Consent Form

- ***What is the study about?***

You are being asked to be a volunteer in a research study called "The Millennium Cohort Study" conducted by the US Department of Defense (DoD). This study will follow the long-term health of military personnel during and after their military service. The purpose is to assess the health outcomes of military deployment, military occupations, and general military service. You have been scientifically selected to represent your service branch, gender, service type, military occupation, and age group from among the over two million military personnel serving as of October 2009 in the regular Active Duty, Reserve, and National Guard forces. ***Your participation will help determine the long-term health effects of military service, define healthcare policy for future generations of service members, and guide prevention and treatment programs for years to come.***

- ***What will participation involve?***

You are being asked to do the following:

Complete the attached survey today. You are also being asked to complete 7 follow-up surveys over 21 years, with one survey to complete every three years. Filling out the survey will take about 30 minutes each time you complete it. The surveys contain questions on a broad range of health topics, including medical conditions, health behaviors, and exposures that may affect your health. We will connect your survey data with other data, medical records, or biomarkers collected and maintained by the Department of Defense, Department of Veterans Affairs health care, disability, and other databases, or federal and state agencies. Additionally, you may be asked to participate in other sub-studies and if you so choose may involve a variety of tests including neurocognitive testing and blood samples.

You will be contacted semi-annually to verify your contact information. In addition, there is a 3% random chance that you will be contacted by telephone for focus group testing. You are one of approximately 200,000 volunteers who are being asked to participate in this very important study.

- ***What risks are involved in the study?***

The data collection procedures are not expected to involve any risk or discomfort to you. The only risks to you are those associated with the inappropriate disclosure of data you provide. However, this research group has collected similar information from numerous studies over many years without any cases of inappropriate disclosure. There is also the risk of possible discomfort from answering some sensitive questions, but you may skip any question(s) that make you uncomfortable. If you feel that you might need medical care or counseling you should make contact with the appropriate health care personnel.

- ***How will your data be protected against those risks?***

All questionnaires will be kept in locked files. When your data are entered into computer files for analysis, your answers will be identified only by a special study identification number known to you and research team members. This number is located on the barcode of your study envelope and survey. Your social security number and any other personal identification information will be removed from your questionnaire and data file upon return to the researchers. Even if someone outside the research team broke into the files, it would be impossible for them to identify your data. To minimize the risk of anyone breaking into the data files, those files will be maintained on DoD computers protected by all the measures required by DoD computer security regulations. All members of the research team with access to data files will be trained in DoD computer security procedures specifically designed to protect sensitive data. Reports of the study findings will contain only group data, so that no individual study participant can be identified. Similar procedures have been used to protect data in previous studies conducted within this research center.

According to the DoD Policy "Interim Regulations to Improve Privacy Protections for DoD Medical Records" dated October 31, 2000, the information you provide is for research purposes only and may not be disclosed except for specifically authorized purposes or with the consent of the individual about whom the information pertains. Uses and disclosures of this information shall comply with provisions of the Privacy Act and implementing regulations.

continued on page 2...

continued from page 1...

- ***How is your information protected if you complete the questionnaire using the Internet web site option?***

All information collected through the Internet questionnaire option is done by using Secure Sockets Layer (SSL) data transmission lines. SSL encrypts, or scrambles, all questionnaire data sent over the Internet. Information will only be understandable when it reaches the investigator database. The same methods of protection listed above will then be followed to further protect your information.

- ***What are the benefits of participating in the study?***

While your participation in this study will not directly benefit you, **your participation will help define health care policy for future generations of military personnel and guide prevention and treatment programs for years to come.**

- ***Will you be provided medical care based on your responses?***

No. This is a population-based study and data collected will not be used to make decisions about treatment that any individual should receive. If you feel that you might need medical care or counseling you should make contact with the appropriate health care personnel.

- ***Do you have to participate?***

No, you do not! Your participation must be completely voluntary. If you decide to participate, you can stop at any time you wish or skip any question you choose. If you choose not to participate or to discontinue your participation, you will not lose any benefit to which you are otherwise entitled. You may change your mind and revoke your permission to further collect or use your health information at any time. If you revoke your permission, no new health information about you will be gathered after that date. However, unless specified otherwise, information that has already been gathered may still be used for analyses. Collected data will be maintained until all research questions are answered. To end participation, contact the principal investigator at milcohortinfo@med.navy.mil, or (888) 942-5222.

Your participation may also be ended by the investigators. While this is not anticipated, available funding or other logistical considerations could conceivably result in the early termination of this study.

- ***Who can provide additional information if you need it?***

Questions about the research (science) aspects of this study should be directed to the principal investigator of the Millennium Cohort Study at milcohortinfo@med.navy.mil or (888) 942-5222. You may also refer to the web site at www.MillenniumCohort.org for more information. Questions about the ethical aspects of this study, your rights as a volunteer, or any problem related to the protection of research volunteers should be directed to Christopher G. Blood, JD, MA, Chairperson, Institutional Review Board, Naval Health Research Center, at telephone (619) 553-8386 or by email at NHRC-IRB@med.navy.mil.

- ***Where can you find your records if you wish to review them?***

The principal investigator will be responsible for storing the consent form and other research records related to this study. The records will be stored at the DoD Center for Deployment Health Research, Naval Health Research Center, 140 Sylvester Road, San Diego, CA 92106. You can review your surveys until the study ends by contacting the principal investigator at milcohortinfo@med.navy.mil, or (888) 942-5222.

Voluntary Consent

I consent to participate in the study described above. My consent is completely voluntary and is based solely on the information provided in this consent form.

Volunteer's signature _____ Date (mm/dd/yy) _____

Volunteer's printed name (first, middle initial, last) _____

7600224450

MILLENNIUM COHORT STUDY

Q

[ ] Consent
[ ] For office use only

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

MARKING INSTRUCTIONS

- Use BLACK or BLUE ink.
- Shade circles like this: ●
- Mistakes must be crossed out with an "X".
- Print in CAPITAL LETTERS and avoid contact with the edge of the box. EXAMPLE:

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

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

1. What is your current mailing address?

Address Line 1:

Address Line 2 (optional)**:**

City (or FPO/APO)**:**

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

ZIP/Postal Code:

Country:

2. Please provide your daytime phone number:

3. Please provide your email address:

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

4. What year were you born?

1 9 _ _

5. What are the last four digits of your Social Security number?

_ _ _ _

6. What is today's date? M M / D D / Y Y Y Y

_ _ / _ _ / 2 0 _ _

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. Are you a twin? (or triplet or one of a multiple birth set)

- ○ No
- ○ Yes
- ○ Do not know

10. Which hand do you use for writing?

- ○ Right
- ○ Left
- ○ Use both equally

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

☐ feet ☐☐ inches

12. What is your **current** weight? ☐☐☐ pounds

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

If you are FEMALE, please continue to question 14
If you are MALE, please skip to question 15 on page 5

14. **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?	○	○	○
d. If **YES:** Do these problems go away by the end of your period?	○	○	○
e. Are you currently pregnant?	○	○	○
f. Have you given birth within the **last 3 years**?	○	○	○
g. Have you **ever** been diagnosed with gestational diabetes by a glucose tolerance test during pregnancy?	○	○	○
h. Have you had a miscarriage within the **last 3 years**?	○	○	○
i. During the **last 3 years**, have you tried and been unable to become pregnant?	○	○	○

15. Has your doctor or other health professional **ever** told you that you have any of the following conditions?

			If **YES**, in what year were you **first** diagnosed?	Mark here if you were **ever** hospitalized for the condition
a. Hypertension (high blood pressure)	○ No	○ Yes		○ Hospitalized
b. High cholesterol requiring medication	○ No	○ Yes		○ Hospitalized
c. Coronary heart disease	○ No	○ Yes		○ Hospitalized
d. Heart attack	○ No	○ Yes		○ Hospitalized
e. Angina (chest pain)	○ No	○ Yes		○ Hospitalized
f. Any other heart condition please specify	○ No	○ Yes		○ Hospitalized
g. Sinusitis	○ No	○ Yes		○ Hospitalized
h. Chronic bronchitis	○ No	○ Yes		○ Hospitalized
i. Emphysema	○ No	○ Yes		○ Hospitalized
j. Asthma	○ No	○ Yes		○ Hospitalized
k. Kidney failure requiring dialysis	○ No	○ Yes		○ Hospitalized
l. Bladder infection	○ No	○ Yes		○ Hospitalized
m. Pancreatitis	○ No	○ Yes		○ Hospitalized
n. Diabetes or sugar diabetes	○ No	○ Yes		○ Hospitalized
o. Gallstones	○ No	○ Yes		○ Hospitalized
p. Kidney stones	○ No	○ Yes		○ Hospitalized
q. Hepatitis B	○ No	○ Yes		○ Hospitalized
r. Hepatitis C	○ No	○ Yes		○ Hospitalized
s. Any other hepatitis	○ No	○ Yes		○ Hospitalized
t. Cirrhosis	○ No	○ Yes		○ Hospitalized
u. Fibromyalgia	○ No	○ Yes		○ Hospitalized
v. Rheumatoid arthritis	○ No	○ Yes		○ Hospitalized
w. Lupus	○ No	○ Yes		○ Hospitalized

Question 15 continued on page 6...

Question 15 continued from previous page

15. Has your doctor or other health professional **ever** told you that you have any of the following conditions?

			If **YES**, in what year were you **first** diagnosed?	Mark here if you were **ever** hospitalized for the condition
x. Multiple sclerosis	○ No	○ Yes		○ Hospitalized
y. Crohn's disease	○ No	○ Yes		○ Hospitalized
z. Stomach, duodenal, or peptic ulcer	○ No	○ Yes		○ Hospitalized
aa. Ulcerative colitis or proctitis	○ No	○ Yes		○ Hospitalized
bb. Acid reflux / gastroesophageal reflux disease requiring medication	○ No	○ Yes		○ Hospitalized
cc. Significant hearing loss	○ No	○ Yes		○ Hospitalized
dd. Significant vision loss even with glasses or contact lenses	○ No	○ Yes		○ Hospitalized
ee. Tinnitus / ringing of the ears	○ No	○ Yes		○ Hospitalized
ff. Migraine headaches	○ No	○ Yes		○ Hospitalized
gg. Stroke	○ No	○ Yes		○ Hospitalized
hh. Neuropathy-caused reduced sensation in hands or feet	○ No	○ Yes		○ Hospitalized
ii. Seizures	○ No	○ Yes		○ Hospitalized
jj. Sleep apnea	○ No	○ Yes		○ Hospitalized
kk. Anemia	○ No	○ Yes		○ Hospitalized
ll. Thyroid condition other than cancer	○ No	○ Yes		○ Hospitalized
mm. Cancer please specify	○ No	○ Yes		○ Hospitalized
nn. Chronic fatigue syndrome	○ No	○ Yes		○ Hospitalized
oo. Depression	○ No	○ Yes		○ Hospitalized
pp. Schizophrenia or psychosis	○ No	○ Yes		○ Hospitalized
qq. Manic-depressive disorder	○ No	○ Yes		○ Hospitalized
rr. Posttraumatic stress disorder	○ No	○ Yes		○ Hospitalized
ss. Infertility	○ No	○ Yes		○ Hospitalized
tt. Other please specify	○ No	○ Yes		○ Hospitalized

16. During the **last 12 months**, have you had persistent or recurring problems with any of the following?

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

17. Over the **past 12 months**, 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

18. Over the **past 12 months**, 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

19. 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	○	○	○
b.	Back pain	○	○	○
c.	Pain in your arms, legs, or joints (knees, hips, etc)	○	○	○
d.	Pain or problems during sexual intercourse	○	○	○
e.	Headaches	○	○	○
f.	Chest pain	○	○	○
g.	Dizziness	○	○	○
h.	Fainting spells	○	○	○
i.	Feeling your heart pound or race	○	○	○
j.	Shortness of breath	○	○	○
k.	Constipation, loose bowels, or diarrhea	○	○	○
l.	Nausea, gas, or indigestion	○	○	○
m.	Ringing in the ears	○	○	○
n.	Difficulty with balance	○	○	○
o.	**Women only:** menstrual cramps or other problems with your periods	○	○	○

20. 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	○	○	○	○
b. Feeling down, depressed, or hopeless	○	○	○	○
c. Trouble falling or staying asleep, or sleeping too much	○	○	○	○
d. Feeling tired or having little energy	○	○	○	○
e. Poor appetite or overeating	○	○	○	○
f. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	○	○	○	○
g. Trouble concentrating on things, such as reading the newspaper or watching television	○	○	○	○
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	○	○	○	○

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.

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21. 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 23 on page 9

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

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22. 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

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23. 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	○	○	○

If you marked NOT AT ALL, skip to question 24

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

24. 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

25. 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

26.

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

27. In the **last 3 months**, have you done any of the following in order to avoid gaining weight?

a. Made yourself vomit?	○ No	○ Yes
b. Took more than twice the recommended dose of laxatives?	○ No	○ Yes
c. Fasted - not eaten anything at all for at least 24 hours?	○ No	○ Yes
d. Exercised for more than an hour specifically to avoid gaining weight after binge eating?	○ No	○ 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**?	○ No	○ Yes

28. Have you and a partner ever tried to get pregnant?

○ No ○ Yes ○ Not applicable

If you marked No or Not applicable, skip to question 30

29. 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

30. 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:

31. 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	○	○	○
b. Your weight or how you look	○	○	○
c. Little or no sexual desire or pleasure during sex	○	○	○
d. Difficulties with husband/wife, partner/lover, or boyfriend/girlfriend	○	○	○
e. The stress of taking care of children, parents, or other family members	○	○	○
f. Stress at work outside of the home or at school	○	○	○
g. Financial problems or worries	○	○	○
h. Having no one to turn to when you have a problem	○	○	○
i. Something bad that happened **recently**	○	○	○
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	○	○	○

32. 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

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

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

35. Please rate your sleep pattern for the **past 2 weeks**.	None	Mild	Moderate	Severe	Very severe
a. Difficulty falling asleep	○	○	○	○	○
b. Difficulty staying asleep	○	○	○	○	○
c. Problem waking up too early	○	○	○	○	○
d. Snoring	○	○	○	○	○

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

○ Very satisfied ○ Generally satisfied ○ Somewhat dissatisfied ○ Very dissatisfied

37. 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

38. 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

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

○ Not at all ○ A little ○ Somewhat ○ Much ○ Very much

40. 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

41. 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	○	○	○	○	○
b. Repeated, disturbing **dreams** of stressful experiences from the past	○	○	○	○	○
c. Suddenly acting or feeling as if stressful experiences were happening again	○	○	○	○	○
d. Feeling very upset when something happened that reminds you of stressful experiences from the past	○	○	○	○	○
e. Trouble remembering important parts of stressful experiences from the past	○	○	○	○	○
f. Loss of interest in activities that you used to enjoy	○	○	○	○	○
g. Feeling distant or cut off from other people	○	○	○	○	○
h. Feeling emotionally numb, or being unable to have loving feelings for those close to you	○	○	○	○	○
i. Feeling as if your future will somehow be cut short	○	○	○	○	○
j. Trouble falling asleep or staying asleep	○	○	○	○	○
k. Feeling irritable or having angry outbursts	○	○	○	○	○
l. Difficulty concentrating	○	○	○	○	○
m. Feeling "super-alert" or watchful or on guard	○	○	○	○	○
n. Feeling jumpy or easily startled	○	○	○	○	○
o. Physical reactions when something reminds you of stressful experiences from the past	○	○	○	○	○
p. Efforts to avoid thinking about your stressful experiences from the past or avoid having feelings about them	○	○	○	○	○
q. Efforts to avoid activities or situations because they remind you of stressful experiences from the past	○	○	○	○	○

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

○ Excellent ○ Very good ○ Good ○ Fair ○ Poor

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

○ Excellent ○ Very good ○ Good ○ Fair ○ Poor

44. 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

45. 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)

	# of **Days per week** you exercise		On those days, how many **minutes per day** on average do you exercise		
a. **STRENGTH TRAINING** or work that strengthens your muscles? (such as lifting/pushing/pulling weights)	☐	AND	☐☐☐	OR	○ None ○ 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)	☐	AND	☐☐☐	OR	○ None ○ 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)	☐	AND	☐☐☐	OR	○ None ○ Cannot physically do

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

47. 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?	○	○	○
b. **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?	○	○	○
c. **Lifting** or carrying groceries?	○	○	○
d. Climbing **several** flights of stairs?	○	○	○
e. Climbing **one** flight of stairs?	○	○	○
f. Bending, kneeling, or stooping?	○	○	○
g. Walking more than a **mile**?	○	○	○
h. Walking **several** blocks?	○	○	○
i. Walking **one** block?	○	○	○
j. Bathing or dressing yourself?	○	○	○

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 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	○	○	○	○	○
b. **Accomplished less** than you would like	○	○	○	○	○
c. Were limited in the **kind** of work or other activities	○	○	○	○	○
d. Had **difficulty** performing the work or other activities (for example, it took extra effort)	○	○	○	○	○

49. 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	○	○	○	○	○
b. **Accomplished less** than you would like	○	○	○	○	○
c. Didn't do work or other activities as **carefully** as usual	○	○	○	○	○

50. 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

---

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

○ None ○ Very mild ○ Mild ○ Moderate ○ Severe ○ Very severe

52. 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

---

53. 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**?	○	○	○	○	○	○
b. Have you been a **very nervous person**?	○	○	○	○	○	○
c. Have you felt so down in the dumps that **nothing could cheer you up**?	○	○	○	○	○	○
d. Have you felt **calm and peaceful**?	○	○	○	○	○	○
e. Did you have a **lot of energy**?	○	○	○	○	○	○
f. Have you felt **downhearted and blue**?	○	○	○	○	○	○
g. Did you feel **worn out**?	○	○	○	○	○	○
h. Have you been **a happy person**?	○	○	○	○	○	○
i. Did you feel **tired**?	○	○	○	○	○	○

54. 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

55. 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	○	○	○	○	○
b. I am as healthy as anybody I know	○	○	○	○	○
c. I expect my health to get worse	○	○	○	○	○
d. My health is excellent	○	○	○	○	○

56. **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

57. **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

58. 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

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

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

60. 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

61. a. Have you ever received the anthrax vaccine? ○ No ○ Yes

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

62. Have you received the smallpox vaccine **after 2001**? ○ No ○ Yes

63. 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	○	○	○	○	○	○
b. I have an appreciation for the value of my own life	○	○	○	○	○	○
c. I am able to do good things with my life	○	○	○	○	○	○
d. I have an understanding of spiritual matters	○	○	○	○	○	○
e. I have a sense of closeness with others	○	○	○	○	○	○
f. I have established a path for my life	○	○	○	○	○	○
g. I know that I can handle difficulties	○	○	○	○	○	○
h. I have religious faith	○	○	○	○	○	○
i. I'm stronger than I thought I was	○	○	○	○	○	○
j. I have learned a great deal about how wonderful people are	○	○	○	○	○	○
k. I have compassion for others	○	○	○	○	○	○

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

64. In your **entire life**, have you had **at least 12 drinks** of any type of alcoholic beverage (including beer and wine)? ○ No ○ Yes

If you marked NO, skip to question 74 on page 16

65. 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 74 on page 16

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

67. In a **typical week**, how many drinks of each type of alcoholic beverage do you have? ☐☐☐ beer(s) ☐☐☐ wine ☐☐☐ liquor

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

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
☐☐	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐

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

70. 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

71. **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

72. **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

73. 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

74. 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

75. 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

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

If you marked NO, skip to question 81 on page 17

77. At what age did you start smoking? ☐☐ years old

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

79. 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

80. Have you ever tried to quit smoking?

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

81. Have you **ever** had any of the following life events happen to you?

			If **YES**, list most recent year
a. 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)	○ No	○ Yes	
b. You or your partner had an unplanned pregnancy	○ No	○ Yes	
c. You were divorced or separated	○ No	○ Yes	
d. Suffered major financial problems (such as bankruptcy)	○ No	○ Yes	
e. Suffered forced sexual relations or sexual assault	○ No	○ Yes	
f. Experienced sexual harassment	○ No	○ Yes	
g. Suffered a violent assault	○ No	○ Yes	
h. Had a family member or loved one who became severely ill	○ No	○ Yes	
i. Had a family member or loved one who died	○ No	○ Yes	
j. Suffered a disabling illness or injury	○ No	○ Yes	

82. Have you **ever** 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	○	○	○	
b. Witnessing instances of physical abuse (torture, beating, rape)	○	○	○	
c. Dead and/or decomposing bodies	○	○	○	
d. Maimed soldiers or civilians	○	○	○	
e. Prisoners of war or refugees	○	○	○	
f. Chemical or biological warfare agents	○	○	○	
g. Medical countermeasures for chemical or biological warfare agent exposure	○	○	○	
h. Alarms necessitating wearing of chemical or biological warfare protective gear	○	○	○	

83. 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	○	○	○	2 0
b. Routine skin contact with paint and/or solvent and/or substances	○	○	○	2 0
c. Depleted uranium (DU)	○	○	○	2 0
d. Microwaves (**excluding** small microwave ovens)	○	○	○	2 0
e. Pesticides, including creams, sprays, or uniform treatments	○	○	○	2 0
f. Pesticides applied in the environment or around living facilities	○	○	○	2 0
g. Any exposure, physical or psychological, during a military deployment that had a significant impact on your health?	○	○	○	2 0

please specify

84. 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 Month / Year	Were you hospitalized or did you lose more than 1 day of work
a. Training or sports injury	○	○	○		M M / Y Y	○ No ○ Yes
b. Blast / explosion / bullet	○	○	○		M M / Y Y	○ No ○ Yes
c. Motor vehicle accident/crash	○	○	○		M M / Y Y	○ No ○ 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 ○ Clinic or office visit only ○ Hospitalized → Number of days:

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):

85. Did any injury you received **ever** 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"	○	○	○	M M / Y Y
b. Not remembering the injury	○	○	○	M M / Y Y
c. Losing consciousness (knocked out)	○	○	○	M M / Y Y

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 86 ONLY if you are ENLISTED (Active Duty, Reserve, or National Guard).
All others please skip to question 87 on page 20

86. 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 87 ONLY if you are an OFFICER or WARRANT OFFICER (Active Duty, Reserve, or National Guard). All others please skip to question 88 on page 21

87. 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 88 ONLY if you have a CIVILIAN job.
All others please skip to question 89 on page 22

88. 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 22

ARCHITECTURE & ENGINEERING

Architect, Surveyor or Cartographer 171
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 Specialist 151
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 22...

Question 88 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

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89. 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 _____

90. 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

STOP: Please be sure to complete questions 89 & 90 on page 22 before moving forward

91. 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	○	○	○	○	○
b. What happens to me in the future mostly depends on me	○	○	○	○	○
c. I can do just about anything I really set my mind to do	○	○	○	○	○

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

Negative	Somewhat Negative	Neither Negative nor Positive	Somewhat Positive	Positive
○	○	○	○	○

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

94. **Since 2001**, have you received imminent danger pay, hardship duty pay, or combat zone tax exclusion benefits for deployment? ○ No ○ Yes

If you marked NO, you have completed the survey

95. If **YES:** 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

01 Afghanistan
02 Bahrain
03 Bosnia or Herzegovina
04 Croatia
05 Iraq
06 Kuwait
07 Kyrgyzstan
08 Macedonia
09 Montenegro
10 Oman
11 Pakistan
12 Philippines
13 Qatar
14 Saudi Arabia
15 Serbia (includes Kosovo)
16 Tajikistan
17 Turkey
18 United Arab Emirates
19 Uzbekistan
20 Other country _____ please specify

Sea Codes

21 Adriatic Sea
22 Arabian Sea
23 Gulf of Aden
24 Gulf of Oman
25 Persian Gulf
26 Red Sea
27 Other sea area _____ please specify

	Location	Date Arrived Month / Year		Date Departed Month / Year
a.		/ 20	TO	/ 20
b.		/ 20	TO	/ 20
c.		/ 20	TO	/ 20
d.		/ 20	TO	/ 20
e.		/ 20	TO	/ 20

96. **Since 2001**, 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

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97. **Since 2001**, 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	○	○	○	2 0
b. Being attacked or ambushed	○	○	○	2 0
c. Receiving small arms fire	○	○	○	2 0
d. Clearing / searching homes or buildings	○	○	○	2 0
e. Having an improvised explosive device (IED) or booby trap explode near you	○	○	○	2 0
f. Being wounded or injured	○	○	○	2 0
g. Seeing dead bodies or human remains	○	○	○	2 0
h. Handling or uncovering human remains	○	○	○	2 0
i. Knowing someone seriously injured or killed	○	○	○	2 0
j. Seeing Americans who were seriously injured or killed	○	○	○	2 0
k. Having a member of your unit be seriously injured or killed	○	○	○	2 0
l. Being directly responsible for the death of an enemy combatant	○	○	○	2 0
m. Being directly responsible for the death of a non-combatant	○	○	○	2 0
n. Being exposed to smoke from burning trash and/or feces	○	○	○	2 0

98. 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:

99. 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.)

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 enclosed consent form, you are volunteering to disclose your information as identified above. If you do not agree to this disclosure, your failure will make the research less useful. The "Blanket Routine Uses" that appears at the beginning of the Department of Defense's compilation of medical 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 disadvantages or 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.

Thank you for completing this important questionnaire!