



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

Authority: Authority to request this information is granted under Title 5, U.S. Code 136, Department of Defense Regulations, Executive Order 9396, DoD RCS#DD-HA(AR)2106 (expires 01/31/13), and OMB #0720-0029 (expires ??). Personal identifiers will be used to link survey data with medical and other military records.

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

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

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

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

PUBLIC BURDEN STATEMENT: Public reporting burden for this collection of information is estimated at 30 minutes. Comments on the burden or content of the instrument should be sent to the Millennium Cohort Study team, PO Box 85777, San Diego, CA 92186-5777. Under 5 CFR 1320.5(b), an Agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection displays a valid control number.

7. What is your **current** marital status?
Choose the single best answer.

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

8. What is the **highest level** of education that you have **completed**?
Choose the single best answer.

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

9. Which hand do you use for writing?

- Right
- Left
- Use both equally

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

feet inches

11. What is your **current** weight? pounds

12. How much did you weigh a **year ago**? pounds

If you are FEMALE, please continue to question 13
If you are MALE, please skip to question 14 on page 4

13. FOR WOMEN ONLY:

a. Have you had at least one menstrual period in the **past 12 months**? No Yes

b. If **NO**: What is the reason that you have not had a menstrual period in the **past 12 months**?
Mark all that apply.

- Pregnancy and/or breast feeding
- Contraception or hormone therapy
- Menopause
- Hysterectomy
- Other please specify
- Unknown

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

14. In the **last 3 years**, has your doctor or other health professional told you that you have any of the following conditions?

If **YES**, in what year were you first diagnosed?

Mark here if you were hospitalized for the condition in the **last 3 years**

a. Hypertension (high blood pressure)	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="radio"/> Hospitalized
b. High cholesterol requiring medication	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="radio"/> Hospitalized
c. Coronary heart disease	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="radio"/> Hospitalized
d. Heart attack	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="radio"/> Hospitalized
e. Angina (chest pain)	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="radio"/> Hospitalized
f. Any other heart condition	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="radio"/> Hospitalized
please specify <input type="text"/>				
g. Sinusitis	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="radio"/> Hospitalized
h. Chronic bronchitis	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="radio"/> Hospitalized
i. Emphysema	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="radio"/> Hospitalized
j. Asthma	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="radio"/> Hospitalized
k. Kidney failure requiring dialysis	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="radio"/> Hospitalized
l. Bladder infection	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="radio"/> Hospitalized
m. Pancreatitis	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="radio"/> Hospitalized
n. Diabetes or sugar diabetes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="radio"/> Hospitalized
o. Gallstones	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="radio"/> Hospitalized
p. Kidney stones	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="radio"/> Hospitalized
q. Hepatitis B	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="radio"/> Hospitalized
r. Hepatitis C	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="radio"/> Hospitalized
s. Any other hepatitis	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="radio"/> Hospitalized
t. Cirrhosis	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="radio"/> Hospitalized
u. Fibromyalgia	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="radio"/> Hospitalized
v. Rheumatoid arthritis	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="radio"/> Hospitalized
w. Lupus	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="radio"/> Hospitalized

Question 14 continued on page 5...

Question 14 continued from previous page

14. In the **last 3 years**, has your doctor or other health professional told you that you have any of the following conditions?

If **YES**, in what year were you first diagnosed?

Mark here if you were hospitalized for the condition in the **last 3 years**

x. Multiple sclerosis	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/>	<input type="radio"/> Hospitalized
y. Crohn's disease	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/>	<input type="radio"/> Hospitalized
z. Stomach, duodenal, or peptic ulcer	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/>	<input type="radio"/> Hospitalized
aa. Ulcerative colitis or proctitis	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/>	<input type="radio"/> Hospitalized
bb. Acid reflux / gastroesophageal reflux disease requiring medication	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/>	<input type="radio"/> Hospitalized
cc. Significant hearing loss	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/>	<input type="radio"/> Hospitalized
dd. Significant vision loss even with glasses or contact lenses	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/>	<input type="radio"/> Hospitalized
ee. Tinnitus / ringing of the ears	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/>	<input type="radio"/> Hospitalized
ff. Migraine headaches	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/>	<input type="radio"/> Hospitalized
gg. Stroke	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/>	<input type="radio"/> Hospitalized
hh. Neuropathy-caused reduced sensation in hands or feet	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/>	<input type="radio"/> Hospitalized
ii. Seizures	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/>	<input type="radio"/> Hospitalized
jj. Sleep apnea	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/>	<input type="radio"/> Hospitalized
kk. Anemia	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/>	<input type="radio"/> Hospitalized
ll. Thyroid condition other than cancer	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/>	<input type="radio"/> Hospitalized
mm. Cancer	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/>	<input type="radio"/> Hospitalized
please specify <input type="text"/>				
nn. Chronic fatigue syndrome	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/>	<input type="radio"/> Hospitalized
oo. Depression	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/>	<input type="radio"/> Hospitalized
pp. Schizophrenia or psychosis	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/>	<input type="radio"/> Hospitalized
qq. Manic-depressive disorder	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/>	<input type="radio"/> Hospitalized
rr. Posttraumatic stress disorder	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/>	<input type="radio"/> Hospitalized
ss. Infertility	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/>	<input type="radio"/> Hospitalized
tt. Other	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/>	<input type="radio"/> Hospitalized
please specify <input type="text"/>				

15. In the **last 3 years**, have you had persistent or recurring problems with any of the following?

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

16. Over the **past 3 years**, approximately how many days were you hospitalized because of illness or injury? (exclude hospitalization for pregnancy and childbirth)

- None
 1 day
 2-5 days
 6-10 days
 11-15 days
 16-20 days
 21 days or more

17. Over the **past 3 years**, approximately how many days were you unable to work or perform your usual activities because of illness or injury? (exclude lost time for pregnancy and childbirth)

- None
 1 day
 2-5 days
 6-10 days
 11-15 days
 16-20 days
 21 days or more

18. During the **last 4 weeks**, how much have you been bothered by any of the following problems?

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

19. Over the **last 2 weeks**, how often have you been bothered by any of the following problems?

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

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

20. a. In the **last 4 weeks**, have you had an anxiety attack - suddenly feeling fear or panic?..... No Yes

If you marked NO, please skip to question 22 on page 8

- b. Has this ever happened to you before? No Yes
- c. Do some of these attacks come **suddenly out of the blue** - that is, in situations where you don't expect to be nervous or uncomfortable? No Yes
- d. Do these attacks bother you a lot, or are you worried about having another attack? No Yes

21. Think about your last bad anxiety attack.

- a. Were you short of breath? No Yes
- b. Did your heart race, pound, or skip? No Yes
- c. Did you have chest pain or pressure? No Yes
- d. Did you sweat? No Yes
- e. Did you feel as if you were choking? No Yes
- f. Did you have hot flashes or chills? No Yes
- g. Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea? No Yes
- h. Did you feel dizzy, unsteady, or faint? No Yes
- i. Did you have tingling or numbness in parts of your body? No Yes
- j. Did you tremble or shake? No Yes
- k. Were you afraid you were dying? No Yes



22. Over the **last 4 weeks**, how often have you been bothered by any of the following problems?
- | | Not
at all | Several
days | More
than half
the days |
|--|-----------------------|-----------------------|-------------------------------|
| a. Feeling nervous, anxious, on edge, or worrying a lot about different things | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

If you marked NOT AT ALL, skip to question 23

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

23. On an **average day**, how many 8-12 oz beverages containing caffeine do you drink (such as coffee, tea, soda)?
- None
 1-2 per day
 3-5 per day
 6-10 per day
 11 or more per day

24. About how many times **each week** do you eat from a fast food restaurant (such as hamburgers, tacos, or pizza)?
- None
 Once a week
 2-3 times/week
 4-7 times/week
 8-14 times/week
 15 or more times/week

25. a. Do you often feel that you can't control **what** or **how much** you eat?
- No Yes
- b. Do you often eat, **within any 2 hour period**, what most people would regard as an unusually **large** amount of food?
- No Yes
- c. If you marked **YES** to either of the above, has this been as often, on average, as **twice a week** for the **LAST 3 MONTHS**?
- No Yes

26. In the **last 3 months**, have you done any of the following in order to avoid gaining weight?
- | | |
|--|--|
| a. Made yourself vomit? | <input type="radio"/> No <input type="radio"/> Yes |
| b. Took more than twice the recommended dose of laxatives? | <input type="radio"/> No <input type="radio"/> Yes |
| c. Fasted - not eaten anything at all for at least 24 hours? | <input type="radio"/> No <input type="radio"/> Yes |
| d. Exercised for more than an hour specifically to avoid gaining weight after binge eating? | <input type="radio"/> No <input type="radio"/> Yes |
| e. If you marked YES to any of these ways of avoiding gaining weight, were any as often, on average, as twice a week ? | <input type="radio"/> No <input type="radio"/> Yes |

27. Have you and a partner ever tried to get pregnant?
- No Yes Not applicable

If you marked No or Not applicable, skip to question 29

28. If **YES**, have you and a partner ever been unsuccessful getting pregnant for **a year or more** (not including time spent apart, such as deployment)? No Yes

29. a. If you and a partner **ever** got pregnant, did you have a miscarriage?
- Does not apply (no pregnancy)
- No miscarriage
- Yes, 1 miscarriage
- Yes, 2 miscarriages
- Yes, 3 or more miscarriages
- b. If **YES**, list the years of the 3 most recent miscarriages:

30. In the **last 4 weeks**, how much have you been bothered by any of the following problems?
- | | Not bothered | Bothered a little | Bothered a lot |
|--|-----------------------|-----------------------|-----------------------|
| a. Worrying about your health | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| b. Your weight or how you look | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| c. Little or no sexual desire or pleasure during sex | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| d. Difficulties with husband/wife, partner/lover, or boyfriend/girlfriend | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| e. The stress of taking care of children, parents, or other family members | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| f. Stress at work outside of the home or at school | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| g. Financial problems or worries | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| h. Having no one to turn to when you have a problem | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| i. Something bad that happened recently | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| j. Thinking or dreaming about something terrible that happened to you in the past - like your house being destroyed, a severe accident, being hit or assaulted, or being forced into a sexual act | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

31. In the **last year**, have you been hit, slapped, kicked, or otherwise physically hurt by someone, or has anyone forced you to have an unwanted sexual act? No Yes

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

33. Over the **past month**, how many hours of sleep did you get in an average 24-hour period? hours

34. Please rate your sleep pattern for the **past 2 weeks**.
- | | None | Mild | Moderate | Severe | Very severe |
|--------------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| a. Difficulty falling asleep | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| b. Difficulty staying asleep | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| c. Problem waking up too early | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| d. Snoring | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

35. How **satisfied**/dissatisfied are you with your current sleep pattern?

- Very satisfied Generally satisfied Somewhat dissatisfied Very dissatisfied

36. To what extent do you consider your sleep pattern to **interfere** with your daily functioning (such as daytime fatigue, ability to function at work/daily chores, concentration, memory, mood, etc.)?

- Not at all interfering A little Somewhat Much Very much interfering

37. How **noticeable** to others do you think your sleeping pattern is in terms of impairing the quality of your life?

- Not at all noticeable Barely Somewhat Much Very much noticeable

38. How **worried**/distressed are you about your current sleep pattern?

- Not at all A little Somewhat Much Very much

39. During the **past month**, how often have you taken medicine (prescribed or "over the counter") to help you sleep?

- Not at all during past month Less than once a week Once or twice a week Three or more times a week

40. In the **past month** have you experienced...?

	Not at all	A little bit	Moderately	Quite a bit	Extremely
a. Repeated, disturbing memories of stressful experiences from the past -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Repeated, disturbing dreams of stressful experiences from the past -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Suddenly acting or feeling as if stressful experiences were happening again -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Feeling very upset when something happened that reminds you of stressful experiences from the past ---	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Trouble remembering important parts of stressful experiences from the past -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Loss of interest in activities that you used to enjoy ----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Feeling distant or cut off from other people-----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Feeling emotionally numb, or being unable to have loving feelings for those close to you-----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Feeling as if your future will somehow be cut short ----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Trouble falling asleep or staying asleep -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. Feeling irritable or having angry outbursts -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l. Difficulty concentrating -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
m. Feeling "super-alert" or watchful or on guard -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
n. Feeling jumpy or easily startled -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
o. Physical reactions when something reminds you of stressful experiences from the past -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
p. Efforts to avoid thinking about your stressful experiences from the past or avoid having feelings about them -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
q. Efforts to avoid activities or situations because they remind you of stressful experiences from the past -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

41. In general, would you say your health is: **(Please select only one)**

- Excellent Very good Good Fair Poor

42. How would you describe the condition of your teeth and gums?

- Excellent Very good Good Fair Poor

43. Choose the single best description of your **USUAL** daily activities.

- You sit during the day and do not walk much.
 You stand or walk a lot during the day, but do not carry or lift things often.
 You lift or carry light loads, or climb stairs or hills often.
 You do heavy work or carry heavy loads often.

44. In a **typical week**, how much time do you spend participating in...
(Please mark both your typical "days per week" and "minutes per day" doing these activities)

On those days,
how many
minutes per day
on average do
you exercise

	# of Days per week you exercise				
a. STRENGTH TRAINING or work that strengthens your muscles? (such as lifting/pushing/pulling weights)	<input type="text"/>	AND	<input type="text"/> <input type="text"/> <input type="text"/>	OR	<input type="radio"/> None <input type="radio"/> Cannot physically do
b. VIGOROUS exercise or work that causes heavy sweating or large increases in breathing or heart rate? (such as running, active sports, marching, biking)	<input type="text"/>	AND	<input type="text"/> <input type="text"/> <input type="text"/>	OR	<input type="radio"/> None <input type="radio"/> Cannot physically do
c. MODERATE or LIGHT exercise or work that causes light sweating or slight increases in breathing or heart rate? (such as walking, cleaning, slow jogging)	<input type="text"/>	AND	<input type="text"/> <input type="text"/> <input type="text"/>	OR	<input type="radio"/> None <input type="radio"/> Cannot physically do

45. On a **typical day**, how much time do you spend sitting and watching TV or videos or using a computer? _____ hours per day

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

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

47. During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?

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

48. During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

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

49. During the **past 4 weeks**, to what extent has your **physical health** or **emotional problems** interfered with your normal social activities with family, friends, neighbors, or groups?

- Not at all Slightly Moderately Quite a bit Extremely

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

- None Very mild Mild Moderate Severe Very severe

51. During the **past 4 weeks**, how much did **pain** interfere with your normal work (including both work outside the home and housework)?

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

52. During the **past 4 weeks**, how much of the time:
(Select the **single best** answer for each question.)

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

53. During the **past 4 weeks**, how much of the time has your **physical health** or **emotional problems** interfered with your social activities (like visiting with friends, relatives)?

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

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

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

55. **Compared to 3 years ago**, how would you rate your **physical health** in general now?

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

56. **Compared to 3 years ago**, how would you rate your **emotional health** or **well-being** (such as feeling anxious, depressed, or irritable) now?

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

57. In the **last 4 weeks**, how well have your family or friends supported you?

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

58. Other than conventional medicine, what other health treatments have you used in the **last 12 months**?

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

59. Have you taken any of the following supplements in the **last 12 months**?

- a. Body building supplements (such as amino acids, weight gain products, creatine, etc.)
- No Yes
- b. Energy supplements (such as energy drinks, pills, or energy enhancing herbs)
- No Yes
- c. Weight loss supplements
- No Yes

60. a. Have you ever received the anthrax vaccine?

No Yes

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

--	--

61. Have you received the smallpox vaccine **after 2001**?

No Yes

62. Indicate the degree to which the following statements are true in your life...

	Not at all	To a very small degree	To a small degree	To a moderate degree	To a great degree	To a very great degree
a. I prioritize what is important in life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. I have an appreciation for the value of my own life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. I am able to do good things with my life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. I have an understanding of spiritual matters	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. I have a sense of closeness with others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. I have established a path for my life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. I know that I can handle difficulties	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. I have religious faith	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. I'm stronger than I thought I was	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. I have learned a great deal about how wonderful people are	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. I have compassion for others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

These next few questions are about drinking alcoholic beverages. Alcoholic beverages include beer, wine, and liquor (such as whiskey, gin, etc.). For the purpose of this questionnaire:

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

63. In the **past year**, how **often** did you typically drink any type of alcoholic beverage?

- Never
 Rarely
 Monthly
 Weekly
 Daily

If you marked NEVER, skip to question 72 on page 15

64. In the **past year**, on those days that you drank alcoholic beverages, on average, how many drinks did you have?..... drinks

65. In a **typical week**, how many drinks of each type of alcoholic beverage do you have?

beer(s)
 wine
 liquor

66. **Last week**, how many drinks of alcoholic beverages did you have?

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>

67. In the **past year**, on how many **days** did you have 5 or more drinks of any alcoholic beverage?..... days

68. In the **past year**, how **often** did you typically get drunk (intoxicated)?

- Never
 Monthly or less
 2-4 times a month
 >4 times per month

69. FOR MEN ONLY:

In the **past year**, how often did you typically have **5** or more drinks of alcoholic beverages within a **2-hour period**?

- Never
 Monthly or less
 2-4 times a month
 >4 times per month

70. FOR WOMEN ONLY:

In the **past year**, how often did you typically have **4** or more drinks of alcoholic beverages within a **2-hour period**?

- Never
 Monthly or less
 2-4 times a month
 >4 times per month

71. In the **last 12 months**, have any of the following happened to you **more than once**?

- a. You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health No Yes
- b. You drank alcohol, were high from alcohol, or hung over while you were working, going to school, or taking care of children or other responsibilities No Yes
- c. You missed or were late for work, school, or other activities because you were drinking or hung over No Yes
- d. You had a problem getting along with people while you were drinking No Yes
- e. You drove a car after having several drinks or after drinking too much No Yes

72. Have you **ever** felt any of the following?

- a. Felt you needed to cut back on your drinking No Yes
- b. Felt annoyed at anyone who suggested you cut back on your drinking No Yes
- c. Felt you needed an "eye-opener" or early morning drink No Yes
- d. Felt guilty about your drinking No Yes

73. In the **past year**, have you used any of the following tobacco products?

- a. Cigarettes No Yes
- b. Cigars No Yes
- c. Pipes No Yes
- d. Smokeless tobacco (chew, dip, snuff) No Yes

74. In **your lifetime**, have you smoked at least 100 cigarettes (5 packs)? No Yes

If you marked NO, skip to question 79 on page 16

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

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

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

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

78. Have you ever tried to quit smoking?

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

79. In the **past 3 years**, have any of the following life events happened to you?

If **YES**, list most recent year

a. You moved or changed residence more than once	<input type="radio"/> No <input type="radio"/> Yes	2	0		
b. You changed job, assignment, or career path involuntarily (for example, you lost a job, or you had to take a job you did not like)	<input type="radio"/> No <input type="radio"/> Yes	2	0		
c. You or your partner had an unplanned pregnancy	<input type="radio"/> No <input type="radio"/> Yes	2	0		
d. You were divorced or separated	<input type="radio"/> No <input type="radio"/> Yes	2	0		
e. Suffered major financial problems (such as bankruptcy)	<input type="radio"/> No <input type="radio"/> Yes	2	0		
f. Suffered forced sexual relations or sexual assault	<input type="radio"/> No <input type="radio"/> Yes	2	0		
g. Experienced sexual harassment	<input type="radio"/> No <input type="radio"/> Yes	2	0		
h. Suffered a violent assault	<input type="radio"/> No <input type="radio"/> Yes	2	0		
i. Had a family member or loved one who became severely ill	<input type="radio"/> No <input type="radio"/> Yes	2	0		
j. Had a family member or loved one who died	<input type="radio"/> No <input type="radio"/> Yes	2	0		
k. Suffered a disabling illness or injury	<input type="radio"/> No <input type="radio"/> Yes	2	0		

80. During the **past 3 years**, have you been **PERSONALLY** exposed to any of the following? (do not include TV, video, movies, computers, or theater)

No Yes, 1 time Yes, more than 1 time If **YES**, list most recent year of exposure

a. Witnessing a person's death due to war, disaster, or tragic event--	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2	0		
b. Witnessing instances of physical abuse (torture, beating, rape)---	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2	0		
c. Dead and/or decomposing bodies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2	0		
d. Maimed soldiers or civilians	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2	0		
e. Prisoners of war or refugees	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2	0		
f. Chemical or biological warfare agents	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2	0		
g. Medical countermeasures for chemical or biological warfare agent exposure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2	0		
h. Alarms necessitating wearing of chemical or biological warfare protective gear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2	0		

81. During the **past 3 years**, were you **PERSONALLY** exposed to any of the following?

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

please specify

82. Were you **ever** injured from any of the following?

	No	Yes, while NOT deployed	Yes, while deployed	Total # of injury events	If YES , list date of most recent injury		Were you hospitalized or did you lose more than 1 day of work
					Month	Year	
a. Training or sports injury-----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> No <input type="radio"/> Yes
b. Blast / explosion / bullet ----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> No <input type="radio"/> Yes
c. Motor vehicle accident/crash	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> No <input type="radio"/> Yes

If **YES**, to the crash question above, please answer the following for your most **severe** accident or crash.

c1. What type of vehicle was involved? ---- Motorcycle Personal car/truck Government vehicle

c2. How many vehicles were involved?---- Your vehicle only Multiple vehicles

c3. What was your role?----- Driver Passenger

c4. What safety features did you use? ---- Seat belt Helmet Both Neither

c5. What time and day of the week did the crash occur?-----
 Day of week: M Tu W Th F Sat Sun
 Time of day: 6 A.M. - Midnight Midnight - 6 A.M.

c6. Which of the following factors (related to the DRIVER) were involved in the crash?
 Speed No Yes | Fatigue/drowsiness No Yes
 Alcohol No Yes | Distraction (i.e. cell phone use) No Yes

c7. Did any of the following contribute to the crash? Bad weather Poor road conditions Combat / enemy fire

c8. Injury treatment: Minor injury, no treatment sought Hospitalized → Number of days:
 Clinic or office visit only

c9. Total number of work days lost as a result of the crash/accident: | c10. Total number of limited work days (do not include lost work days):

83. Did any injury you received in the **past 3 years** involve the following?

	No	Yes, while deployed	Yes, while NOT deployed	If YES , list date of most recent injury
a. Being dazed, confused, or "seeing stars" -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
b. Not remembering the injury-----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
c. Losing consciousness (knocked out)-----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>

If **YES**, approximately how long were you unconscious (knocked out) for?
 Less than 1 minute 1-4 minutes 5-30 minutes More than 30 minutes

Please answer question 84 ONLY if you are ENLISTED (Active Duty, Reserve, or National Guard).
All others please skip to question 85 on page 19

84. Review the list of military occupational categories below. Select the **two** categories that **best match** your military job and fill in the two-digit codes for your **primary** job code and your **secondary** job code.

PRIMARY JOB CODE

--	--

SECONDARY JOB CODE

--	--

ENLISTED MILITARY OCCUPATIONAL CATEGORIES

INFANTRY, GUN CREWS & SEAMANSHIP SPECIALISTS

Infantry.....	01
Armor or Amphibious.....	02
Combat Engineering.....	03
Artillery/Gunnery, Rockets or Missiles.....	04
Air Crew.....	05
Seamanship.....	06
Installation Security.....	07

ELECTRONIC EQUIPMENT REPAIRERS

Radio/Radar.....	10
Fire Control Electric Systems, Non-Missile.....	11
Missile Guidance, Control or Check-out.....	12
Sonar Equipment.....	13
Nuclear Weapons Equipment.....	14
ADP Computers.....	15
Teletype or Cryptographic Equipment.....	16
Other Electronic Equipment.....	19

COMMUNICATIONS & INTELLIGENCE SPECIALISTS

Radio or Radio Code.....	20
Sonar.....	21
Radar or Air Traffic Control.....	22
Signal Intel/Electronic Warfare.....	23
Intelligence.....	24
Combat Operations Control.....	25
Communications Center Operations.....	26

HEALTH CARE SPECIALISTS

Medical Care.....	30
Ancillary Medical Support.....	31
Biomedical Sciences or Allied Health.....	32
Dental Care.....	33
Medical Administration or Logistics.....	34

OTHER TECHNICAL AND ALLIED SPECIALISTS

Photography.....	40
Mapping, Surveying, Drafting or Illustrating.....	41
Weather.....	42
Ordnance Disposal or Diving.....	43
Musician.....	45
Technical Specialist.....	49

FUNCTIONAL SUPPORT & ADMINISTRATION

Personnel.....	50
Administration.....	51
Clerical/Personnel.....	52
Data Processing.....	53
Accounting, Finance or Disbursing.....	54
Other Functional Support.....	55
Religious, Morale or Welfare.....	56
Information or Education.....	57

ELECTRICAL/MECHANICAL EQUIPMENT REPAIRERS

Aircraft or Aircraft Related.....	60
Automotive.....	61
Wire Communications.....	62
Missile Mechanical or Electrical.....	63
Armament or Munitions.....	64
Shipboard Propulsion.....	65
Power Generating Equipment.....	66
Precision Equipment.....	67
Other Mechanical or Electrical Equipment.....	69

CRAFTWORKERS

Metalworking.....	70
Construction.....	71
Utilities.....	72
Lithography.....	74
Industrial Gas or Fuel Production.....	75
Fabric, Leather or Rubber.....	76
Other Craftworker.....	79

SERVICE & SUPPLY HANDLERS

Food Service.....	80
Motor Transport.....	81
Material Receipt, Storage or Issue.....	82
Law Enforcement.....	83
Personnel Service.....	84
Auxiliary Labor.....	85
Forward Area Equipment Support.....	86
Other Services.....	87

OTHER

Patients or Prisoners.....	90
Officer Candidate or Student.....	91
Undesignated Occupations.....	92
Not Occupationally Qualified.....	95

Please answer question 85 ONLY if you are an OFFICER or WARRANT OFFICER (Active Duty, Reserve, or National Guard). All others please skip to question 86 on page 20

85. Review the list of military occupational categories below. Select the **two** categories that **best match** your military job and fill in the two-digit codes for your **primary** job code and your **secondary** job code.

PRIMARY JOB CODE

SECONDARY JOB CODE

OFFICER or WARRANT OFFICER MILITARY OCCUPATIONAL CATEGORIES

TACTICAL OPERATIONS OFFICERS

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

INTELLIGENCE OFFICERS

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

ENGINEERING & MAINTENANCE OFFICERS

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

SCIENTISTS & PROFESSIONALS

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

GENERAL OFFICERS & EXECUTIVES

General or Flag.....1A
 Executive.....1B

HEALTH CARE OFFICERS

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

ADMINISTRATORS

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

SUPPLY, PROCUREMENT & ALLIED OFFICERS

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

OTHER

Patient.....9A
 Student.....9B
 Other.....9E

Please answer question 86 ONLY if you have a CIVILIAN job.
All others please skip to question 87 on page 22

86. Review the list of **civilian** occupational categories on this page and the next page. Select the **two** categories that **best match** your civilian job and fill in the three-digit codes for your **primary** and your **secondary** job codes.

PRIMARY JOB CODE

SECONDARY JOB CODE

CIVILIAN OCCUPATIONAL CATEGORIES

More categories listed on page 21

ARCHITECTURE & ENGINEERING

Architect, Surveyor or Cartographer171
Engineer.....172
Drafter, Engineering or Mapping Technician.....173

ARTS, DESIGN, MEDIA, ENTERTAINMENT & SPORTS

Art or Design.....271
Entertainer, Performer, Sports or Related Worker.....272
Media Communication Worker.....273
Media Communication Equipment Worker.....274

BUILDING & GROUNDS CLEANING & MAINTENANCE

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

BUSINESS & FINANCIAL OPERATIONS

Business Operations Specialist.....131
Financial Specialist.....132

COMMUNITY & SOCIAL SERVICES

Counselor, Social Worker or Other Community
or Social Service Specialist.....211
Religious Worker.....212

COMPUTER & MATHEMATICAL

Computer Specialist151
Mathematical Specialist.....152
Mathematical Technician.....153

CONSTRUCTION & EXTRACTION

Supervisor, Construction or Extraction Worker.....471
Construction Trades Worker.....472
Helper, Construction Trades.....473
Other Construction or Related Worker.....474
Extraction Worker.....475

EDUCATION, TRAINING & LIBRARY

Postsecondary Teacher.....251
Primary, Secondary or Special Education
School Teacher.....252
Other Teacher or Instructor.....253
Librarian, Curator or Archivist.....254
Other Education, Training or Library Occupation.....259

FARMING, FISHING & FORESTRY WORKERS

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

FOOD PREPARATION & SERVING RELATED

Supervisor, Food Preparation or Serving.....351
Cook or Food Preparation Worker.....352
Food and Beverage Worker.....353
Other Food Preparation or Serving Related Worker.....359

HEALTH CARE

Physician.....295
Nursing, Psychiatric or Home Health Aid.....311
Occupational or Physical Therapist Assistant or Aid.....312
Other Health Care Occupation.....319

INSTALLATION, REPAIR & MAINTENANCE

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

More categories listed on page 21...

Question 86 continued, Civilian occupational categories...

CIVILIAN OCCUPATIONAL CATEGORIES

LEGAL

Lawyer, Judge or Related Worker.....	231
Legal Support Worker.....	232

LIFE, PHYSICAL & SOCIAL SCIENCES

Life Scientist.....	191
Physical Scientist.....	192
Social Scientist or Related Worker.....	193
Life, Physical or Social Sciences Technician.....	194

MANAGEMENT

Top Executive.....	111
Advertising, Marketing, Promotions, PR or Sales Manager.....	112
Operations Specialties Manager.....	113
Other Management Occupation.....	119

OFFICE & ADMINISTRATIVE SUPPORT

Supervisor, Office or Administrative Support.....	431
Communications Equipment Operator.....	432
Financial Clerk.....	433
Information or Record Clerk.....	434
Material Recording, Scheduling, Dispatching or Distributing Worker.....	435
Secretary or Administrative Assistant.....	436
Other Office or Administrative Support.....	439

PERSONAL CARE SERVICE

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

PRODUCTION

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

PROTECTIVE SERVICES

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

SALES-RELATED

Supervisor, Sales.....	411
Retail Sales Worker.....	412
Sales Representative, Services.....	413
Sales Representative, Wholesale or Manufacturing.....	414
Counter or Rental Clerk or Parts Salesperson.....	415
Other Sales or Related Worker.....	419

TRANSPORTATION & MATERIAL MOVING

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

87. Which of the following **best** describes your employment status? Choose the single best answer.
- Full-time (greater than or equal to 30 hours per week)
 - Part-time (less than 30 hours per week)
 - Not employed, looking for work
 - Not employed, not looking for work
 - Not employed, retired
 - Not employed, disabled
 - Homemaker
 - Other please specify

88. What is your annual **household** income?
- less than \$25,000
 - \$25,000-\$49,999
 - \$50,000-\$74,999
 - \$75,000-\$99,999
 - \$100,000-\$124,999
 - \$125,000-\$149,999
 - \$150,000 or more

89. Please indicate your level of agreement with these statements:

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
a. I have little control over the things that happen to me ----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. What happens to me in the future mostly depends on me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. I can do just about anything I really set my mind to do ----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

90. What is your overall feeling about your military service?

	Negative	Somewhat Negative	Neither Negative nor Positive	Somewhat Positive	Positive
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

91. Are you currently serving in the US military? ----- Yes, Active Duty Yes, Reserve or National Guard No

If you marked YES, skip to question 96 on page 23

92. How much did each of the following reasons affect your decision to leave the military?

	Not at all	A little bit	Moderately	Quite a bit	Extremely
a. Dissatisfaction with deployments and/or frequent moves -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Military service created hardship for family -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Dissatisfaction with promotion, pay, or other benefits__	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Dissatisfaction with job or leadership/supervision -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Desire to continue your education, start a new career, or change in personal goals -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Disability or other medical reasons -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Difficulty meeting weight standards and/or fitness standards -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Incompatibility with the military -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Legal problems or problems meeting a military obligation -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Fulfilled term of service or was retirement eligible -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

93. a. Has the VA determined that you have one or more service connected disabilities? No Yes

b. If **YES**, indicate the total percent of your VA service connected disabilities. percent disability

94. Have you **ever** received any medical care from VA facilities? None Some of my care All of my care

95. Are you currently employed by a US Federal agency or the US Federal government? No Yes

96. In the **last 3 years**, have you received imminent danger pay, hardship duty pay, or combat zone tax exclusion benefits for deployment? No Yes

If you marked NO, skip to question 101 on page 24

97. Use the country and sea codes (01-27) assigned to the locations below to indicate the region(s) where you received imminent danger pay, hardship duty pay, or combat zone tax exclusion benefits. **Please list the most recent first.**

Country Codes		Sea Codes
01 Afghanistan	11 Pakistan	21 Adriatic Sea
02 Bahrain	12 Philippines	22 Arabian Sea
03 Bosnia or Herzegovina	13 Qatar	23 Gulf of Aden
04 Croatia	14 Saudi Arabia	24 Gulf of Oman
05 Iraq	15 Serbia (includes Kosovo)	25 Persian Gulf
06 Kuwait	16 Tajikistan	26 Red Sea
07 Kyrgyzstan	17 Turkey	27 Other sea area <input style="width: 150px; height: 20px;" type="text"/>
08 Macedonia	18 United Arab Emirates	please specify
09 Montenegro	19 Uzbekistan	
10 Oman	20 Other country <input style="width: 200px; height: 20px;" type="text"/>	please specify

	Location	Date Arrived				TO	Date Departed			
		Month	Year	Month	Year		Month	Year		
a.	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>		<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>
b.	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>		<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>
c.	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>		<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>
d.	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>		<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>
e.	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>		<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>
f.	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>		<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>

98. In the **last 3 years**, have you been to more regions where you received imminent danger pay, hardship duty pay, or combat zone tax exclusion benefits than fit into the space allowed above? No Yes

99. In the **last 3 years**, how often have you experienced the following during deployment?

	Never	1 time	More than 1 time	List most recent year of exposure
a. Feeling that you were in great danger of being killed.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2 0
b. Being attacked or ambushed.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2 0
c. Receiving small arms fire	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2 0
d. Clearing / searching homes or buildings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2 0
e. Having an improvised explosive device (IED) or booby trap explode near you	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2 0
f. Being wounded or injured.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2 0
g. Seeing dead bodies or human remains	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2 0
h. Handling or uncovering human remains	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2 0
i. Knowing someone seriously injured or killed.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2 0
j. Seeing Americans who were seriously injured or killed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2 0
k. Having a member of your unit be seriously injured or killed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2 0
l. Being directly responsible for the death of an enemy combatant	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2 0
m. Being directly responsible for the death of a non-combatant	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2 0
n. Being exposed to smoke from burning trash and/or feces	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2 0

100. When you were returning from deployment, did you first go to a separate location other than your home station and complete a structured decompression program? No Yes

If **YES**, please specify location:

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

Thank you for completing this important questionnaire!
 Your responses will help service members and veterans.
 More information on the Millennium Cohort Study can be found at
<http://www.MillenniumCohort.org>