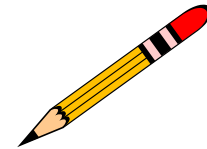




This booklet has questions about your behavior, feelings, and experiences. Please answer each question as honestly as you can. No one will see your answers except for the scientists and staff at WHI. Your answers will be kept secret and will never be put with your name in a report. Please answer using you first thoughts about each question. Do not go back later to ‘figure out’ answers. Your answers will help us to understand the health of women like you. Thank you for your help.

MARKING INSTRUCTIONS

- Use a No. 2 pencil only.
• Darken the oval completely next to the answer you choose.
• Erase cleanly any marks you wish to change.
• Do not make any stray marks on this form.



CORRECT MARK



INCORRECT MARKS



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OFFICE USE ONLY

1. Date Received:

Month Day Year

2. Reviewed By:

3. Contact Type

- 1 Phone
○2 Mail
○8 Other

○ FCA ○ OU1 ○ OU2

5. Language:

- 1 E
○2 S

AFFIX LABEL BETWEEN LINES
BAR CODE HERE

Serial number input area with 15 ovals

PLEASE MAKE NO MARKS IN THIS AREA

SERIAL #

Form 155 – Lifestyle Questionnaire (Draft)

Please answer each question below as accurately as possible.

- | | | | | | |
|---|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| | Excellent | Very good | Good | Fair | Poor |
| 1. In general, would you say your health is: | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| | Much better now than 1 year ago | Somewhat better now than 1 year ago | About the same | Somewhat worse now than 1 year ago | Much worse now than 1 year ago |
| 2. Compared to one year ago, how would you rate your health in general now? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |

3. Overall, how would you rate your quality of life? **(Mark one box below.)**

<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
Worst			Halfway				Best			

As bad or worse than being dead

Best quality of life

- | | Excellent | Very good | Average | Poor | Very poor |
|--|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| 4. How would you describe (Mark one box for each line.) | | | | | |
| 4.1 Your hearing? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 4.2 The condition of your mouth and teeth? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 4.3 Your vision (corrected with glasses or lenses as needed)? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 4.4 Your appetite? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 4.5 Your balance? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |

5. Have you lost 10 pounds or more in the past year?

- ₀ No
₁ Yes

6. Do you smoke cigarettes now?

- ₀ No
₁ Yes →

6.1 If yes, how many cigarettes do you usually smoke each day?

<input type="checkbox"/> ₁ Less than 1	<input type="checkbox"/> ₅ 25 - 34
<input type="checkbox"/> ₂ 1 - 4	<input type="checkbox"/> ₆ 35 - 44
<input type="checkbox"/> ₃ 5 - 14	<input type="checkbox"/> ₇ 45 or more
<input type="checkbox"/> ₄ 15 - 24	

7. Are you taking a calcium supplement such as Oscal, Viactiv, or Tums?

- ₀ No ₁ Yes

Form 155 – Lifestyle Questionnaire (Draft)

The next question is about female hormones you got with a doctor's prescription in the last year, even if you are not taking them right now.

8. In the past year, did you use any of the following female hormones—ESTROGEN, PROGESTERONE (also called PROGESTIN), or TESTOSTERONE—that were prescribed by a doctor? (These may have been in the form of a pill; skin patch; shot; cream; vaginal ring, pellet, or suppository, or bioidentical compound.)
- ₀ No
₁ Yes
₉ Don't know
9. In the past 3 months, how often have you had drinks containing alcohol?
- ₀ Never
₁ less than once per week
₂ 1 or 2 times per week
₃ 3 or 4 times per week
₄ Everyday

The next questions are about your living conditions.

10. Who lives with you? (Answer No or Yes for each line.)

	No	Yes	
10.1	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	I live alone
10.2	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	I live with my husband or partner
10.3	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	I live with my children
10.4	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	I live with other relatives
10.5	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	I live with friends
10.6	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	Other (please describe): _____

11. Does the place where you live have special services for older people (such as help with meals, medicines, bathing, or transportation)?

₀ No

₁ Yes



11.1 Are you currently receiving any of these services?

₀ No

₁ Yes

12. In the past year, have you stayed in a nursing home?

₀ No

₁ Yes

Form 155 – Lifestyle Questionnaire (Draft)

The following are questions about a typical (or usual) day's activities. Does your health now limit you in these activities and, if so, how much? (Mark one box for each question.)

		No, not limited at all	Yes, limited a little	Yes, limited a lot		
13.	Vigorous activities, such as running, lifting heavy objects, or strenuous sports	<input type="checkbox"/> ₃	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁		
14.	Moderate activities, such as moving a table, vacuuming, bowling, or golfing	<input type="checkbox"/> ₃	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁		
15.	Lifting or carrying groceries	<input type="checkbox"/> ₃	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁		
16.	Climbing several flights of stairs	<input type="checkbox"/> ₃	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁		
17.	Climbing one flight of stairs	<input type="checkbox"/> ₃	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁		
18.	Bending, kneeling, stooping	<input type="checkbox"/> ₃	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁		
19.	Walking more than a mile	<input type="checkbox"/> ₃	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁		
20.	Walking several blocks	<input type="checkbox"/> ₃	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁		
21.	Walking one block	<input type="checkbox"/> ₃	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁		
22.	Bathing or dressing yourself	<input type="checkbox"/> ₃	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁		
23.	What aid, if any, do you usually use to walk on a level surface? (Mark one.)	I do not use any aid <input type="checkbox"/> ₁	I use a cane <input type="checkbox"/> ₂	I use crutches <input type="checkbox"/> ₃	I use a walker <input type="checkbox"/> ₄	I use a wheelchair <input type="checkbox"/> ₅

These next questions ask about how much help (if any) you need to do routine activities for yourself. Help can be defined as getting assistance from another person or using a device. (Mark one box for each question)

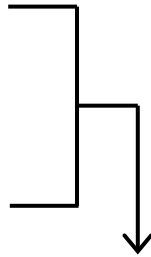
	I can do this activity:	By myself without help	With some help	Completely unable to do this by myself
24.	Can you feed yourself?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
25.	Can you dress and undress yourself?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
26.	Can you get in and out of bed yourself?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
27.	Can you take a bath or shower?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
28.	Can you do your own grocery shopping?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
29.	Can you keep track of and take your medicines?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

Form 155 – Lifestyle Questionnaire (Draft)

The next questions ask about your physical activity.

30. Think about the walking you do outside the home. How often do you walk outside the home for more than 10 minutes without stopping? (Mark only one)

- ₁ Rarely or never
- ₂ 1 to 3 times each month
- ₃ 1 time each week
- ₄ 2 to 3 times each week
- ₅ 4 to 6 times each week
- ₆ 7 or more times each week



When you walk outside the home for more than 10 minutes without stopping,

30.1 For how many minutes do you usually walk?

- ₁ Less than 20 minutes
- ₂ 20 to 39 minutes
- ₃ 40 to 59 minutes
- ₄ 1 hour or more

30.2 What is your usual speed?

- ₁ Casual strolling (2 miles per hour)
- ₂ Average or normal (2-3 miles per hour)
- ₃ Fairly fast (3-4 miles per hour)
- ₄ Very fast (more than 4 miles per hour)
- ₅ Don't know

31. Not counting walking outside the home, how often each week (7 days) do you usually do the exercises listed below?

31.1 Moderate or strenuous exercise. For example, biking outdoors, using an exercise machine (like a stationary bike or treadmill), aerobics, swimming, folk or popular dancing, jogging, tennis.

- ₁ No
- ₂ 1 day per week
- ₃ 2 days per week
- ₄ 3 days per week
- ₅ 4 days per week
- ₆ 5 or more days per week

31.2 How long do you usually exercise like this at one time?

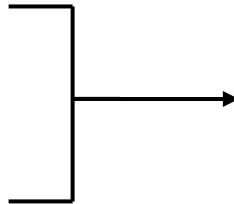
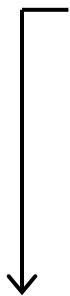
- ₁ Less than 20 minutes
- ₂ 20 to 39 minutes
- ₃ 40 to 59 minutes
- ₄ 1 hour or more

Go to the next page

Form 155 – Lifestyle Questionnaire (Draft)

31.3 Mild exercise. For example, slow dancing, bowling or golf.

- ₁ No
- ₂ 1 day per week
- ₃ 2 days per week
- ₄ 3 days per week
- ₅ 4 days per week
- ₆ 5 or more days per week



31.4 How long do you usually exercise like this at one time?

- ₁ Less than 20 minutes
- ₂ 20 to 39 minutes
- ₃ 40 to 59 minutes
- ₄ 1 hour or more

Now some questions about your social activities. How often, if at all, do you do any of the following activities? (Check one box on each line.)

	At least once per week	Several times per month	Once a month	Rarely or never
32. Eat out of the house	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
33. Go shopping	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
34. Go to a cultural event such as a movie, concert, play or lecture	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
35. Meet with family or friends who do not live with you	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
36. Communicate with family or friends by phone or email	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
37. Go to a church or other religious center	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

With growing older, we may rely on others more to help us with everyday care (meals or bathing or transportation, etc.).

38. How often in the past 4 weeks have you felt that people you rely on for everyday care have neglected your needs?

- ₀ Does not apply. I don't need help with my everyday care
- ₁ Almost no problems with obtaining everyday care
- ₂ Occasional problems with obtaining everyday care
- ₃ Frequent problems with obtaining everyday care

Form 155 – Lifestyle Questionnaire (Draft)

Questions 39-43 ask about your feelings during the past week. For each of the statements, please indicate the choice that tells how often you felt this way.

	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
39. You felt depressed (blue or down)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
40. Your sleep was restless	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
41. You enjoyed life	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
42. You felt sad	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
43. You felt that people disliked you	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

44. In the past year, have you had 2 weeks or more during which you felt sad, blue or depressed, or lost pleasure in things that you usually cared about or enjoyed?

₀ No ₁ Yes

45. Have you had 2 years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?

₀ No ₁ Yes

45.1 If yes, have you felt depressed or sad much of the time in the past year?

₀ No ₁ Yes

46. During the past 4 weeks, how much bodily pain have you had?

	None	Very mild	Mild	Moderately (Medium)	Severe
	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

47. During the past 4 weeks, how much did pain interfere with your normal work (both outside your home and at home)?

	Not at all	A little bit	Moderately (Medium)	Quite a bit	Extremely (A lot)
	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

Form 155 – Lifestyle Questionnaire (Draft)

Questions 48-56 ask about how you feel and how things have been during the past 4 weeks. Give one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks...

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
48. Did you feel full of pep?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
49. Did you have a lot of energy?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
50. Did you feel worn out?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
51. Did you feel tired?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
52. Have you been a very nervous person?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
53. Have you felt so down in the dumps that nothing could cheer you up?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
54. Have you felt calm and peaceful?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
55. Have you felt downhearted and blue?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
56. Have you been happy?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆

During the past 4 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days
57. Feeling nervous, anxious, on edge, or worrying a lot about different things	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
58. Feeling restless so that it is hard to sit still	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
59. Trouble concentrating on things, such as reading a book or watching TV	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
60. Having an anxiety attack—suddenly feeling fear or panic	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
61. Getting tired very easily	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
62. Muscle tension aches or soreness	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
63. Trouble falling asleep or staying asleep	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
64. Becoming easily annoyed or irritable	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

Form 155 – Lifestyle Questionnaire (Draft)

The following questions are about emotions you may have been feeling. Please mark one box for each statement

How true have the following been for you in this past week (7 days)?

	Not at all	A little bit	Some- what	Quite a bit	Very much
65. I am not interested in activities that will expand my horizons.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
66. I think it is important to have new experiences that challenge how you think about yourself and the world.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
67. When I think about it, I haven't really improved much as a person over the years.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
68. I have the sense that I have developed a lot as a person over time.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
69. For me, life has been a continuous process of learning, changing, and growth	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
70. I gave up trying to make big improvements or changes in my life a long time ago.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
71. I do not enjoy being in new situations that require me to change my old familiar ways of doing things	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
72. I live life one day at a time and don't really think about the future.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
73. I have a sense of direction and purpose in life.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
74. I don't have a good sense of what it is I'm trying to accomplish in life.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
75. My daily activities often seem trivial and unimportant to me.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
76. I enjoy making plans for the future and working to make them a reality.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
77. I am an active person in carrying out the plans I set for myself.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
78. Some people wander aimlessly through life, but I am not one of them.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
79. I sometimes feel as if I've done all there is to do in life.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

Form 155 – Lifestyle Questionnaire (Draft)

Below are some hard things that sometimes happen to people. Please try to think back over the past year to remember if any of these things happened. Mark the answer that seems best.

<u>Over the past year:</u>	Yes, and it upset me:			
	No	Not too much	Moderately (Medium)	Very much
80. Did your spouse or partner have a serious illness?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
81. Did you have any major problems with money?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
82. Did you have a major conflict with children or grandchildren?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
83. Were you physically abused by being hit, slapped, pushed, shoved, punched or threatened with a weapon by a family member or close friend?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
84. Were you verbally abused by being made fun of, severely criticized, told you were a stupid or worthless person, or threatened with harm to yourself, your possessions, or your pets, by a family member or close friend?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
85. Did a close friend or family member die or have a serious illness (other than your spouse or partner)?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
86. Did you have a divorce or break-up with a spouse or partner?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
87. Did a family member or close friend have a divorce or break-up?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
88. Did you have any major accidents, disasters, mugging, unwanted sexual experiences, robberies, or similar events?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
89. Did you or a family member or close friend lose their job or retire?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
90. Did a pet die?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
91. Did your spouse or partner die?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃



If you answered yes to Question 91, please mark the answer that best describes how you feel right now about the person who died.	Never	Rarely	Some- times	Often	Always
91.1 I feel myself longing or yearning for my spouse or partner who died--I miss them so much it's hard to care about anything else.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
91.2 I think about this person so much that it's hard for me to do the things I normally do.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

Form 155 – Lifestyle Questionnaire (Draft)

Questions 92-100 are about your sleep habits and experiences. Pick the answer that best describes how often you experienced the situation in the past 4 weeks.

	No, not in past 4 weeks	Yes, less than once a week	Yes, 1 or 2 times a week	Yes, 3 or 4 times a week	Yes, 5 or more times a week
92. Did you take any kind of medication or alcohol at bedtime to help you sleep?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
93. Did you fall asleep during quiet activities like reading, watching TV, or riding in a car?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
94. Did you nap during the day?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
95. Did you have trouble falling asleep?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
96. Did you wake up several times at night?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
97. Did you wake up earlier than you planned to?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
98. Did you have trouble getting back to sleep after you woke up too early?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

99. About how many hours of sleep did you get on a typical night during the past 4 weeks?

5 or less hours	6 hours	7 hours	8 hours	9 hours	10 or more hours
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆

100. Overall, was your typical night's sleep during the past 4 weeks:

Very sound or restful	Sound or restful	Average quality	Restless	Very restless
<input type="checkbox"/> ₅	<input type="checkbox"/> ₄	<input type="checkbox"/> ₃	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁

Form 155 – Lifestyle Questionnaire (Draft)

In the <u>past 4 weeks</u>, how often have you felt:	Never	Almost never	Some-times	Fairly often	Very often	
101. That you were unable to control the important things in your life?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	
102. Confident about your ability to handle your personal problems?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	
103. That things were going your way?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	
104. That difficulties were piling up so high that you could not overcome them?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	
In general...	Strongly disagree	Disagree somewhat	Disagree slightly	Agree slightly	Agree somewhat	Agree strongly
105. I tend to bounce back quickly after hard times.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
106. It does not take me long to recover from a stressful event.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
107. I have a hard time making it through stressful events.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆

During the past 4 weeks, how intensively did you suffer from the following?

	Not at all	Symptom occurred and was:		
		Mild	Moderate	Severe
108. Cold hands or feet	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
109. Feeling too warm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
110. Perspiring (without exercise)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
111. "Gooseflesh" or shivering	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
112. Generally uncomfortable with the temperature	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

Form 155 – Lifestyle Questionnaire (Draft)

Below is a list of symptoms women sometimes have as they become older or after menopause. For each item, mark the one box that best describes how bothersome the symptom was over the past year. **Be sure to mark one box on each line.**

If you did not have the problem, please mark the box under “symptom did not occur.” If you had the symptom, use the following key to indicate how bothersome it was:

- Mild = symptom did not interfere with usual activities
 Moderate = symptom interfered somewhat with usual activities
 Severe = symptom was so bothersome that usual activities could not be performed

		Symptom did not occur	Symptom occurred and was:		
			Mild	Moderate	Severe
113.	Night sweats	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
114.	General aches or pains	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
115.	Breast tenderness	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
116.	Hot flashes	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
117.	Mood swings	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
118.	Irritability	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
119.	Feeling tired	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
120.	Forgetfulness	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
121.	Skin dryness or scaling	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
122.	Headaches or migraines	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
123.	Difficulty concentrating	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
124.	Joint pain or stiffness	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
125.	Uncontrolled leaking of urine	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
126.	Uncontrolled leaking of feces	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
127.	Vaginal or genital irritation or itching	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
128.	Vaginal or genital dryness	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
129.	Other (<i>Specify</i>): _____	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

Form 155 – Lifestyle Questionnaire (Draft)

People sometimes look to others for help, friendship, or other types of support. Next are some questions about the support that you have. How often is each of the following kinds of support available to you if you need it?

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
130. Someone to give you good advice about a problem	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
131. Someone to take you to the doctor if you need it	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
132. Someone to have a good time with	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
133. Someone to love you and make you feel wanted	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
134. Someone you can count on to listen to you when you need to talk	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
135. Someone to help you understand a problem when you need it	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
136. Someone to help with daily chores if you are sick	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
137. Someone to share your most private worries and fears	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
138. Someone to do something fun with	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

Form 155 – Lifestyle Questionnaire (Draft)

How true have the following been for you in the past week (7 days)?

	Not at all	A little bit	Some- what	Quite a bit	Very much
139. I felt peaceful.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
140. I had a reason for living.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
141. My life has been productive.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
142. I had trouble feeling peace of mind.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
143. I felt a sense of purpose in my life.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
144. I was able to reach down deep into myself for comfort.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
145. I felt a sense of harmony within myself.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
146. My life lacked meaning and purpose.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
147. I found comfort in my faith or spiritual beliefs.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
148. I found strength in my faith or spiritual beliefs.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
149. I am always hopeful about my future.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

Form 155 – Lifestyle Questionnaire (Draft)

The last questions are about emotions you may have been feeling. Please mark one box for each statement.

Mark the answer that best corresponds to how much you agree with each statement.

	Strongly disagree	Disagree	Slightly disagree	Neither agree or disagree	Slightly agree	Agree	Strongly Agree
150. In most ways my life is close to my ideal.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
151. The conditions of my life are excellent.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
152. I am satisfied with my life.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
153. So far I have gotten the important things I want in life.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
154. If I could live my life over, I would change almost nothing.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇

Please take a few minutes to review this form for any questions you may have missed.

Thank you for taking the time to complete this questionnaire

Add any comments you may have here.

Form 155 – Lifestyle Questionnaire (Draft)

Form 155

Spanish translation under way.
Instructions to WHI staff under way.