormone replacement therapy before my periods fully stopped.
- My periods stopped after my uterus or ovaries were removed (be sure to answer questions 151 and 152).
- My periods stopped due to radiation or chemotherapy.
- My periods stopped due to medicine that suppresses ovarian function.
- My periods stopped because I am taking the kind of birth control pills that eliminate periods.
- My periods stopped for some other reason, please describe:

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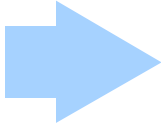


REPRODUCTIVE HISTORY AND HORMONES

111. Have you been pregnant since August 1, 2006?

No → GO TO PAGE 32, QUESTION 118

Yes



111a. Are you currently pregnant? No
 Yes

111b. How many times have you been pregnant since August 1, 2006 (including your current pregnancy, if applicable)?

TIMES



THIS SECTION IS FOR WOMEN WHO HAVE BEEN PREGNANT SINCE AUGUST 1, 2006. ALL OTHERS GO TO THE NEXT PAGE, QUESTION 118.

Please use a ballpoint pen for this form

	FIRST PREGNANCY (since August 1, 2006)	SECOND PREGNANCY (since August 1, 2006)
112. How did this pregnancy end?	<input type="radio"/> Still pregnant now <input type="radio"/> Single live birth <input type="radio"/> Twins, live births <input type="radio"/> Other multiple live births → <input type="text"/> # BABIES <input type="radio"/> Stillbirth(s) <input type="radio"/> Miscarriage <input type="radio"/> Induced abortion <input type="radio"/> Molar or ectopic pregnancy	<input type="radio"/> Still pregnant now <input type="radio"/> Single live birth <input type="radio"/> Twins, live births <input type="radio"/> Other multiple live births → <input type="text"/> # BABIES <input type="radio"/> Stillbirth(s) <input type="radio"/> Miscarriage <input type="radio"/> Induced abortion <input type="radio"/> Molar or ectopic pregnancy
113. How many weeks did this pregnancy last (or has it lasted, if now pregnant)?	<input type="radio"/> less than 8 weeks <input type="radio"/> 8 to 12 weeks <input type="radio"/> 13 to 16 weeks <input type="radio"/> 17 to 24 weeks <input type="radio"/> 25 to 36 weeks <input type="radio"/> 37 to 41 weeks <input type="radio"/> 42 weeks or more	<input type="radio"/> less than 8 weeks <input type="radio"/> 8 to 12 weeks <input type="radio"/> 13 to 16 weeks <input type="radio"/> 17 to 24 weeks <input type="radio"/> 25 to 36 weeks <input type="radio"/> 37 to 41 weeks <input type="radio"/> 42 weeks or more
114. What month and year did this pregnancy end?	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> <input type="text"/> MONTH YEAR OR <input type="radio"/> Still pregnant now	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> <input type="text"/> MONTH YEAR OR <input type="radio"/> Still pregnant now
115. What was the sex of the baby or babies?	<input type="radio"/> Single male <input type="radio"/> Single female <input type="radio"/> Multiple → <input type="text"/> # MALES <input type="text"/> # FEMALES <input type="radio"/> Don't know	<input type="radio"/> Single male <input type="radio"/> Single female <input type="radio"/> Multiple → <input type="text"/> # MALES <input type="text"/> # FEMALES <input type="radio"/> Don't know
116. How long did you breastfeed (or have you been breastfeeding)?	<input type="radio"/> less than one month <input type="radio"/> 1-3 months <input type="radio"/> 4-6 months <input type="radio"/> 7-12 months <input type="radio"/> 13-24 months <input type="radio"/> more than 24 months } GO TO 117 <input type="radio"/> did not breastfeed/ not applicable → GO TO NEXT PREGNANCY OR QUESTION 118	<input type="radio"/> less than one month <input type="radio"/> 1-3 months <input type="radio"/> 4-6 months <input type="radio"/> 7-12 months <input type="radio"/> 13-24 months <input type="radio"/> more than 24 months } GO TO 117 <input type="radio"/> did not breastfeed/ not applicable → GO TO NEXT PREGNANCY OR QUESTION 118
117. Are you still breastfeeding?	<input type="radio"/> no <input type="radio"/> yes	<input type="radio"/> no <input type="radio"/> yes

IF YOU HAVE HAD MORE THAN 2 PREGNANCIES SINCE AUGUST 1, 2006, PLEASE ANSWER THE SAME QUESTIONS FOR EACH PREGNANCY AND RECORD YOUR ANSWERS ON A SEPARATE SHEET OF PAPER.



Since August 1, 2006, have you used...		NO	YES	a. If yes, how many months in all have you used this since August 1, 2006?	b. Are you currently using this?
118.	birth control pills?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
119.	birth control patches?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
120.	a hormonal IUD (intrauterine device)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
121.	a Norplant implant?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
122.	a Nuva Ring?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
123.	Depo Provera?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
124.	any other hormonal birth control?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes



125. Since August 1, 2006, have you taken any fertility medications?

No → GO TO THE NEXT PAGE, QUESTION 135

Yes



Since August 1, 2006, have you taken...		NO	YES	a. If yes, how many months or cycles in all have you used this since August 1, 2006?
126.	Clomiphene, Clomid, Serophene?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS/CYCLES
127.	Follicle-stimulating hormones (FSH) - Follistim, Puregon, Gonal-F?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS/CYCLES
128.	Urofollitropin, Metrodin, Fertinex, Bravelle?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS/CYCLES
129.	Human menopausal gonadotropin (hMG) - menotropin, Pergonal, Humegon, Repronex?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS/CYCLES
130.	Human chorionic gonadotropin (hCG) - Pregnyl, Novarel, Profasi, A.P.L.?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS/CYCLES
131.	Gonadotropin-releasing hormone (GnRH) - gonadorelin, Factrel, Lutrepulse, Synarel, nafarelin acetate; and related drugs such as Lupron, leuprolide?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS/CYCLES
132.	Gonadotropin inhibitors - Danocrine, Danazol, Antagon, ganirelix acetate?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS/CYCLES
133.	Prolactin reducers - Bromocriptine, Parlodel?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS/CYCLES
134.	Other: <input type="text"/>	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS/CYCLES

Please use a ballpoint pen for this form



The next questions are about *female hormone products* often used for hormone replacement therapy (HRT).

Since August 1, 2006, have you used...		NO	YES	a. If yes, how many months in all have you used this since August 1, 2006?	b. Do you currently use this female hormone product(s)?
135.	a combined pill containing both estrogen and progesterone (such as Prempro)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
136.	an estrogen-only pill (such as Premarin) with no additional progesterone in any form?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
137.	an estrogen pill (such as Premarin) and a separate progesterone pill (such as Provera) or progesterone shot?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
138.	an estrogen-only patch with no additional progesterone in any form?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
139.	a patch containing both estrogen and progesterone (such as Combipatch)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
140.	an estrogen-only patch and a separate progesterone pill or progesterone shot?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes



<p>Since August 1, 2006, have you used...</p>	<p>NO</p>	<p>YES</p> <p>a. If yes, how many months in all have you used this since August 1, 2006?</p>
<p>141. vaginal estrogen creams, rings, or suppositories?</p>	<p><input type="radio"/> No</p>	<p><input type="radio"/> Yes</p> <p>a. <input type="text"/> <input type="text"/> # MONTHS</p> <p>b. Do you currently use this female hormone product(s)?</p> <p><input type="radio"/> No <input type="radio"/> Yes</p> <p>c. Does this product also contain progesterone?</p> <p><input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't know</p> <p>d. Did you also take progesterone in another form (e.g., patch, pill) during the time you were using vaginal estrogen creams, rings, or suppositories?</p> <p><input type="radio"/> No <input type="radio"/> Yes</p>
<p>142. any other estrogen products, including "natural" estrogens?</p>	<p><input type="radio"/> No</p>	<p><input type="radio"/> Yes</p> <p>a. <input type="text"/> <input type="text"/> # MONTHS</p> <p>b. Do you currently use this female hormone product(s)?</p> <p><input type="radio"/> No <input type="radio"/> Yes</p> <p>c. Which of the following products have you used since August 1, 2006? (Please mark all that apply.)</p> <p><input type="radio"/> Capsules <input type="radio"/> Gel or cream applied to the skin <input type="radio"/> Injection <input type="radio"/> Liquid <input type="radio"/> Troche or lozenge (dissolved under the tongue) <input type="radio"/> Other</p>



Since August 1, 2006, have you used...		NO	YES	a. If yes, how many months in all have you used this since August 1, 2006?	b. Do you currently use this?
143.	tamoxifen or Nolvadex?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
144.	raloxifene or Evista?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
145.	Herceptin?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
146.	aromatase inhibitors such as Arimidex, Aromasin, or Femara?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
147.	testosterone supplements?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes

SURGERIES

Have you <i>ever</i> had...	NEVER OR BEFORE 8/1/2006	HAD PROCEDURE 8/1/2006 OR LATER	a. If you had this procedure August 1, 2006 or later, what was the month and year?
148. gallbladder surgery?	<input type="radio"/> Never had procedure <input type="radio"/> Had procedure <u>before</u> August 1, 2006	<input type="radio"/> Had procedure August 1, 2006 or later	<input type="text"/> <input type="text"/> / 2 0 <input type="text"/> <input type="text"/> MONTH YEAR
149. angioplasty?	<input type="radio"/> Never had procedure <input type="radio"/> Had procedure <u>before</u> August 1, 2006	<input type="radio"/> Had procedure August 1, 2006 or later	<input type="text"/> <input type="text"/> / 2 0 <input type="text"/> <input type="text"/> MONTH YEAR
150. coronary artery bypass graft surgery?	<input type="radio"/> Never had procedure <input type="radio"/> Had procedure <u>before</u> August 1, 2006	<input type="radio"/> Had procedure August 1, 2006 or later	<input type="text"/> <input type="text"/> / 2 0 <input type="text"/> <input type="text"/> MONTH YEAR



Have you <i>ever</i> had...	NEVER OR BEFORE 8/1/2006	HAD PROCEDURE 8/1/2006 OR LATER	a. If you had this procedure August 1, 2006 or later, what was the month and year?
151. a hysterectomy (surgical removal of the uterus)?	<input type="radio"/> Never had procedure <input type="radio"/> Had procedure <u>before</u> August 1, 2006	<input type="radio"/> Had procedure August 1, 2006 or later	a. MONTH/YEAR HAD PROCEDURE <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-around; width: 100%; margin-top: 5px;"> MONTH YEAR </div> b. Did you have all or part of either of your ovaries removed at the same time you had the hysterectomy? <input type="radio"/> No → GO TO QUESTION 152 <input type="radio"/> Yes c. Did you have... <input type="radio"/> both ovaries completely removed <input type="radio"/> one ovary and part of the other ovary removed <input type="radio"/> one ovary removed <input type="radio"/> part of one or part of both ovaries removed d. Did you have all or part of either ovary left after this surgery? <input type="radio"/> No <input type="radio"/> Yes
152. a separate surgery to remove part or all of one or both ovaries (but not your uterus)?	<input type="radio"/> Never had procedure <input type="radio"/> Had procedure <u>before</u> August 1, 2006	<input type="radio"/> Had procedure August 1, 2006 or later	a. MONTH/YEAR HAD PROCEDURE <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-around; width: 100%; margin-top: 5px;"> MONTH YEAR </div> b. Did you have... <input type="radio"/> both ovaries completely removed <input type="radio"/> one ovary and part of the other ovary removed <input type="radio"/> one ovary removed <input type="radio"/> part of one or part of both ovaries removed c. Did you have all or part of either ovary left after this surgery? <input type="radio"/> No <input type="radio"/> Yes

Please use a ballpoint pen for this form



SYMPTOMS OF MENOPAUSE

	No	Yes
153. Have you had <u>hot flashes</u> at any time since August 1, 2006?	<input type="radio"/>	<input type="radio"/>
154. Have you had <u>night sweats</u> at any time since August 1, 2006?	<input type="radio"/>	<input type="radio"/>
155. Have you had <u>any other symptoms of menopause</u> since August 1, 2006, such as poor sleeping, irritability or depression?	<input type="radio"/>	<input type="radio"/>



MEDICATIONS

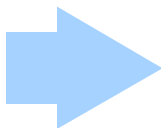
Since August 1, 2006, have you used any prescription medicines to treat or to prevent...	NO	YES	a. If yes, are you currently using this?
156. hypertension (high blood pressure)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
157. high cholesterol?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
158. cardiac arrhythmia (irregular heartbeat)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
159. diabetes?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
160. thyroid disease?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
161. osteoporosis (bone loss, or bone thinning)? Do not count calcium or vitamin D.	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
162. arthritis?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
163. migraines?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
164. depression?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
165. asthma?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
166. Parkinson's disease?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
167. anxiety?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes

Please use a ballpoint pen for this form

168. Have you had allergy shots since August 1, 2006?

No → GO TO THE NEXT PAGE, QUESTION 169

Yes



168a. Are you still getting these allergy shots?

No

Yes



Since August 1, 2006, have you regularly (at least once a week for at least three months in a row) taken...		NO	YES	a. If yes, for about how long have you used this regularly (at least once a week for at least three months in a row) since August 1, 2006?
169.	acetaminophen (Tylenol)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 12 months <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> More than 4 years
170.	"baby aspirin" or low-dose aspirin (100mg/tablet or less)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 12 months <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> More than 4 years
171.	aspirin or other aspirin-containing products (325 mg/tablet or more)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 12 months <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> More than 4 years
172.	ibuprofen (such as Advil, Motrin, Nuprin, etc.)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 12 months <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> More than 4 years
173.	Celebrex, Vioxx, Bextra, or other COX-2 inhibitors?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 12 months <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> More than 4 years
174.	Aleve, Naprosyn, Relafen, Ketoprofen, Anaprox, or other non-steroidal anti-inflammatories?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 12 months <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> More than 4 years
175.	antibiotics?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 12 months <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> More than 4 years



Please use a ballpoint pen for this form

b. On average, how many days per week have you taken this?	c. On days when you take it, how many times do you take it?	d. Are you currently using this?
<input type="radio"/> 1 day per week <input type="radio"/> 2-3 days per week <input type="radio"/> 4-5 days per week <input type="radio"/> 6-7 days per week	<input type="radio"/> 1 time per day <input type="radio"/> 2 times per day <input type="radio"/> 3 times per day <input type="radio"/> 4 times per day <input type="radio"/> 5 or more times per day	<input type="radio"/> No <input type="radio"/> Yes
<input type="radio"/> 1 day per week <input type="radio"/> 2-3 days per week <input type="radio"/> 4-5 days per week <input type="radio"/> 6-7 days per week	<input type="radio"/> 1 time per day <input type="radio"/> 2 times per day <input type="radio"/> 3 times per day <input type="radio"/> 4 times per day <input type="radio"/> 5 or more times per day	<input type="radio"/> No <input type="radio"/> Yes
<input type="radio"/> 1 day per week <input type="radio"/> 2-3 days per week <input type="radio"/> 4-5 days per week <input type="radio"/> 6-7 days per week	<input type="radio"/> 1 time per day <input type="radio"/> 2 times per day <input type="radio"/> 3 times per day <input type="radio"/> 4 times per day <input type="radio"/> 5 or more times per day	<input type="radio"/> No <input type="radio"/> Yes
<input type="radio"/> 1 day per week <input type="radio"/> 2-3 days per week <input type="radio"/> 4-5 days per week <input type="radio"/> 6-7 days per week	<input type="radio"/> 1 time per day <input type="radio"/> 2 times per day <input type="radio"/> 3 times per day <input type="radio"/> 4 times per day <input type="radio"/> 5 or more times per day	<input type="radio"/> No <input type="radio"/> Yes
<input type="radio"/> 1 day per week <input type="radio"/> 2-3 days per week <input type="radio"/> 4-5 days per week <input type="radio"/> 6-7 days per week	<input type="radio"/> 1 time per day <input type="radio"/> 2 times per day <input type="radio"/> 3 times per day <input type="radio"/> 4 times per day <input type="radio"/> 5 or more times per day	<input type="radio"/> No <input type="radio"/> Yes
<input type="radio"/> 1 day per week <input type="radio"/> 2-3 days per week <input type="radio"/> 4-5 days per week <input type="radio"/> 6-7 days per week	<input type="radio"/> 1 time per day <input type="radio"/> 2 times per day <input type="radio"/> 3 times per day <input type="radio"/> 4 times per day <input type="radio"/> 5 or more times per day	<input type="radio"/> No <input type="radio"/> Yes
<input type="radio"/> 1 day per week <input type="radio"/> 2-3 days per week <input type="radio"/> 4-5 days per week <input type="radio"/> 6-7 days per week	<input type="radio"/> 1 time per day <input type="radio"/> 2 times per day <input type="radio"/> 3 times per day <input type="radio"/> 4 times per day <input type="radio"/> 5 or more times per day	<input type="radio"/> No <input type="radio"/> Yes



These last questions are about prescription and non-prescription medications that you *currently take regularly*. This includes all pills, patches, shots, inhaled medicines, vitamins, and herbal supplements. Please include inhalers, even if you use them occasionally and include all medicines prescribed in once a month or once a year doses such as some medicines to prevent osteoporosis.

Do not include:

- Medicines used only occasionally, such as a pain reliever once in a while for a headache
- Aspirin or other pain medications already reported in previous questions

176. Do you *currently* take any prescription or non-prescription medications *regularly or seasonally*? Please include inhalers that you currently use as needed.

No → GO TO END, PAGE 47

Yes

--	--

TOTAL #

a.	b.
What is/are the name(s) of the prescription or non-prescription medication(s) that you <i>currently take regularly</i> ?	For how long have you used this regularly?
1. <table border="1" style="width: 100%; height: 25px;"></table>	<input type="radio"/> Less than 12 months <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> More than 4 years
2. <table border="1" style="width: 100%; height: 25px;"></table>	<input type="radio"/> Less than 12 months <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> More than 4 years
3. <table border="1" style="width: 100%; height: 25px;"></table>	<input type="radio"/> Less than 12 months <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> More than 4 years
4. <table border="1" style="width: 100%; height: 25px;"></table>	<input type="radio"/> Less than 12 months <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> More than 4 years
5. <table border="1" style="width: 100%; height: 25px;"></table>	<input type="radio"/> Less than 12 months <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> More than 4 years





c. How often do you take it?	d. On days when you take it, how many times do you take it?	e. In what form did you take this? <i>(Mark all that apply.)</i>
<input type="radio"/> Once a month or less <input type="radio"/> Less than once a week <input type="radio"/> Once a week <input type="radio"/> 2-3 days a week <input type="radio"/> 4-5 days a week <input type="radio"/> 6-7 days a week	<input type="radio"/> 1 time per day <input type="radio"/> 2 times per day <input type="radio"/> 3 times per day <input type="radio"/> 4 times per day <input type="radio"/> 5 or more times per day	<input type="radio"/> pill <input type="radio"/> inhaled <input type="radio"/> cream <input type="radio"/> liquid <input type="radio"/> patch <input type="radio"/> spray <input type="radio"/> shot <input type="radio"/> other
<input type="radio"/> Once a month or less <input type="radio"/> Less than once a week <input type="radio"/> Once a week <input type="radio"/> 2-3 days a week <input type="radio"/> 4-5 days a week <input type="radio"/> 6-7 days a week	<input type="radio"/> 1 time per day <input type="radio"/> 2 times per day <input type="radio"/> 3 times per day <input type="radio"/> 4 times per day <input type="radio"/> 5 or more times per day	<input type="radio"/> pill <input type="radio"/> inhaled <input type="radio"/> cream <input type="radio"/> liquid <input type="radio"/> patch <input type="radio"/> spray <input type="radio"/> shot <input type="radio"/> other
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<input type="radio"/> Once a month or less <input type="radio"/> Less than once a week <input type="radio"/> Once a week <input type="radio"/> 2-3 days a week <input type="radio"/> 4-5 days a week <input type="radio"/> 6-7 days a week	<input type="radio"/> 1 time per day <input type="radio"/> 2 times per day <input type="radio"/> 3 times per day <input type="radio"/> 4 times per day <input type="radio"/> 5 or more times per day	<input type="radio"/> pill <input type="radio"/> inhaled <input type="radio"/> cream <input type="radio"/> liquid <input type="radio"/> patch <input type="radio"/> spray <input type="radio"/> shot <input type="radio"/> other



c. How often do you take it?	d. On days when you take it, how many times do you take it?	e. In what form did you take this? <i>(Mark all that apply.)</i>	
<input type="radio"/> Once a month or less <input type="radio"/> Less than once a week <input type="radio"/> Once a week <input type="radio"/> 2-3 days a week <input type="radio"/> 4-5 days a week <input type="radio"/> 6-7 days a week	<input type="radio"/> 1 time per day <input type="radio"/> 2 times per day <input type="radio"/> 3 times per day <input type="radio"/> 4 times per day <input type="radio"/> 5 or more times per day	<input type="radio"/> pill <input type="radio"/> inhaler <input type="radio"/> cream <input type="radio"/> liquid	<input type="radio"/> patch <input type="radio"/> spray <input type="radio"/> shot <input type="radio"/> other
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<input type="radio"/> Once a month or less <input type="radio"/> Less than once a week <input type="radio"/> Once a week <input type="radio"/> 2-3 days a week <input type="radio"/> 4-5 days a week <input type="radio"/> 6-7 days a week	<input type="radio"/> 1 time per day <input type="radio"/> 2 times per day <input type="radio"/> 3 times per day <input type="radio"/> 4 times per day <input type="radio"/> 5 or more times per day	<input type="radio"/> pill <input type="radio"/> inhaler <input type="radio"/> cream <input type="radio"/> liquid	<input type="radio"/> patch <input type="radio"/> spray <input type="radio"/> shot <input type="radio"/> other
<input type="radio"/> Once a month or less <input type="radio"/> Less than once a week <input type="radio"/> Once a week <input type="radio"/> 2-3 days a week <input type="radio"/> 4-5 days a week <input type="radio"/> 6-7 days a week	<input type="radio"/> 1 time per day <input type="radio"/> 2 times per day <input type="radio"/> 3 times per day <input type="radio"/> 4 times per day <input type="radio"/> 5 or more times per day	<input type="radio"/> pill <input type="radio"/> inhaler <input type="radio"/> cream <input type="radio"/> liquid	<input type="radio"/> patch <input type="radio"/> spray <input type="radio"/> shot <input type="radio"/> other
<input type="radio"/> Once a month or less <input type="radio"/> Less than once a week <input type="radio"/> Once a week <input type="radio"/> 2-3 days a week <input type="radio"/> 4-5 days a week <input type="radio"/> 6-7 days a week	<input type="radio"/> 1 time per day <input type="radio"/> 2 times per day <input type="radio"/> 3 times per day <input type="radio"/> 4 times per day <input type="radio"/> 5 or more times per day	<input type="radio"/> pill <input type="radio"/> inhaler <input type="radio"/> cream <input type="radio"/> liquid	<input type="radio"/> patch <input type="radio"/> spray <input type="radio"/> shot <input type="radio"/> other
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Please check to see that all questions are answered.

Thank you for completing this questionnaire and for your continued participation in the Sister Study.

Please mail this form to us at the address below.
A postage-paid envelope is provided.

The Sister Study, 1009 Slater Road, Suite 120, Durham, NC 27703
phone: 1-877-4SISTER (1-877-474-7837); email: update@sisterstudy.org







The Sister Study

Lifestyle 'UbX'9bj Jfcba Ybh

Version 4



Instructions:

- Please use **DARK BLUE OR BLACK BALLPOINT PEN**.
- Mark only one answer for each question unless otherwise indicated.
- Follow the arrow from your response to find the next question.
- Do not write comments on the form.
- Please keep this questionnaire clean, flat, and dry.
- Do not fold or tear any of the pages.

Fill in the bubbles **COMPLETELY** for each of the questions in this form.

Like this: ●

Not like this: ⊗ ⊙

If you must change an answer, please mark a single horizontal line through it and bubble in the correct answer completely.

Like this: ● ~~YES~~

Not like this: ⊗ ~~YES~~

Please write responses in all capital letters and numbers without touching the sides of the boxes.

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
---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---

1	2	3	4	5	6	7	8	9	0
---	---	---	---	---	---	---	---	---	---

When writing dates, please follow this example.

EXAMPLE: June 7, 2004 =

0	6
---	---

 /

0	7
---	---

 /

2	0	0	4
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(month) (day) (year)

Public reporting burden for this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0522). Do not return the completed form to this address.

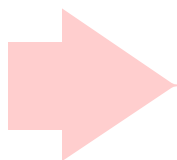


Your continued participation in the Sister Study is completely voluntary and greatly appreciated. If you are not comfortable answering a question, just skip it and go on to the next one. All information you share will be kept confidential.

Today's Date: / / 2 0
(month) (day) (year)

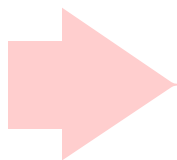
1. Which of the following best describes your *current* marital status?

- Never married
- Widowed
- Divorced
- Separated



GO TO QUESTION 2

- Married, civil union or living with someone as though married



1a. How many years have you been married or living as though married with that spouse/partner?

YEARS

OR Less than 1 year

1b. Is your spouse/partner a Man
man or a woman? Woman

2. Thinking about last year, which of the following best describes your total income from all household members before taxes? Please include income from all sources such as annuities, social security, stocks, alimony and child support earned in the past year.

- Less than \$20,000
- \$20,000 to \$49,999
- \$50,000 to \$99,999
- \$100,000 to \$200,000
- More than \$200,000



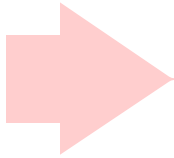
3. Last year, how many people, including yourself, were supported by that income?

- 1
- 2
- 3-4
- 5-6
- 7-8
- More than 8

4. Did you smoke at least 10 cigarettes since August 1, 2006?

No → GO TO QUESTION 5

Yes



4a.	When did you <i>first</i> start smoking?	<input type="radio"/> Before 2006 <input type="radio"/> 2006 <input type="radio"/> 2007 <input type="radio"/> 2008 <input type="radio"/> 2009 <input type="radio"/> 2010			
4b.	When did you <i>last</i> smoke cigarettes?	<input type="radio"/> I am a current smoker <input type="radio"/> I last smoked in 2010 <input type="radio"/> I last smoked in 2009 <input type="radio"/> I last smoked in 2008 <input type="radio"/> I last smoked in 2007 <input type="radio"/> I last smoked in 2006			
4c.	During the years you smoked since 2006, how many days per week do/did you smoke?	<input type="radio"/> Less than one day per week <input type="radio"/> 1-3 days per week <input type="radio"/> 4-6 days per week <input type="radio"/> every day			
4d.	During the years you smoked since 2006, how many cigarettes do/did you usually smoke per day on the days that you smoked?	<table border="1"><tr><td> </td><td> </td><td> </td></tr></table> # CIGARETTES			

5. Since August 1, 2006, how many regular smokers have you lived with (not counting yourself, if you smoke)?

- None
- 1
- 2
- 3-4
- 5 or more

Please use a ballpoint pen for this form



6. About how many hours or minutes per day are you exposed to other people's tobacco smoke (include all locations—home, work, and all other places you spend time where others might smoke)?

- None
- Less than 30 minutes
- 30-59 minutes
- 1-2 hours
- 3-4 hours
- 5-6 hours
- 7-8 hours
- More than 8 hours

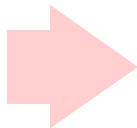
Since August 1, 2006...	NO	YES	a. IF YES, about how often did you drink these beverages?	b. On average, how many drinks did you have on the days that you drank?	c. How many years in all have you done this since August 1, 2006?
7. ...have you drunk <i>beer or other malt beverages?</i>	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> a few times per year <input type="radio"/> once per month <input type="radio"/> 2-3 times per month <input type="radio"/> once per week <input type="radio"/> 2 times per week <input type="radio"/> 3-4 times per week <input type="radio"/> 5-6 times per week <input type="radio"/> every day	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 or more	<input type="radio"/> less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> 5 years
8. ...have you drunk <i>white wine or white wine coolers?</i>	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> a few times per year <input type="radio"/> once per month <input type="radio"/> 2-3 times per month <input type="radio"/> once per week <input type="radio"/> 2 times per week <input type="radio"/> 3-4 times per week <input type="radio"/> 5-6 times per week <input type="radio"/> every day	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 or more	<input type="radio"/> less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> 5 years
9. ...have you drunk <i>red wine or red wine coolers?</i>	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> a few times per year <input type="radio"/> once per month <input type="radio"/> 2-3 times per month <input type="radio"/> once per week <input type="radio"/> 2 times per week <input type="radio"/> 3-4 times per week <input type="radio"/> 5-6 times per week <input type="radio"/> every day	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 or more	<input type="radio"/> less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> 5 years
10. ...have you drunk <i>liquor?</i>	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> a few times per year <input type="radio"/> once per month <input type="radio"/> 2-3 times per month <input type="radio"/> once per week <input type="radio"/> 2 times per week <input type="radio"/> 3-4 times per week <input type="radio"/> 5-6 times per week <input type="radio"/> every day	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 or more	<input type="radio"/> less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> 5 years



11. Since August 1, 2006, did you ever drink four or more alcoholic beverages in a row, in one sitting?

No → GO TO QUESTION 12

Yes



11a. How many times has this happened since August 1, 2006?	<input type="radio"/> once or twice <input type="radio"/> once a year <input type="radio"/> 2-3 times a year <input type="radio"/> 4-6 times a year <input type="radio"/> 7-11 times a year <input type="radio"/> once a month <input type="radio"/> more than once a month but less than once a week <input type="radio"/> once a week <input type="radio"/> more than once a week
---	---

12. Since August 1, 2006, has a doctor or other health professional told you that your drinking was hurting your health?

No

Yes

We are interested in finding out about the kinds of *physical activities* that people do as part of their everyday lives. The questions will ask you about the time you spent being physically active in the *past 7 days*. Please answer each question even if you do not consider yourself to be an active person. Please think about the activities you do at work, as part of your house and yard work, to get from place to place, and in your spare time for recreation, exercise or sport.

During the <i>past 7 days</i> , on how many days did you...		a. How much time did you usually spend doing these physical activities on one of those days?
13. ...do <i>vigorous</i> physical activities? These take hard physical effort and make you breathe much harder than normal, for example running or swimming at a fast pace. Think only about activities that you did for at least 10 minutes at a time.	<input type="text"/> # DAYS OR <input type="radio"/> No vigorous physical activity	<input type="text"/> AND <input type="text"/> HOURS PER DAY MINUTES PER DAY <small>(up to 59)</small> <input type="radio"/> Not sure
14. ...do <i>moderate</i> physical activities? These take moderate physical effort and make you breathe somewhat harder than normal, for example dancing or doing yard work. Think only about those physical activities that you did for at least 10 minutes at a time. Do not include walking.	<input type="text"/> # DAYS OR <input type="radio"/> No moderate physical activity	<input type="text"/> AND <input type="text"/> HOURS PER DAY MINUTES PER DAY <small>(up to 59)</small> <input type="radio"/> Not sure
15. ... <i>walk</i> for at least 10 minutes at a time? This includes walking at work and at home, walking to travel from place to place, and any other walking you might do solely for recreation, sport, exercise or leisure.	<input type="text"/> # DAYS OR <input type="radio"/> No walking for at least 10 mins	<input type="text"/> AND <input type="text"/> HOURS PER DAY MINUTES PER DAY <small>(up to 59)</small> <input type="radio"/> Not sure

Please use a ballpoint pen for this form



During the *past 7 days*, how much time did you...

16. ...usually spend *sitting* on a *weekday*? This includes sitting while at work, at home, while doing course work and during leisure time. This may include time spent sitting at a desk, visiting friends, reading or sitting or lying down to watch television.

HOURS
PER DAY

AND

MINUTES
PER DAY
(up to 59)

Not sure

17. ...usually spend *standing* on a *weekday*? This includes standing while at work, at home, and during leisure time.

HOURS
PER DAY

AND

MINUTES
PER DAY
(up to 59)

Not sure

18. How similar was your level of activity this past week to your usual level of activity?

- less than usual
- about the same
- more than usual

19. Since August 1, 2006, have you done any of the following *hobbies* at least 5 hours per week for at least 6 weeks? (Mark all that apply.)

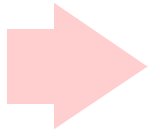
- oil painting or other artistic painting
- developing photographs chemically
- woodworking
- refinishing furniture
- ceramics or pottery making
- glass blowing
- etching
- hobbies that involve soldering such as stained glass or jewelry making
- hobbies that involve welding
- leather crafting
- print making or silk screening
- auto or engine repair
- gardening
- I have not done any of these hobbies



20. Since August 1, 2006, have you used *hair dye* to color your hair?

No → GO TO QUESTION 21

Yes



20a. In what years did you do this? (*Mark all that apply.*)

- 2006
- 2007
- 2008
- 2009
- 2010

20b. What color did you *usually* use?

- Black
- Light brown
- Dark brown
- Light blonde
- Dark blonde
- Light red
- Dark red
- Other

20c. What type of hair dye do you use most often?

- Temporary dyes (wash out with a few shampoos)
- Semi-permanent dyes (colors are pre-mixed or require mixing but no other chemicals are added; color fades out in about 4-8 weeks)
- Demi-permanent dyes (other chemicals are mixed with the color; has strong smell; color fades out)
- Permanent dyes (other chemicals are mixed with the color; has strong smell; color grows out over time, sometimes leaving your "roots" showing)

21. Since August 1, 2006, about how often have you used *chemical insect repellents on your skin, hair, or clothing in the summer?* Please do not include products that contain only citronella.

- Never
- A few times
- Once per month
- 2-3 times per month
- Once or twice per week
- 3-6 times per week
- Every day

22. Since August 1, 2006, about how often have you used *chemical insect repellents on your skin, hair, or clothing the rest of the year?* Please do not include products that contain only citronella.

- Never
- A few times
- Once per month
- 2-3 times per month
- Once or twice per week
- 3-6 times per week
- Every day

Please use a ballpoint pen for this form



23. Since August 1, 2006, about how often have you used an over-the-counter or prescription *lice control product* on yourself, or applied it to someone else's skin, hair, or clothing?
- Never
 - Once
 - Twice
 - Three times
 - Four or more times
24. Since August 1, 2006, about how many hours per day do you usually spend outdoors in daylight on weekend or vacation days *in the summer*?
- Less than 1 hour per day
 - 1-2 hours per day
 - 3-4 hours per day
 - 5-8 hours per day
 - 9-12 hours per day
 - More than 12 hours per day
25. Since August 1, 2006, about how many hours per day do you usually spend outdoors in daylight on other days *in the summer*?
- Less than 1 hour per day
 - 1-2 hours per day
 - 3-4 hours per day
 - 5-8 hours per day
 - 9-12 hours per day
 - More than 12 hours per day
26. Since August 1, 2006, about how many hours per day do you usually spend outdoors in daylight on weekend or vacation days *the rest of the year*?
- Less than 1 hour per day
 - 1-2 hours per day
 - 3-4 hours per day
 - 5-8 hours per day
 - 9-12 hours per day
 - More than 12 hours per day
27. Since August 1, 2006, about how many hours per day do you usually spend outdoors in daylight on other days *the rest of the year*?
- Less than 1 hour per day
 - 1-2 hours per day
 - 3-4 hours per day
 - 5-8 hours per day
 - 9-12 hours per day
 - More than 12 hours per day



32. How much time per day do you spend traveling by bicycle, motorcycle, car, van, truck, or bus *on most days?*

- Less than 15 minutes
- 15-29 minutes
- 30-44 minutes
- 45-59 minutes
- 60-89 minutes
- 90-119 minutes
- 2-3 hours
- 4-5 hours
- More than 5 hours

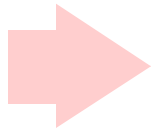
33. What is the traffic condition that best describes your travel time (by bicycle, motorcycle, car, van, truck, or bus) *on most days?*

- Little or no traffic
- Light traffic, moving at or above the speed limit
- Heavy traffic, moving below the speed limit
- Congested or "stop and go"
- Heavy traffic, moving at or above the speed limit
- Not applicable, I travel by train or subway
- Not applicable, I walk to work

34. Since August 1, 2006, about how often has your residence been treated with insecticides or pesticides to control insects, rodents, or other pests, either inside or around the foundation?

Never → GO TO THE NEXT PAGE, QUESTION 35

- Less than once a year
- Once a year
- Every 4-6 months
- Every 2-3 months
- Monthly
- Weekly
- Daily



34a. For what kinds of pests were pest control chemicals used at your residence?
(Mark all that apply.)

- Ants
- Cockroaches
- Bees or wasps
- Flies
- Spiders
- Mosquitoes
- Fleas or ticks, not on pets
- Termites
- Any other pest such as moths, silverfish, caterpillars, mice, rats, gophers, or moles

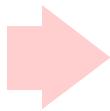
34b. When pest control chemicals were applied since August 1, 2006, about how often did you *personally* apply them?

- All of the time
- Most of the time
- About half the time
- Some of the time
- Never
- Not applicable



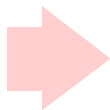
35. Since August 1, 2006, about how often was the garden or yard around this residence treated with weed killers or insecticides, including those labeled organic such as pyrethrum or rotenone?

- Never
- Not applicable



GO TO QUESTION 36

- Less than once a year
- Once a year
- Every 4-6 months
- Every 2-3 months
- Monthly
- Weekly
- Daily



35a. When weed killers or insecticides were used in the garden or yard since August 1, 2006, about how often did you *personally* apply them?

- All of the time
- Most of the time
- About half the time
- Some of the time
- Never
- Not applicable

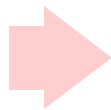
36. Since August 1, 2006, about how often have you used household cleaning solutions other than dish washing and laundry detergents?

- Never
- Less than once a year
- Once a year
- Every 4-6 months
- Every 2-3 months
- Monthly
- Weekly
- Daily

37. Since August 1, 2006, have you regularly used air fresheners in your home? Please include air fresheners that plug in, hang, sit on a shelf, or stick on the wall, as well as sprays that are used at least three times a week.

No → GO TO THE NEXT PAGE, QUESTION 38

Yes



37a. What types of air fresheners do you use at home? (*Mark all that apply.*)

- Aerosol sprays
- Solid table top
- Stick-on (disc shaped)
- Plug-in
- Candle style
- Other

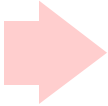
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38. Since August 1, 2006, have you regularly used air fresheners in your car? Please include the hanging types, as well as those that plug in, and sprays that are used at least three times a week.

No → GO TO QUESTION 39

Yes



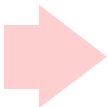
38a. What types of air fresheners do you use in your car? (*Mark all that apply.*)

- Aerosol sprays
- Hanging type - paper
- Hanging type - gel
- Hanging type - other
- Canister type
- Attached to car air vent - oil filled
- Attached to car air vent - gel filled
- Attached to car air vent - stick filled

39. Do you currently have any household pets?

No → GO TO QUESTION 40

Yes

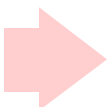


How many of each of the following do you have?

	<u>None</u>	<u>1</u>	<u>2</u>	<u>3-4</u>	<u>5 or more</u>
39a. dogs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
39b. birds	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
39c. cats	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
39d. other furry animals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

40. Since August 1, 2006 have you had a full-time or part-time job other than homemaking that you held for at least 12 months (at least 9 months if it was a teaching job)?

No



40a. Which of the following *best* describes your current situation?

- Homemaker
- Student
- Unemployed
- Retired
- On medical leave
- Disabled

GO TO THE END

Yes → GO TO THE NEXT PAGE, QUESTION 41



OF JOBS

Please tell us about the jobs you have had since August 1, 2006, starting with the most recent and working backwards.

	JOB 1	JOB 2
41. When did you first start this job?	<input type="radio"/> Before 2006 <input type="radio"/> 2006 <input type="radio"/> 2007 <input type="radio"/> 2008 <input type="radio"/> 2009 <input type="radio"/> 2010	<input type="radio"/> Before 2006 <input type="radio"/> 2006 <input type="radio"/> 2007 <input type="radio"/> 2008 <input type="radio"/> 2009 <input type="radio"/> 2010
42. When did you last have this job?	<input type="radio"/> 2006 <input type="radio"/> 2007 <input type="radio"/> 2008 <input type="radio"/> 2009 <input type="radio"/> 2010 <input type="radio"/> I still work there	<input type="radio"/> 2006 <input type="radio"/> 2007 <input type="radio"/> 2008 <input type="radio"/> 2009 <input type="radio"/> 2010 <input type="radio"/> I still work there
43. Where did you work? Please write down the name of the company you worked for and the <i>full street address</i> of this workplace. Knowing the name and addresses of the places you work will allow us to evaluate the impact of air pollution and other factors in the general environment on your health. We will never use this information for any other purpose and will never contact your employer.	<input type="text"/> NAME OF COMPANY/PLACE OF WORK <input type="text"/> STREET # <input type="text"/> STREET NAME <input type="text"/> APT # <input type="text"/> CITY OR TOWN <input type="text"/> <input type="text"/> STATE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> ZIP CODE <input type="text"/> COUNTY	<input type="text"/> NAME OF COMPANY/PLACE OF WORK <input type="text"/> STREET # <input type="text"/> STREET NAME <input type="text"/> APT # <input type="text"/> CITY OR TOWN <input type="text"/> <input type="text"/> STATE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> ZIP CODE <input type="text"/> COUNTY

Please use a ballpoint pen for this form

SPACE IS PROVIDED FOR TWO JOBS. IF YOU HAVE HAD MORE THAN TWO JOBS LASTING 12 MONTHS OR MORE SINCE AUGUST 1, 2006, PLEASE ANSWER THE SAME QUESTIONS FOR EACH JOB AND RECORD YOUR ANSWERS ON A SEPARATE SHEET OF PAPER.

21681





	JOB 1	JOB 2
--	-------	-------

44. On this job, do/did you usually spend time...

- Outdoors
- Indoors in a basement
- Indoors on the ground (first) floor
- Indoors on the second floor
- Indoors on the third floor or higher
- Traveling in a vehicle
(e.g., truck, auto, train, plane)

- Outdoors
- Indoors in a basement
- Indoors on the ground (first) floor
- Indoors on the second floor
- Indoors on the third floor or higher
- Traveling in a vehicle
(e.g., truck, auto, train, plane)

45. What was/is your job title?

JOB TITLE

JOB TITLE

46. What type of company or organization do/did you work for? (What do they make or what services do they provide?)

INDUSTRY

INDUSTRY

47. What are the specific tasks that you usually do/did in your job?

JOB DUTIES

JOB DUTIES



48. How many hours per week do/did you usually work at this job?

- Less than 10
- 11-20
- 21-30
- 31-40
- More than 40

- Less than 10
- 11-20
- 21-30
- 31-40
- More than 40

49. What hours of the day do/did you usually work at this job?

START TIME: *(mark one)*

		:		
<i>(hr)</i>			<i>(min)</i>	

AM
 PM

START TIME: *(mark one)*

		:		
<i>(hr)</i>			<i>(min)</i>	

AM
 PM

STOP TIME: *(mark one)*

		:		
<i>(hr)</i>			<i>(min)</i>	

AM
 PM

STOP TIME: *(mark one)*

		:		
<i>(hr)</i>			<i>(min)</i>	

AM
 PM

OR

- I work(ed) irregular hours
- I work(ed) rotating shifts

OR

- I work(ed) irregular hours
- I work(ed) rotating shifts

50. How many times per month do/did you work at night?

“Work at night” means any shift that includes at least one hour between midnight and 2:00 AM.

- Never
- 1-2 times/month
- 3-5 times/month
- 6-10 times/month
- 11-15 times/month
- More than 15 times per month

- Never
- 1-2 times/month
- 3-5 times/month
- 6-10 times/month
- 11-15 times/month
- More than 15 times per month

Please use a ballpoint pen for this form





		JOB 1		JOB 2			
		NO	YES	NO	YES		
51.	While working at this job do/did you regularly...	a. work in dusty conditions?	<input type="radio"/>	<input type="radio"/>	a. work in dusty conditions?	<input type="radio"/>	<input type="radio"/>
		b. breathe in chemical vapors or fumes?	<input type="radio"/>	<input type="radio"/>	b. breathe in chemical vapors or fumes?	<input type="radio"/>	<input type="radio"/>
		c. get chemicals or oils on your skin or clothing?	<input type="radio"/>	<input type="radio"/>	c. get chemicals or oils on your skin or clothing?	<input type="radio"/>	<input type="radio"/>
		d. come in contact with solvents or degreasers?	<input type="radio"/>	<input type="radio"/>	d. come in contact with solvents or degreasers?	<input type="radio"/>	<input type="radio"/>
		e. come in contact with metal chips, dust, or fumes?	<input type="radio"/>	<input type="radio"/>	e. come in contact with metal chips, dust, or fumes?	<input type="radio"/>	<input type="radio"/>
		f. come in contact with pesticides?	<input type="radio"/>	<input type="radio"/>	f. come in contact with pesticides?	<input type="radio"/>	<input type="radio"/>
		g. use cleaning solutions (not counting dish or laundry detergents)?	<input type="radio"/>	<input type="radio"/>	g. use cleaning solutions (not counting dish or laundry detergents)?	<input type="radio"/>	<input type="radio"/>

Please check to see that all questions are answered.

Thank you for completing this questionnaire and for your continued participation in the Sister Study.

Please mail this form to us at the address below.
A postage-paid envelope is provided.

The Sister Study, 1009 Slater Road, Suite 120, Durham, NC 27703
phone: 1-877-4SISTER (1-877-474-7837); email: update@sisterstudy.org





The Sister Study

Stress and Coping Version 2



Instructions:

- Please use **DARK BLUE OR BLACK BALLPOINT PEN.**
- Mark only one answer for each question unless otherwise indicated.
- Do not write comments on the form.
- Please keep this questionnaire clean, flat, and dry.
- Do not fold or tear any of the pages.

Fill in the bubbles **COMPLETELY** for each of the questions in this form.

Like this: ●

Not like this: ⊗ ⊙

If you must change an answer, please mark a single horizontal line through it and bubble in the correct answer completely.

Like this: ● ~~YES~~

Not like this: ● ~~YES~~

Please write responses without touching the sides of the boxes.

Like this:

1	2	3	4	5	6	7	8	9	0
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When writing dates, please follow this example.

EXAMPLE: June 7, 2004 =

0	6
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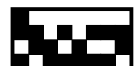
0	7
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2	0	0	4
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(month) (day) (year)

Public reporting burden for this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0522). Do not return the completed form to this address.



This one-time survey asks about your experiences and how you have felt at different times in your life. Some of the questions are about the past week or month and others focus on your entire life. Please pay careful attention to the time-frame for each question.

Your continued participation in the Sister Study is completely voluntary and greatly appreciated. Some questions may be personal or sensitive. *All of your answers will be kept confidential.* You will not be identified in any way. However, if you are not comfortable answering a question, just skip it and go on to the next one.

Please mark the category that best describes your response. There are no right or wrong answers. Try not to let your response to one statement influence your responses to other statements. Answer according to your own feelings, rather than how you think "most people" would answer. Don't take too long thinking over your replies; your immediate reaction will probably be more accurate than a long thought out response.

Today's Date: / / 2 0
(month) (day) (year)

1. How often during the *past 30 days*, have you...

	Never	Almost Never	Some- times	Fairly often	Very often
a. ...felt that you were unable to control the important things in your life?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. ...felt confident about your ability to handle your personal problems?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. ...felt that things were going your way?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. ...felt difficulties were piling up so high that you could not overcome them?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



2. For each statement below, choose the answer that best indicates how often the statement is true for you.

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
a. I can count on someone to provide me with emotional support (someone to confide in about myself or a problem or who will listen to me when I need to talk).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. I can count on someone if I need help (for example, to take me to the doctor or help with daily chores if I am sick).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. There is someone in my immediate family who believes in me and wants me to succeed.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. There is someone in my immediate family who makes me feel important or special.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. When I was a child, there was someone in my immediate family who believed in me and wanted me to succeed.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. When I was a child, there was someone in my immediate family who made me feel important or special.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. In general, how many relatives or friends do you feel close to (people you feel at ease with, can talk to about private matters, or call on for help)?

- NONE
- 1-2
- 3-5
- 6-9
- 10 or more

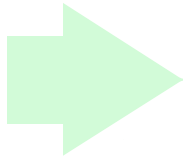
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4. During the past 12 months, about how many hours *per week* on average did you provide care for children or grandchildren?

NONE → GO TO QUESTION 5

- 1-8 hours
- 9-20 hours
- 21-40 hours
- 41 or more hours

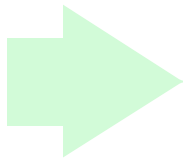


- | | | |
|-----|---|---|
| 4a. | How stressful would you say it is to provide care for these children or grandchildren? | <input type="radio"/> Not at all |
| | | <input type="radio"/> A little |
| | | <input type="radio"/> A moderate amount |
| | | <input type="radio"/> A lot |
| 4b. | During the past 12 months, for whom did you provide such care? <i>(Please mark all that apply.)</i> | <input type="radio"/> My children |
| | | <input type="radio"/> My grandchildren |
| | | <input type="radio"/> Other children |

5. During the past 12 months, about how many hours *per week* on average did you provide care for a disabled or ill parent, child, sibling, spouse, partner, or other relative?

NONE → GO TO THE NEXT PAGE, QUESTION 6

- 1-8 hours
- 9-20 hours
- 21-40 hours
- 41 or more hours



- | | | |
|-----|---|---|
| 5a. | How stressful would you say it is to provide care for these disabled or ill individuals? | <input type="radio"/> Not at all |
| | | <input type="radio"/> A little |
| | | <input type="radio"/> A moderate amount |
| | | <input type="radio"/> A lot |
| 5b. | During the past 12 months, for whom did you provide such care? <i>(Please mark all that apply.)</i> | <input type="radio"/> Parent |
| | | <input type="radio"/> Child |
| | | <input type="radio"/> Sibling |
| | | <input type="radio"/> Spouse |
| | | <input type="radio"/> Partner |
| | | <input type="radio"/> Other relative |



6. There are many ways to deal with problems. These items ask what you do, *in general*, to cope with the stress in your life. To what extent do you do the following?

	Not at all	A little	A moderate amount	A lot
a. I get emotional support or comfort and understanding from others.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. I give up trying to deal with things or trying to cope.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. I take action to try to make the situation better.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. I refuse to believe that things have happened.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. I criticize or blame myself.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. I express my negative feelings.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. I learn to live with things.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. I try to laugh or make fun of the situation.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. I try to grow as a person from the experience.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7. How important is your religious faith or spirituality to you?

- Not at all
- A little
- A moderate amount
- A lot

8. How much is religion or spirituality a source of strength and comfort to you?

- Not at all
- A little
- A moderate amount
- A lot

9. How often do you pray or meditate?

- Never
- Less than once a year
- Yearly or a few times a year
- Monthly or a few times per month
- 1 to 3 times per week
- 4 to 6 times per week
- Every day

Please use a ballpoint pen for this form



10. Please read each statement below and mark the one response that best matches how you feel.

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
a. In uncertain times, I usually expect the best.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. If something can go wrong for me, it will.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. I'm always optimistic about my future.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. I hardly ever expect things to go my way.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. I rarely count on good things happening to me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Overall, I expect more good things to happen to me than bad.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

11. Below is a list of some of the ways you may have felt or behaved. During the *past week*, how often did you feel or act this way?

	Rarely or none of the time	A little of the time	A moderate amount of the time	Most or all of the time
a. I was bothered by things that usually don't bother me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. I had trouble keeping my mind on what I was doing.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. I felt depressed.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. I felt that everything I did was an effort.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. I felt hopeful about the future.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. I felt fearful.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. My sleep was restless.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. I was happy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. I felt lonely.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. I could not "get going."	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



The next questions are about personal experiences that may have happened at any time in your life. Think about how old *you* were when reporting when these experiences took place.

	NO	YES	a. IF YES, this happened... (Mark all that apply.)	b. Regardless of when this happened, how much distress or anxiety has this caused you in the past 4 weeks?
12. Have you ever been in a <u>major fire, flood, or other natural disaster</u> that resulted in <i>serious injury to yourself or the fear of your own death, or serious injury or death of someone with whom you were very close, or serious damage to your home?</i>	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> at age 12 or younger <input type="radio"/> at age 13 to age 17 <input type="radio"/> at age 18 to last year <input type="radio"/> in the past 12 months	<input type="radio"/> none <input type="radio"/> a little <input type="radio"/> a moderate amount <input type="radio"/> a lot
13. Have you ever been in a <u>major accident involving a car or other vehicle, or a work site accident</u> that resulted in <i>serious injury to yourself or the fear of your own death, or serious injury or death of someone with whom you were very close?</i>	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> at age 12 or younger <input type="radio"/> at age 13 to age 17 <input type="radio"/> at age 18 to last year <input type="radio"/> in the past 12 months	<input type="radio"/> none <input type="radio"/> a little <input type="radio"/> a moderate amount <input type="radio"/> a lot
14. Have you ever been <u>deliberately hit or attacked</u> so severely as to result in marks, bruises, burns, blood, or broken bones <i>by someone with whom you were very close?</i>	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> at age 12 or younger <input type="radio"/> at age 13 to age 17 <input type="radio"/> at age 18 to last year <input type="radio"/> in the past 12 months	<input type="radio"/> none <input type="radio"/> a little <input type="radio"/> a moderate amount <input type="radio"/> a lot
15. Have you ever been <u>deliberately hit or attacked</u> so severely as to result in marks, bruises, burns, blood, or broken bones <i>by someone with whom you were not so close?</i>	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> at age 12 or younger <input type="radio"/> at age 13 to age 17 <input type="radio"/> at age 18 to last year <input type="radio"/> in the past 12 months	<input type="radio"/> none <input type="radio"/> a little <input type="radio"/> a moderate amount <input type="radio"/> a lot
16. Have you ever been made to have <u>unwanted sexual contact</u> , such as touching or penetration <i>by someone with whom you were very close?</i>	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> at age 12 or younger <input type="radio"/> at age 13 to age 17 <input type="radio"/> at age 18 to last year <input type="radio"/> in the past 12 months	<input type="radio"/> none <input type="radio"/> a little <input type="radio"/> a moderate amount <input type="radio"/> a lot
17. Have you ever been made to have <u>unwanted sexual contact</u> , such as touching or penetration <i>by someone with whom you were not so close?</i>	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> at age 12 or younger <input type="radio"/> at age 13 to age 17 <input type="radio"/> at age 18 to last year <input type="radio"/> in the past 12 months	<input type="radio"/> none <input type="radio"/> a little <input type="radio"/> a moderate amount <input type="radio"/> a lot
18. Have you ever been <u>emotionally or psychologically mistreated</u> (such as being yelled or screamed at, insulted or belittled) over a significant period of time <i>by someone with whom you were very close?</i>	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> at age 12 or younger <input type="radio"/> at age 13 to age 17 <input type="radio"/> at age 18 to last year <input type="radio"/> in the past 12 months	<input type="radio"/> none <input type="radio"/> a little <input type="radio"/> a moderate amount <input type="radio"/> a lot

Please use a ballpoint pen for this form



	NO	YES	a. IF YES, this happened... (Mark all that apply.)	b. Regardless of when this happened, how much distress or anxiety has this caused you in the past 4 weeks?
19. Have you ever been <u>emotionally or psychologically mistreated</u> (such as being yelled or screamed at, insulted or belittled) over a significant period of time <i>by someone with whom you were not so close</i> ?	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> at age 12 or younger <input type="radio"/> at age 13 to age 17 <input type="radio"/> at age 18 to last year <input type="radio"/> in the past 12 months	<input type="radio"/> none <input type="radio"/> a little <input type="radio"/> a moderate amount <input type="radio"/> a lot
20. Have you ever personally witnessed <i>someone with whom you were very close</i> committing suicide, or being <u>attacked</u> so severely as to result in marks, bruises, burns, blood, broken bones or teeth, or death?	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> at age 12 or younger <input type="radio"/> at age 13 to age 17 <input type="radio"/> at age 18 to last year <input type="radio"/> in the past 12 months	<input type="radio"/> none <input type="radio"/> a little <input type="radio"/> a moderate amount <input type="radio"/> a lot
21. Have you ever personally witnessed <i>someone with whom you were not so close</i> committing suicide, or being <u>attacked</u> so severely as to result in marks, bruises, burns, blood, broken bones or teeth, or death?	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> at age 12 or younger <input type="radio"/> at age 13 to age 17 <input type="radio"/> at age 18 to last year <input type="radio"/> in the past 12 months	<input type="radio"/> none <input type="radio"/> a little <input type="radio"/> a moderate amount <input type="radio"/> a lot
22. Have you ever personally witnessed <i>someone with whom you were very close</i> <u>deliberately attack another family member</u> so severely as to result in marks, bruises, burns, blood, broken bones or teeth?	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> at age 12 or younger <input type="radio"/> at age 13 to age 17 <input type="radio"/> at age 18 to last year <input type="radio"/> in the past 12 months	<input type="radio"/> none <input type="radio"/> a little <input type="radio"/> a moderate amount <input type="radio"/> a lot
23. Have you ever personally witnessed or learned of <u>your own child's experience of unwanted sexual contact</u> , sexual abuse, physical or psychological abuse?	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> before age 18 <input type="radio"/> age 18 to last year <input type="radio"/> in the past 12 months	<input type="radio"/> none <input type="radio"/> a little <input type="radio"/> a moderate amount <input type="radio"/> a lot
24. Have you ever experienced the <u>death of a spouse</u> ?	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> before age 18 <input type="radio"/> age 18 to last year <input type="radio"/> in the past 12 months	<input type="radio"/> none <input type="radio"/> a little <input type="radio"/> a moderate amount <input type="radio"/> a lot
25. Have you ever experienced the <u>death of your child</u> ?	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> before age 18 <input type="radio"/> age 18 to last year <input type="radio"/> in the past 12 months	<input type="radio"/> none <input type="radio"/> a little <input type="radio"/> a moderate amount <input type="radio"/> a lot



Please use a ballpoint pen for this form

	NO	YES	a. IF YES, this happened... (Mark all that apply.)	b. Regardless of when this happened, how much distress or anxiety has this caused you in the past 4 weeks?
26. Have you ever experienced the <u>death of a sibling</u> ?	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> at age 12 or younger <input type="radio"/> at age 13 to age 17 <input type="radio"/> at age 18 to last year <input type="radio"/> in the past 12 months	<input type="radio"/> none <input type="radio"/> a little <input type="radio"/> a moderate amount <input type="radio"/> a lot
27. Have you ever experienced the <u>death of a parent</u> ?	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> at age 12 or younger <input type="radio"/> at age 13 to age 17 <input type="radio"/> at age 18 to last year <input type="radio"/> in the past 12 months	<input type="radio"/> none <input type="radio"/> a little <input type="radio"/> a moderate amount <input type="radio"/> a lot
28. Have you ever experienced the <u>death of a close personal friend</u> ?	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> at age 12 or younger <input type="radio"/> at age 13 to age 17 <input type="radio"/> at age 18 to last year <input type="radio"/> in the past 12 months	<input type="radio"/> none <input type="radio"/> a little <input type="radio"/> a moderate amount <input type="radio"/> a lot
29. Have you ever <u>personally experienced a major illness</u> (life threatening or severely disabling to you)?	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> at age 12 or younger <input type="radio"/> at age 13 to age 17 <input type="radio"/> at age 18 to last year <input type="radio"/> in the past 12 months	<input type="radio"/> none <input type="radio"/> a little <input type="radio"/> a moderate amount <input type="radio"/> a lot

30a. Thinking about breast cancer in some of your blood relatives, how old were you when you had a sister diagnosed with breast cancer? (Mark all that apply.)

- Age 12 or younger
- Age 13 to age 17
- Age 18 to last year
- In the past 12 months

30b. Regardless of when this happened, how much distress or anxiety has this caused you in the past 4 weeks?

- None
- A little
- A moderate amount
- A lot



	NO	YES	a. IF YES, this happened... (Mark all that apply.)	b. Regardless of when this happened, how much distress or anxiety has this caused you in the past 4 weeks?
31. Have you ever experienced <u>your mother getting breast cancer</u> ?	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> at age 12 or younger <input type="radio"/> at age 13 to age 17 <input type="radio"/> at age 18 to last year <input type="radio"/> in the past 12 months	<input type="radio"/> none <input type="radio"/> a little <input type="radio"/> a moderate amount <input type="radio"/> a lot
32. Have you ever experienced a <u>daughter of yours getting breast cancer</u> ?	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> at age 18 to last year <input type="radio"/> in the past 12 months	<input type="radio"/> none <input type="radio"/> a little <input type="radio"/> a moderate amount <input type="radio"/> a lot
33. Have you ever experienced a <u>major illness</u> other than breast cancer (life threatening or severely disabling) <i>in someone close to you</i> ?	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> at age 12 or younger <input type="radio"/> at age 13 to age 17 <input type="radio"/> at age 18 to last year <input type="radio"/> in the past 12 months	<input type="radio"/> none <input type="radio"/> a little <input type="radio"/> a moderate amount <input type="radio"/> a lot
34. Have you ever experienced a <u>major change in, or serious difficulty with a personal relationship</u> (such as a divorce, or child custody issues)?	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> at age 12 or younger <input type="radio"/> at age 13 to age 17 <input type="radio"/> at age 18 to last year <input type="radio"/> in the past 12 months	<input type="radio"/> none <input type="radio"/> a little <input type="radio"/> a moderate amount <input type="radio"/> a lot
35. Have you ever experienced <u>serious financial or legal troubles</u> such as arrest or bankruptcy (either you or another family member whose troubles would directly affect you)?	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> at age 12 or younger <input type="radio"/> at age 13 to age 17 <input type="radio"/> at age 18 to last year <input type="radio"/> in the past 12 months	<input type="radio"/> none <input type="radio"/> a little <input type="radio"/> a moderate amount <input type="radio"/> a lot
36. Have you ever experienced <u>serious family problems related to alcohol, drug, or other substance abuse, or mental illness</u> (either you or another family member whose troubles would directly affect you)?	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> at age 12 or younger <input type="radio"/> at age 13 to age 17 <input type="radio"/> at age 18 to last year <input type="radio"/> in the past 12 months	<input type="radio"/> none <input type="radio"/> a little <input type="radio"/> a moderate amount <input type="radio"/> a lot
37. Have you ever experienced a <u>seriously traumatic event not already covered</u> in any of these questions?	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> at age 12 or younger <input type="radio"/> at age 13 to age 17 <input type="radio"/> at age 18 to last year <input type="radio"/> in the past 12 months	<input type="radio"/> none <input type="radio"/> a little <input type="radio"/> a moderate amount <input type="radio"/> a lot



38. People may be frightened of being a victim of violence due to where they live or work. About how often were you afraid of being personally attacked or injured...

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
a. ...as a child?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. ...as a teen?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. ...as an adult?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

39. Please choose the answer that best describes how you feel about safety these days.

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
a. Nowadays, I worry about my personal safety.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Nowadays, I feel heightened tension when I am in crowded places.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. I am afraid of a terror strike harming me or my family.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please use a ballpoint pen for this form



	NO	YES	a. IF YES, has this happened in the past five years?
40. Have you ever been <u>treated unfairly in home renting, buying, or mortgage</u> due to your <i>race or ethnicity</i> ?	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> no <input type="radio"/> yes
41. Have you ever been <u>treated unfairly in being stopped, searched, or threatened by police</u> due to your <i>race or ethnicity</i> ?	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> no <input type="radio"/> yes
42. Have you ever been <u>treated unfairly in receiving service at a store or restaurant</u> due to your <i>race or ethnicity</i> ?	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> no <input type="radio"/> yes
43. Have you ever been <u>treated as though you were less intelligent, worthy, or honest</u> than others due to your <i>race or ethnicity</i> ?	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> no <input type="radio"/> yes
44. Have you ever experienced <u>people acting as if they are afraid of you</u> due to your <i>race or ethnicity</i> ?	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> no <input type="radio"/> yes
45. Have you ever <u>felt discriminated against</u> because of your <i>sexual orientation</i> ?	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> no <input type="radio"/> yes
46. Have you ever been <u>treated unfairly in home renting, buying, or mortgage</u> due to your <i>sexual orientation</i> ?	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> no <input type="radio"/> yes
47. Have you ever been <u>treated unfairly in receiving service at a store, restaurant or other place of business</u> due to your <i>sexual orientation</i> ?	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> no <input type="radio"/> yes

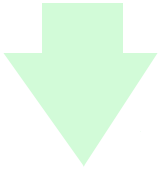


The following questions are about how you have been treated at work.

48. Have you *ever* held a full-time or part-time job other than homemaking that took at least 10 hours per week, where you worked for one year or longer?

No → GO TO END, PAGE 16

Yes



	NO	YES	a. IF YES, has this happened in the past five years?
49. Have you ever been <u>treated unfairly in job hiring, promotion or firing</u> due to your <i>sex</i> ?	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> no <input type="radio"/> yes
50. Have you ever been <u>treated unfairly in job hiring, promotion or firing</u> due to your <i>age</i> ?	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> no <input type="radio"/> yes
51. Have you ever been <u>treated unfairly in job hiring, promotion or firing</u> due to your <i>race or ethnicity</i> ?	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> no <input type="radio"/> yes
52. Have you ever been <u>treated unfairly in job hiring, promotion or firing</u> due to your <i>sexual orientation</i> ?	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> no <input type="radio"/> yes
53. Have you ever been <u>treated unfairly in job hiring, promotion or firing</u> due to <i>an illness or medical condition</i> ?	<input type="radio"/> no	<input type="radio"/> yes	<input type="radio"/> no <input type="radio"/> yes

Please use a ballpoint pen for this form



54. The following questions are about possible mistreatment at work.

	No	Yes	Not applicable
a. <i>In the past 12 months</i> , have you been repeatedly mistreated, harassed, or otherwise prevented from doing your job successfully?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Have you been repeatedly mistreated, harassed, or otherwise prevented from doing your job successfully <i>at any other time in your working life</i> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Have you <i>ever</i> lost, quit, or otherwise changed your job as a result of being mistreated or harassed on the job?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Have you <i>ever</i> had to seek medical or professional help as a result of being mistreated or harassed on the job?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



The next questions are about your current or most recent jobs, not including volunteer work.

55. Thinking about your *current (or most recent) job(s)*, indicate how much you agree or disagree with the following statements.

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
a. My job requires that I learn new things.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. My job requires me to be creative.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. My job requires working very fast.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. My job requires working very hard.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. My job involves a lot of repetitive work.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. My job allows me to make a lot of decisions.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. My job requires a lot of skill.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. On my job I have very little freedom to decide how to do my work.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. I get to do a variety of things on my job.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. I have a lot of say about what happens on my job.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. I have an opportunity to develop my own special abilities.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l. I am not asked to do an excessive amount of work.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
m. I have enough time to get my job done.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
n. I am free from conflicting demands that others make.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
o. My job security is good.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
p. My prospects for career development and promotions are good.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
q. In five years my skills will still be valuable.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please use a ballpoint pen for this form



	None of the time	A little of the time	Some of the time	Most of the time	All of the time	Not applicable
56. In the <i>past 12 months</i> , how often have the demands of your job interfered with your family life?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
57. In the <i>past 12 months</i> , how often have the demands of your family life interfered with your work on the job?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

58. In the *past 12 months*, have you had to quit, reduce your hours, or change your job in order to meet the needs of your family life?

- No
- Yes
- Not applicable

Please check to see that all questions are answered.

Thank you for completing this questionnaire and for your continued participation in the Sister Study.

Please mail this form to us at the address below.
A postage-paid envelope is provided.

The Sister Study, 1009 Slater Road, Suite 120, Durham, NC 27703
phone: 1-877-4SISTER (1-877-474-7837); email: update@sisterstudy.org





Contact Information Update Form

Please return this form even if there are no changes to report.

Help us keep in touch with you by reporting changes to your contact information. If you've moved, are about to move, or changed your phone number or email address, please provide your updated information.

Today's date: / / 20
(month) (day) (year)

There have been no changes to any of my contact information. (Check box and go to next page.)

Name and Primary Address

Name: «FirstName»
«MiddleInitial»
«LastName»

Update or Correction

If you have more than one residence, provide information for your primary address, where you live most of the year.

Street Address: «Address1»

«Address2»

«City», «State»

,

«Zip»

-

If you have moved, what was the date of your move? OR,
If you are moving in 2-3 months, what date will you move?

/ / 20
(month) (day) (year)

Mailing Address:

«Address1»

Same as street address

«Address2»

«City», «State»

,

«Zip»

-

Telephone Numbers We Can Use to Reach You:

Home phone: «HomePhoneNumber»

() -

Work phone: «WorkPhoneNumber» «WorkPhoneExt»

() - ext.

Cell phone: «OtherPhoneNumber»

() -

Email Address We Can Use to Reach You:

Email: «Email1»

@ .

PAGE ONE - PLEASE CONTINUE TO NEXT PAGE

ID#: SIS



Please return this form even if there are no changes to report.

We request the names of two people who do not live with you, but who will always know how to reach you. Please be sure their information is up to date. You may replace a contact person with someone else by filling in the new information. If we do not have two contacts for you, please provide the information below.

There have been no changes to any of the information for my contact people. (Check box and return form.)

First Contact

Update/Correction/New Contact

Name: «FirstName»
«LastName»

Relationship to you: «Relationship»

Address: «StreetNumber» «StreetName»
«ApartmentNumber»
«City», «State»
«Zip»

_____, _____
_____ - _____

Phone Number: «PhoneNumber»

(_____) _____ - _____

What is the reason for the changes you made?

updating old or outdated information
 correcting errors in current information
 replacing old contact with a new contact person

Second Contact

Update/Correction/New Contact

Name: «FirstName»
«LastName»

Relationship to you: «Relationship»

Address: «StreetNumber» «StreetName»
«ApartmentNumber»
«City», «State»
«Zip»

_____, _____
_____ - _____

Phone Number: «PhoneNumber»

(_____) _____ - _____

What is the reason for the changes you made?

updating old or outdated information
 correcting errors in current information
 replacing old contact with a new contact person

After completing both pages of this form, please mail it to the address below. A postage-paid envelope is provided. Thank you!

*The Sister Study, 1009 Slater Road, Suite 120, Durham, NC 27703
phone: 1-877-4SISTER (1-877-474-7837); email: update@sisterstudy.org*

Biennial Follow-up
Reminder Letter

Date

FirstName LastName
Mailing Address 1
Mailing Address 2
City, State Zip

Dear Ms. Last Name:

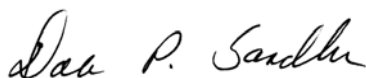
We have not yet received your Sister Study Follow-Up forms. Finding out about changes in your health and exposures will allow us to learn what environmental and lifestyle factors contribute to developing breast cancer and other conditions. We recently sent you update forms about your Health and Medical History, Lifestyle and Environment, and Stress and Coping, along with a Contact Information Update Form. Please take some time to complete your forms within the next few days.

You can also complete these updates over the telephone by calling the Sister Study helpdesk toll-free at 1-877-4SISTER (1-877-474-7837).

Information you share will be kept confidential. Your participation in the Sister Study is completely voluntary and you may choose to skip questions or stop at any time. If you have already returned your forms, please accept our thanks for your continued participation in the Sister Study.

Woman by woman, sister by sister, we can make a difference.

Sincerely,



Dale P. Sandler, Ph.D.
Principal Investigator

<SIS STUDY ID>

Biennial Follow-up *Telephone Prompt*

1. Hello Ms. LAST NAME, my name is... and I am calling on behalf of the Sister Study. We recently sent you a package containing a newsletter and questionnaires about your Health and Medical History, Lifestyle and ENvironment, and Stress and Coping. Do you remember receiving this?

- NO → GO TO 5
 YES → GO TO 2

2. We are calling because we have not yet received your completed biennial 200[N] forms. While your participation is voluntary, it is important that women in the Sister Study complete these forms so we can learn how the environmental and lifestyle factors you already told us about affect changes in health, including why some women develop breast cancer. We hope you will complete these forms soon. You can complete them over the phone now or at a more convenient time or you can complete them yourselves and return them by mail. Will you be able to complete the updates now or some time soon?

- 3.
- NEEDS A REMAIL → GO TO 5
 ALREADY RETURNED → Thank you very much - **CODE MAIL**, GO TO 7
 WILL DO OR NOT SURE → GO TO 3
 WILL DO INTERVIEW NOW → GO TO INVITATION FOR TELEPHONE INTERVIEW, #2
 WILL SET APPOINTMENT → DETERMINE CALLBACK TIME, RECORD IN COMMENTS
 PARTICIPANT WILL NOT DO FOLLOW-UP → Thank you for your past participation. If you change your mind, please feel free to contact us. GO TO UPDATE CONTACT INFORMATION
 PARTICIPANT REFUSES ALL FUTURE CONTACT → Thank you for your past participation. If you change your mind, please feel free to contact us.

3. Do you still have the forms we sent?

- NO → GO TO 5
 YES → GO TO 4

4. We would appreciate if you could complete the forms and return them as soon as possible in the postage-paid envelope that was provided. We'll hope to receive your questionnaires in the next few weeks. We may call you in a few weeks if they haven't arrived. ANSWER QUESTIONS AS NEEDED. **CODE WILL MAIL**, GO TO 7

[IF FORMS ARE NOT RECEIVED, CALLBACK WILL BE MADE 14 DAYS LATER]

5. We can send you a new package. → GO TO 6

6. CONFIRM OR CORRECT MAILING ADDRESS ON LABEL. We will send a new package to you in the next few days. We would appreciate if you could take some time to complete the forms and return them in the postage-paid envelope that is provided. **CODE REMAIL, GO TO 7**

7. At this time, we would like to update your (other) contact information. Have there been any changes to your:

- Name
- Mailing address
- Street address
- Any of your phone numbers
- Any email address

MAKE CORRECTIONS AS NEEDED.

Also, have there been any changes to the information for the contact people you provided? PROMPT FOR NAME, RELATIONSHIP, ADDRESS, PHONE NUMBER

Thank you for your help. Next year, we will need only a brief update on your contact information and health, similar to what you received last year. If anything changes in the meantime, you can update your contact information by sending an email to **update@sisterstudy.org** or by calling the Sister Study helpdesk toll-free at 1-877-4SISTER (1-877-474-7837). When you call or email us, it will be helpful to give your Sister Study ID number, which is ...

You can always visit our website at **www.sisterstudy.org** for more news about the Sister Study. Thank you again for contributing to this important research.

Biennial Follow-up
Invitation for Equirigkqp 'd{ 'Telephone

1. Hello Ms. LAST NAME, my name is... and I am calling on behalf of the Sister Study. We recently sent you a package containing a newsletter and forms about your Health and Medical History, Lifestyle and Environemtn, and Stress and Coping. We have not y et received your completed forms so we are calling to ask if you would help by taking some time to answer these questions with us now over the phone.

- YES → GO TO 2
- NOT A GOOD TIME NOW → DETERMINE CALLBACK TIME, RECORD IN COMMENTS
- ALREADY RETURNED → Thank you very much. We'll hope to receive your forms in the next week or so. We may call you in a couple of weeks if they still haven't arrived. Good-bye. [IF FORMS ARE NOT RECEIVED, CALLBACK WILL BE MADE 10 DAYS LATER]
- PARTICIPANT WILL NOT DO FOLLOW-UP → Thank you for your past participation. If you change your mind, please feel free to contact us. GO TO UPDATE CONTACT INFORMATION
- PARTICIPANT REFUSES ALL FUTURE CONTACT → Thank you for your past participation. If you change your mind, please feel free to contact us.

2. PROCEED TO HEALTH FORM.
WHEN ALL FORMS COMPLETE, GO TO 3

3. Thank you for co mpleting these updates. At this time, we would like to update your contact information. Have there been any changes to your:

- Name
- Mailing address
- Street address
- Any of your phone numbers
- Any email address

MAKE CORRECTIONS AS NEEDED.

Also, have there been any changes to the information for the contact people you provided? PROMPT FOR NAME, RELATIONSHIP, ADDRESS, PHONE NUMBER

Thank you for your help. Next year, we will need only a brief update on your contact information and health, similar to what you received last year. In the meantime, if anything changes you can update your contact information by sending an email to update@sisterstudy.org or by calling the Sister Study helpdesk toll-free at 1-877-4SISTER (1-877-474-7837). When you call or email us, it will be helpful to give your Sister Study ID namber, which is ... You can always visit our website at www.sisterstudy.org for more news about the Sister Study. Thank you again for contributing to this important research.