ATTACHMENT 2A

Form: 49 Vers: 02 ID#: SIS OMB No. 0925-0522

The Sister Study
Health and Medical History
Version 2

Instructions:

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

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

Like this: ● Not like this: ⊗ ✓

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

Like this: ● ~~YES~~ Not like this: ● YES

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

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

1	2	3	4	5	6	7	8	9	0

When writing dates, please follow this example.

EXAMPLE: June 7, 2011 = 0 6 / 0 7 / 2 0 1 1

(month) (day) (year)

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

Today's Date: ☐☐ / ☐☐ / 2 0 ☐☐
MONTH DAY YEAR

GENERAL HEALTH

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

- ○ excellent,
- ○ very good,
- ○ good,
- ○ fair, or
- ○ poor?

2. In the past 24 months, have you…

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

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

○ No
○ Yes

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

○ No
○ Yes

5. Since January 1, 2009, have you ever been unable to get screening mammography because your insurance doesn't cover it or you don't have access to screening through your work or other sources?

○ No
○ Yes

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

POUNDS

7. What is your current height?

FEET INCHES

8. Since January 1, 2009, how many times have you lost 20 pounds (9 kilograms) or more and then later gained all the weight back? *(If none, please enter "00".)*

TIMES

Please use a ballpoint pen for this form

9. Have you **ever** been vaccinated for shingles (herpes zoster)?

○ No → **GO TO QUESTION 10**

○ Yes

9a. In what month and year did you have a shingles vaccination? MONTH / YEAR

10. In the past 12 months, did you get vaccinated for the flu (either a flu shot or nasal spray)?

○ No → **GO TO QUESTION 11**

○ Yes

10a. In what month and year did you receive the flu vaccine? MONTH / 2 0 YEAR

11. During the past 12 months, did you have any cold sores?

○ No
○ Yes, 1-2 times
○ Yes, 3 or more times

12. During the past 12 months, did you have any colds?

○ No → **GO TO QUESTION 13**

○ Yes

12a. How many colds did you have?

○ 1-2
○ 3-4
○ 5 or more

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

○ No
○ Yes

FAMILY MEDICAL HISTORY

14. Since January 1, 2009, were **any** of your sisters diagnosed with breast cancer **for the first time**?

○ No
○ Yes

15. Since January 1, 2009, have any **other** close blood relatives of yours been diagnosed with breast cancer **for the first time**?

○ No → **GO TO QUESTION 16**

○ Yes

15a. What is/are the relative(s)' relationship to you? *(Please mark all that apply.)*

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

16. Since January 1, 2009, have **any** close blood relatives of yours been diagnosed with ovarian cancer **for the first time**?

○ No → **GO TO THE NEXT PAGE, QUESTION 17**

○ Yes

16a. What is/are the relative(s)' relationship to you? *(Please mark all that apply.)*

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

Please use a ballpoint pen for this form

17. Have **any** close blood relatives of yours **ever** been diagnosed with Parkinson's disease?

○ No → **GO TO QUESTION 18**

○ Yes

17a. What is/are the relative(s)' relationship to you? *(Please mark all that apply.)*

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

18. Have **any** close blood relatives of yours **ever** been diagnosed with Alzheimer's disease?

○ No → **GO TO QUESTION 19**

○ Yes

18a. What is/are the relative(s)' relationship to you? *(Please mark all that apply.)*

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

19. Have **any** close blood relatives of yours **ever** been diagnosed with diabetes?

○ No → **GO TO THE NEXT PAGE, QUESTION 20**

○ Yes

19a. What is/are the relative(s)' relationship to you? *(Please mark all that apply.)*

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

20. Have **any** close blood relatives of yours **ever** been diagnosed with heart disease?

○ No → **GO TO QUESTION 21**

○ Yes

20a. What is/are the relative(s)' relationship to you? *(Please mark all that apply.)*

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

21. Have **any** close blood relatives of yours **ever** had a stroke?

○ No → **GO TO THE NEXT PAGE, QUESTION 22**

○ Yes

21a. What is/are the relative(s)' relationship to you? *(Please mark all that apply.)*

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

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Draft

PERSONAL MEDICAL HISTORY

We are interested in changes to your health in the past few years. Please think about your medical history **since January 1, 2009.**

Has a doctor or other health professional told you that you had…	**NEVER OR BEFORE1/1/2009**	**DIAGNOSED 1/1/2009 OR LATER**	a. If diagnosed January 1, 2009 or later, what month and year were you diagnosed?
22. breast cancer? Please do **not** include in situ cancer.	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
23. ductal (breast) carcinoma in situ (DCIS)?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
24. lobular (breast) carcinoma in situ (LCIS)?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
25. lung cancer?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
26. ovarian cancer?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
27. cancer of the uterus or endometrium?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
28. cancer of the colon or rectum?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
29. Hodgkin's disease or Hodgkin's lymphoma?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
30. non-Hodgkin's lymphoma?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
31. leukemia?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR

Has a doctor or other health professional told you that you had…	**NEVER OR BEFORE1/1/2009**	**DIAGNOSED 1/1/2009 OR LATER**	a. If diagnosed January 1, 2009 or later, what month and year were you diagnosed?
32. malignant melanoma?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
33. skin cancer (**not** malignant melanoma)?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	a. MONTH/YEAR DIAGNOSED MONTH / 2 0 YEAR b. Was it… *(Please mark all that apply.)* ○ basal cell? ○ squamous cell? ○ other?
34. any other type of cancer not already listed?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	a. MONTH/YEAR DIAGNOSED MONTH / 2 0 YEAR b. Please specify what type of cancer: c. If you were diagnosed with a second **other** type of cancer January 1, 2009 or later, what month and year were you diagnosed? MONTH / 2 0 YEAR d. Please specify what type of cancer:

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Draft

Has a doctor or other health professional **ever** told you that you had…	NO	YES	b. Have you experienced any symptoms in the **past 12 months?**
35. hypertension or high blood pressure?	○ No	○ Yes, first diagnosed before January 1, 2009 ○ Yes, first diagnosed January 1, 2009 or later → a. What month and year were you diagnosed? ☐☐ / 2 0 ☐☐ MONTH YEAR	○ No ○ Yes
36. angina?	○ No	○ Yes, first diagnosed before January 1, 2009 ○ Yes, first diagnosed January 1, 2009 or later → a. What month and year were you diagnosed? ☐☐ / 2 0 ☐☐ MONTH YEAR	○ No ○ Yes
37. cardiac arrhythmia (irregular heartbeat)?	○ No	○ Yes, first diagnosed before January 1, 2009 ○ Yes, first diagnosed January 1, 2009 or later → a. What month and year were you diagnosed? ☐☐ / 2 0 ☐☐ MONTH YEAR	○ No ○ Yes
38. congestive heart failure?	○ No	○ Yes, first diagnosed before January 1, 2009 ○ Yes, first diagnosed January 1, 2009 or later → a. What month and year were you diagnosed? ☐☐ / 2 0 ☐☐ MONTH YEAR	○ No ○ Yes

Has a doctor or other health professional told you that you had…	NO	YES	b. Have you had another incident since then?
39. a heart attack or myocardial infarction?	○ No	○ Yes, my first heart attack was before January 1, 2009 ○ Yes, my first heart attack was January 1, 2009 or later ↓ a. What month and year was your first heart attack? __ __ / 2 0 __ __ MONTH YEAR	○ No ○ Yes ↓ c. What month and year was your most recent heart attack? __ __ / __ __ __ __ MONTH YEAR
40. a stroke (this does not include TIA or "mini-stroke")?	○ No	○ Yes, my first stroke was before January 1, 2009 ○ Yes, my first stroke was January 1, 2009 or later ↓ a. What month and year was your first stroke? __ __ / 2 0 __ __ MONTH YEAR	○ No ○ Yes ↓ c. What month and year was your most recent stroke? __ __ / __ __ __ __ MONTH YEAR
41. a mini-stroke or TIA (transient ischemic attack)?	○ No	○ Yes, my first mini-stroke was before January 1, 2009 ○ Yes, my first mini-stroke was January 1, 2009 or later ↓ a. What month and year was your first mini-stroke? __ __ / 2 0 __ __ MONTH YEAR	○ No ○ Yes ↓ c. What month and year was your most recent mini-stroke? __ __ / __ __ __ __ MONTH YEAR

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Since January 1, 2009, have you had…	NEVER OR BEFORE 1/1/2009	1/1/2009 OR LATER	a. How many times has this happened since January 1, 2009?	b. What was the month and year that this **first** happened since January 1, 2009?
42. a hip fracture?	○ Never ○ Before January 1, 2009	○ January 1, 2009 or later	# TIMES	MONTH / 20 YEAR
43. a wrist fracture?	○ Never ○ Before January 1, 2009	○ January 1, 2009 or later	# TIMES	MONTH / 20 YEAR

44. Since January 1, 2009, have you had any other broken bones?

○ Never
○ Yes, before January 1, 2009

GO TO QUESTION 45

○ Yes, January 1, 2009 or later

What broken bones did you have?

44a. What was the month and year that this happened? MONTH / 20 YEAR

44b. FIRST BROKEN BONE

44c. What was the month and year that this happened? MONTH / 20 YEAR

44d. SECOND BROKEN BONE

			a. **If yes**, how many times?	b. Age at **first** injury?	c. Age at **most recent** injury?
45. Have you **ever** had a serious head injury that resulted in unconsciousness, coma, or hospitalization?	○ No	○ Yes	# TIMES	AGE	AGE

46. Since January 1, 2009, have you had <u>any other major injury</u> that required hospitalization?

○ Never

○ Yes, <u>before</u> January 1, 2009 → **GO TO QUESTION 47**

○ Yes, January 1, 2009 or later →

If you were injured January 1, 2009 or later, what type of injuries did you have?

46a. What month and year were you injured? ☐☐ / 2 0 ☐☐
MONTH YEAR

46b. ☐
FIRST OTHER MAJOR INJURY

46c. What month and year were you injured? ☐☐ / 2 0 ☐☐
MONTH YEAR

46d. ☐
SECOND OTHER MAJOR INJURY

Please use a ballpoint pen for this form

Has a doctor or other health professional **ever** told you that you had…	**NO**	**YES**
47. diabetes?	○ No	○ Yes, <u>first</u> diagnosed <u>before</u> January 1, 2009 ○ Yes, <u>first</u> diagnosed January 1, 2009 or later → a. What month and year were you diagnosed? ☐☐ / 2 0 ☐☐ MONTH YEAR b. Do you still have this condition? ○ No ○ Yes c. Do you currently take insulin for diabetes? ○ No → **GO TO THE NEXT PAGE, QUESTION 48** ○ Yes d. If yes, when did you **first** use insulin? ☐☐ / ☐☐☐☐ MONTH YEAR

Has a doctor or other health professional **ever** told you that you had…	**NO**	**YES**	b. Have you experienced any symptoms in the **past 12 months?**
48. allergic rhinitis, hay fever, or seasonal allergies?	○ No	○ Yes, first diagnosed before January 1, 2009 ○ Yes, first diagnosed January 1, 2009 or later → a. What month and year were you diagnosed? ☐☐ / 2 0 ☐☐ MONTH YEAR	○ No ○ Yes
49. asthma?	○ No	○ Yes, first diagnosed before January 1, 2009 ○ Yes, first diagnosed January 1, 2009 or later → a. What month and year were you diagnosed? ☐☐ / 2 0 ☐☐ MONTH YEAR	○ No ○ Yes
50. depression?	○ No	○ Yes, first diagnosed before January 1, 2009 ○ Yes, first diagnosed January 1, 2009 or later → a. What month and year were you diagnosed? ☐☐ / 2 0 ☐☐ MONTH YEAR	○ No ○ Yes
51. periodontal (gum) disease?	○ No	○ Yes, first diagnosed before January 1, 2009 ○ Yes, first diagnosed January 1, 2009 or later → a. What month and year were you diagnosed? ☐☐ / 2 0 ☐☐ MONTH YEAR	○ No ○ Yes

Since January 1, 2009, has a doctor or other health professional told you that you had...	NEVER OR BEFORE 1/1/2009	DIAGNOSED 1/1/2009 OR LATER	a. If diagnosed January 1, 2009 or later, what month and year were you diagnosed?
52. chronic bronchitis?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
53. emphysema?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
54. chronic obstructive pulmonary disease (COPD)?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
55. Graves' disease?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
56. other hyperthyroidism (overactive thyroid)?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
57. Hashimoto's thyroiditis?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
58. other hypothyroidism (underactive thyroid)?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
59. an enlarged thyroid or goiter?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
60. thyroid nodules?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
61. another thyroid problem? Please do **not** include thyroid cancer.	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	a. MONTH/YEAR DIAGNOSED MONTH / 2 0 YEAR b. Please specify the problem:

Please use a ballpoint pen for this form

Since January 1, 2009, has a doctor or other health professional told you that you had…	NEVER OR BEFORE 1/1/2009	DIAGNOSED 1/1/2009 OR LATER	a. If diagnosed January 1, 2009 or later, what month and year were you diagnosed?
62. osteoporosis?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
63. osteopenia, or low bone density?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
64. osteoarthritis (age-related arthritis)?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
65. rheumatoid arthritis?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
66. multiple sclerosis?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
67. scleroderma or systemic sclerosis?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
68. systemic lupus erythematosus (SLE)?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
69. discoid lupus?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
70. Sjögren's syndrome?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
71. Crohn's disease?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
72. ulcerative colitis?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
73. shingles?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR

Draft

Has a doctor or other health professional **ever** told you that you had…	**NO**	**YES**
74. migraine headaches?	○ No	○ Yes, first diagnosed before January 1, 2009 ○ Yes, first diagnosed January 1, 2009 or later → a. What month and year were you diagnosed? ☐☐ / 2 0 ☐☐ MONTH YEAR b. Was the diagnosis of migraine made by a… *(Please mark all that apply.)* ○ Headache specialist ○ Neurologist ○ Other physician ○ Other health professional c. Which kind of migraines do you get? ○ With visual aura ○ Without visual aura ○ Both types with similar frequency d. During the past 12 months, how often have you had a migraine? ○ Never ○ Monthly or less ○ Biweekly ○ Weekly ○ Daily e. During the past 12 months, how long on average have your migraines usually lasted? ○ A few hours or less ○ About half a day ○ A day ○ Several days ○ One week or longer

Please use a ballpoint pen for this form

Has a doctor or other health professional told you that you had…	NEVER OR BEFORE 1/1/2009	DIAGNOSED 1/1/2009 OR LATER	a. If diagnosed January 1, 2009 or later, what month and year were you diagnosed?
75. polyps in the colon or rectum?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
76. polycystic ovarian syndrome or PCOS?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
77. ovarian cysts?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
78. endometriosis?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
79. uterine fibroids or fibroid tumors?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
80. gallstones or gallbladder disease?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
81. Parkinson's disease?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
82. Alzheimer's disease?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
83. mild cognitive impairment?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
84. kidney failure requiring dialysis or transplant?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
85. kidney stones?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
86. other kidney disease?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR

Has a doctor or other health professional told you that you had…	NEVER OR BEFORE 1/1/2009	DIAGNOSED 1/1/2009 OR LATER	a. If diagnosed January 1, 2009 or later, what month and year were you diagnosed?
87. gout?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
88. cataracts?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
89. glaucoma?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
90. macular degeneration?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
91. hearing loss?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR

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

Has a doctor or other health professional **ever** told you that you had…	NO	YES	a. If yes, what year were you **first** diagnosed?
91b. pulmonary embolism?	○ No	○ Yes	YEAR
91c. deep vein thrombosis, DVT, or deep vein blood clots in your legs or somewhere else?	○ No	○ Yes	YEAR

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92. Since January 1, 2009, have you experienced any of the following medical symptoms? *(Please mark a response for each item below.)*

	No	Yes
a. swelling in your wrist, finger, elbow, or knee joints **lasting six or more weeks**?	○	○
b. joint stiffness in the mornings, lasting at least one hour, and for more than six weeks (do not include stiffness related or due to an injury or surgery)?	○	○
c. daily, persistent, troublesome dry eyes for more than 3 months, or a recurrent feeling of sand or gravel in your eyes, or use of tear substitutes more than 3 times a day?	○	○
d. a daily feeling of dry mouth for more than 3 months, or frequent drinking of liquids to aid in swallowing dry foods, or recurrently or persistently swollen salivary glands?	○	○
e. a tremor or trembling in either of your hands?	○	○
f. walking or other movements getting noticeably slower?	○	○
g. handwriting getting noticeably smaller?	○	○
h. difficulty getting started when walking or making other movements?	○	○
i. wheezing or whistling in your chest?	○	○
j. shortness of breath when hurrying on level ground, or when walking up a slight hill, or when climbing a flight of stairs at your usual pace?	○	○
k. shortness of breath when at rest?	○	○
l. shortness of breath when lying down?	○	○
m. shortness of breath when walking?	○	○
n. swelling (or edema) in your legs?	○	○
o. excessive sweating other than due to menopause?	○	○
p. unexplained and unintentional weight loss of 10 or more pounds?	○	○

93. Do you suffer from a decrease in or loss of your sense of smell?

○ No → **GO TO QUESTION 94**

○ Yes

93a. How old were you the **first** time you noticed this problem?

AGE

93b. Are there any reasons (such as head injury) that explain the decrease in your sense of smell?

○ No
○ Yes, specify:

94. Have you experienced the following **at least once a week in the past year**?
(Please mark a response for each item below.)

a. Heartburn (a burning discomfort behind the breast bone in your chest)

○ No
○ Yes

b. Acid regurgitation/reflux (a bitter or sour tasting fluid coming into your throat or mouth)

○ No
○ Yes

	NO	YES	a. If yes, for how many years have you had this symptom?
95. Since January 1, 2009, have you experienced coughing on most days for three months or more out of a year?	○ No	○ Yes	○ 1 year ○ 2 or more years
96. Since January 1, 2009, have you brought up phlegm on most days for three months or more out of a year (do not count phlegm from the nose)?	○ No	○ Yes	○ 1 year ○ 2 or more years

Please use a ballpoint pen for this form

97. Since January 1, 2009, have you had a mammogram, breast ultrasound, or breast MRI?

○ No → **GO TO THE NEXT PAGE, QUESTION 98**

○ Yes

97a. How many times did you have a mammogram, breast ultrasound, or breast MRI since January 1, 2009?

☐☐ # TIMES

97b. What was the month and year of your most recent mammogram, breast ultrasound, or breast MRI?

☐☐ / 2 0 ☐☐
MONTH YEAR

97c. Since January 1, 2009, have you been told you had abnormal findings on a mammogram, breast ultrasound, or breast MRI?

○ No → **GO TO THE NEXT PAGE, QUESTION 98**

○ Yes

97d. What was the month and year of your most recent test with abnormal findings?

☐☐ / 2 0 ☐☐
MONTH YEAR

97e. Which breast showed abnormal findings at the most recent test?

○ Left breast
○ Right breast
○ Both breasts

97f. After completing the work-up for this abnormal test, what was the doctors' recommendation? Did they tell you to...

○ Come back in 12 months or more for usual follow-up
○ Come back in 6-11 months
○ Come back in 3-5 months
○ Come back in less than 3 months
○ Have a breast biopsy, surgery, or other treatment
○ Don't know

97g. Were you told this test showed any of the following? *(Please mark all that apply.)*

○ Breast cysts
○ Fibrocystic breasts
○ Breast calcifications
○ Dense breasts
○ Uneven or one-sided densities
○ Fibroadenoma
○ Other
○ Don't know

98. Since January 1, 2009, have you had a breast cyst or cysts drained (aspirated) or removed?

○ No → **GO TO QUESTION 99**

○ Yes

98a. On how many occasions have you had this since January 1, 2009?
OCCASIONS

98b. What was the month and year of your most recent procedure?
MONTH / 2 0 YEAR

98c. On which breast was the most recent cyst aspiration or removal performed?
- ○ Left breast
- ○ Right breast
- ○ Both breasts

98d. Following the most recent procedure, what was the doctors' recommendation? Did they tell you to...
- ○ Come back in 12 months or more for usual follow-up
- ○ Come back in 6-11 months
- ○ Come back in 3-5 months
- ○ Come back in less than 3 months
- ○ Have a breast biopsy, surgery, or other treatment
- ○ Don't know

99. Since January 1, 2009, have you had a needle biopsy to diagnose or rule out a breast condition?

○ No → **GO TO THE NEXT PAGE, QUESTION 100**

○ Yes

99a. On how many occasions have you had this since January 1, 2009?
OCCASIONS

99b. What was the month and year of your most recent procedure?
MONTH / 2 0 YEAR

99c. On which breast was the most recent needle biopsy performed?
- ○ Left breast
- ○ Right breast
- ○ Both breasts

99d. Following the most recent procedure, what was the doctors' recommendation? Did they tell you to...
- ○ Come back in 12 months or more for usual follow-up
- ○ Come back in 6-11 months
- ○ Come back in 3-5 months
- ○ Come back in less than 3 months
- ○ Have a different type of breast biopsy, surgery, or other treatment
- ○ Don't know

Please use a ballpoint pen for this form

100. Since January 1, 2009, have you had a surgical biopsy or a biopsy other than a needle biopsy to diagnose or rule out a breast condition?

○ No → **GO TO THE NEXT PAGE, QUESTION 101**

○ Yes

100a. On how many occasions have you had this since January 1, 2009?

☐☐ # OCCASIONS

100b. What was the month and year of your most recent procedure?

☐☐ / 2 0 ☐☐

MONTH YEAR

100c. On which breast was the most recent biopsy performed?

○ Left breast
○ Right breast
○ Both breasts

100d. Following the most recent procedure, what was the doctors' recommendation? Did they tell you to...

○ Come back in 12 months or more for usual follow-up
○ Come back in 6-11 months
○ Come back in 3-5 months
○ Come back in less than 3 months
○ Have a different type of breast biopsy, surgery, or other treatment
○ Don't know

101. Since January 1, 2009, have you had a breast lump or lumps removed (lumpectomy or excisional biopsy)?

○ No → **GO TO QUESTION 102**

○ Yes

101a. On how many occasions have you had this since January 1, 2009?

☐☐ # OCCASIONS

101b. What was the month and year of your most recent procedure?

☐☐ / 2 0 ☐☐
MONTH YEAR

101c. On which breast was the most recent lumpectomy or excisional biopsy performed?

○ Left breast
○ Right breast
○ Both breasts

101d. Following the most recent procedure, what was the doctors' recommendation? Did they tell you to...

○ Come back in 12 months or more for usual follow-up
○ Come back in 6-11 months
○ Come back in 3-5 months
○ Come back in less than 3 months
○ Have a different type of biopsy, surgery, or other treatment
○ Don't know

Please use a ballpoint pen for this form

Since January 1, 2009, have you had…	**NEVER OR BEFORE 1/1/2009**	**1/1/2009 OR LATER**	a. Why was this done?	b. If you had this procedure January 1, 2009 or later, what was the month and year?
102. a mastectomy of your **left** breast?	○ Never ○ Yes, before January 1, 2009	○ Yes, January 1, 2009 or later	○ To treat breast cancer ○ To prevent breast cancer ○ Both	☐☐ / 2 0 ☐☐ MONTH YEAR
103. a mastectomy of your **right** breast?	○ Never ○ Yes, before January 1, 2009	○ Yes, January 1, 2009 or later	○ To treat breast cancer ○ To prevent breast cancer ○ Both	☐☐ / 2 0 ☐☐ MONTH YEAR

Draft

Since January 1, 2009, were you told you had any of the following after a cyst aspiration, cyst removal, needle biopsy, surgical biopsy, lumpectomy, or mastectomy?

Since January 1, 2009, have you had…		NEVER OR BEFORE 1/1/2009	1/1/2009 OR LATER	a. If you had this January 1, 2009 or later, what was the month and year?
104.	fibrocystic or **benign nonproliferative** changes within normal range? For example, cysts, mild hyperplasia, benign calcifications, fibrosis, etc.	○ Never ○ Yes, before January 1, 2009	○ Yes, January 1, 2009 or later	MONTH / 2 0 YEAR
105.	fibroadenoma?	○ Never ○ Yes, before January 1, 2009	○ Yes, January 1, 2009 or later	MONTH / 2 0 YEAR b. What type? ○ Simple fibroadenoma ○ Complex fibroadenoma ○ Both ○ Don't know
106.	proliferation **without atypia**? For example, sclerosing adenosis, intraductal papilloma, moderate hyperplasia, suspicious calcifications, etc.	○ Never ○ Yes, before January 1, 2009	○ Yes, January 1, 2009 or later	MONTH / 2 0 YEAR
107.	atypical hyperplasia?	○ Never ○ Yes, before January 1, 2009	○ Yes, January 1, 2009 or later	MONTH / 2 0 YEAR b. What type? ○ Atypical ductal hyperplasia ○ Atypical lobular hyperplasia ○ Both ○ Don't know
108.	ductal carcinoma in situ (DCIS)?	○ Never ○ Yes, before January 1, 2009	○ Yes, January 1, 2009 or later	MONTH / 2 0 YEAR
109.	lobular carcinoma in situ (LCIS)?	○ Never ○ Yes, before January 1, 2009	○ Yes, January 1, 2009 or later	MONTH / 2 0 YEAR
110.	breast cancer?	○ Never ○ Yes, before January 1, 2009	○ Yes, January 1, 2009 or later	MONTH / 2 0 YEAR
111.	other changes?	○ Never ○ Yes, before January 1, 2009	○ Yes, January 1, 2009 or later	MONTH / 2 0 YEAR

112. Regardless of the findings, did you keep a copy of the pathology report(s) from the cyst aspiration, cyst removal, needle biopsy, surgical biopsy, lumpectomy, or mastectomy that you are willing to share with us?

○ No

○ Yes → **PLEASE INCLUDE A COPY WITH YOUR COMPLETED QUESTIONNAIRE.**

○ Not applicable

113. Other than during breastfeeding or pregnancy, were you ever diagnosed with mastitis?

○ No

○ Yes

Since January 1, 2009, have you had…	**NEVER OR BEFORE1/1/2009**	**1/1/2009 OR LATER**	a. If you had this procedure January 1, 2009 or later, what was the month and year?
114. breast reduction surgery on your **left** breast?	○ Never ○ Yes, before January 1, 2009	○ Yes, January 1, 2009 or later	☐☐ / 2 0 ☐☐ MONTH YEAR
115. breast reduction surgery on your **right** breast?	○ Never ○ Yes, before January 1, 2009	○ Yes, January 1, 2009 or later	☐☐ / 2 0 ☐☐ MONTH YEAR

Please use a ballpoint pen for this form

Since January 1, 2009, have you had…		NEVER OR BEFORE 1/1/2009	1/1/2009 OR LATER	a. If you had this procedure January 1, 2009 or later, what was the month and year?	b. Did you have a silicone gel implant?
116.	breast reconstruction surgery on your **left** breast?	○ Never ○ Yes, before January 1, 2009	○ Yes, January 1, 2009 or later	MONTH / 2 0 YEAR	○ No ○ Yes
117.	breast reconstruction surgery on your **right** breast?	○ Never ○ Yes, before January 1, 2009	○ Yes, January 1, 2009 or later	MONTH / 2 0 YEAR	○ No ○ Yes
118.	breast enlargement surgery on your **left** breast?	○ Never ○ Yes, before January 1, 2009	○ Yes, January 1, 2009 or later	MONTH / 2 0 YEAR	○ No ○ Yes
119.	breast enlargement surgery on your **right** breast?	○ Never ○ Yes, before January 1, 2009	○ Yes, January 1, 2009 or later	MONTH / 2 0 YEAR	○ No ○ Yes

Since January 1, 2009, have you had…		NEVER OR BEFORE 1/1/2009	1/1/2009 OR LATER	a. If you had this procedure January 1, 2009 or later, what was the month and year?	b. Was this a silicone gel implant?
120.	a breast implant surgically removed from your **left** breast?	○ Never ○ Yes, before January 1, 2009	○ Yes, January 1, 2009 or later	MONTH / 2 0 YEAR	○ No ○ Yes
121.	a breast implant surgically removed from your **right** breast?	○ Never ○ Yes, before January 1, 2009	○ Yes, January 1, 2009 or later	MONTH / 2 0 YEAR	○ No ○ Yes

122. Since January 1, 2009, have you had <u>any other major health condition</u>?

○ Never diagnosed

○ Diagnosed <u>before</u> January 1, 2009

→ **GO TO QUESTION 123**

○ Diagnosed January 1, 2009 or later

If you were diagnosed January 1, 2009 or later, what other major health conditions did you have?

122a. What month and year were you diagnosed? ☐☐ / 2 0 ☐☐
MONTH YEAR

122b. ☐
FIRST OTHER MAJOR HEALTH CONDITION

122c. What month and year were you diagnosed? ☐☐ / 2 0 ☐☐
MONTH YEAR

122d. ☐
SECOND OTHER MAJOR HEALTH CONDITION

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MENSTRUAL HISTORY

123. Have you had a menstrual period or pregnancy in the past 10 years?

○ No → **GO TO PAGE 34, QUESTION 132**

○ Yes → **GO TO PAGE 30, QUESTION 124**

124. Are you currently pregnant or breastfeeding?

○ No → **GO TO NEXT QUESTION, 124a**

○ Yes → **GO TO PAGE 32, QUESTION 125**

124a. Have you had a menstrual period in the past 12 months?

○ No → **ANSWER BOX A BELOW**

○ Yes → **ANSWER BOX B ON THE NEXT PAGE**

BOX A

THIS BOX IS FOR WOMEN WHO HAVE NOT HAD A MENSTRUAL PERIOD IN THE PAST 12 MONTHS AND ARE NOT PREGNANT OR BREASTFEEDING. ALL OTHERS GO TO QUESTION 124d.

124b. Why did your periods stop?

○ My periods stopped on their own (naturally).

○ My periods stopped on their own but I began taking hormone replacement therapy before my periods fully stopped.

○ My periods stopped after my uterus or ovaries were removed
(be sure to answer questions 163 and 164).

○ My periods stopped due to radiation or chemotherapy.

○ My periods stopped due to medicine that causes the ovaries to make less hormones or medicine that has this as a side effect.

○ My periods stopped because I am taking the kind of birth control pills that make me not have periods.

○ My periods stopped for some other reason, please describe:

124c. What month and year did you have your last menstrual period or how old were you when you had your last menstrual period?

		/					**OR**		
MONTH			YEAR					AGE	

GO TO PAGE 32, QUESTION 125

BOX B

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

124d. When was your last menstrual period?

		/	2	0		
MONTH			YEAR			

124e. What statement best describes you?

- O My periods have not stopped and I am not taking hormones.
- O My periods have not stopped but I am taking hormones.
- O My periods stopped temporarily but restarted when I stopped taking birth control pills.
- O My periods stopped temporarily, but I have had episodes of bleeding since the time when I started taking hormones.
- O My periods stopped temporarily but restarted when I began taking hormone replacement therapy.

GO TO PAGE 32, QUESTION 125

OR

- O My periods stopped sometime in the last 12 months. → **GO TO QUESTION 124f**

124f. Why did your periods stop?

- O My periods stopped on their own (naturally).
- O My periods stopped on their own but I began taking hormone replacement therapy before my periods fully stopped.
- O My periods stopped after my uterus or ovaries were removed **(be sure to answer questions 163 and 164).**
- O My periods stopped due to radiation or chemotherapy.
- O My periods stopped due to medicine that causes the ovaries to make less hormones or medicine that has this as a side effect.
- O My periods stopped because I am taking the kind of birth control pills that make me not have periods.
- O My periods stopped for some other reason, please describe:

Please use a ballpoint pen for this form

125. Have you had a pregnancy since January 1, 2009?

○ No → **GO TO PAGE 34, QUESTION 132**

○ Yes

125a. Are you currently pregnant?
○ No
○ Yes

125b. How many times have you been pregnant since January 1, 2009 (including your current pregnancy, if you are pregnant now)?
☐ # TIMES

THIS SECTION IS FOR WOMEN WHO HAVE BEEN PREGNANT SINCE JANUARY 1, 2009. ALL OTHERS GO TO THE NEXT PAGE, QUESTION 132.

		FIRST PREGNANCY (since January 1, 2009)	SECOND PREGNANCY (since January 1, 2009)
126.	How did this pregnancy end?	○ Still pregnant now ○ Single live birth ○ Twins, live births ○ Other multiple live births → [ ] # BABIES ○ Stillbirth(s) ○ Miscarriage ○ Induced abortion ○ Molar or ectopic pregnancy	○ Still pregnant now ○ Single live birth ○ Twins, live births ○ Other multiple live births → [ ] # BABIES ○ Stillbirth(s) ○ Miscarriage ○ Induced abortion ○ Molar or ectopic pregnancy
127.	How many weeks did this pregnancy last (or has it lasted so far, if now pregnant)?	○ Less than 8 weeks ○ 8 to 12 weeks ○ 13 to 16 weeks ○ 17 to 24 weeks ○ 25 to 36 weeks ○ 37 to 41 weeks ○ 42 weeks or more	○ Less than 8 weeks ○ 8 to 12 weeks ○ 13 to 16 weeks ○ 17 to 24 weeks ○ 25 to 36 weeks ○ 37 to 41 weeks ○ 42 weeks or more
128.	What month and year did this pregnancy end?	[ ][ ] / [2][0][ ][ ] MONTH YEAR **OR** ○ Still pregnant now	[ ][ ] / [2][0][ ][ ] MONTH YEAR **OR** ○ Still pregnant now
129.	What was the sex of the baby or babies?	○ Single male ○ Single female ○ Multiple → [ ] # MALES [ ] # FEMALES ○ Don't know	○ Single male ○ Single female ○ Multiple → [ ] # MALES [ ] # FEMALES ○ Don't know
130.	How long did you breastfeed (or have you been breastfeeding)?	○ Less than one month ○ 1-3 months ○ 4-6 months ○ 7-12 months ○ 13-24 months ○ More than 24 months → **GO TO 131** ○ Did not breastfeed/ not applicable → **GO TO NEXT PREGNANCY OR QUESTION 132**	○ Less than one month ○ 1-3 months ○ 4-6 months ○ 7-12 months ○ 13-24 months ○ More than 24 months → **GO TO 131** ○ Did not breastfeed/ not applicable → **GO TO NEXT PREGNANCY OR QUESTION 132**
131.	Are you still breastfeeding?	○ No ○ Yes	○ No ○ Yes

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IF YOU HAVE HAD MORE THAN 2 PREGNANCIES SINCE JANUARY 1, 2009, PLEASE ANSWER THE SAME QUESTIONS FOR EACH PREGNANCY AND RECORD YOUR ANSWERS ON A SEPARATE SHEET OF PAPER.

Draft

132. Since January 1, 2009, have you used <u>any hormonal birth control</u>?

○ No → **GO TO QUESTION 140**

○ Yes

Since January 1, 2009, have you used…		NO	YES	a. If yes, how many months in all have you used this since January 1, 2009?	b. Are you currently using this?
133.	birth control pills?	○ No	○ Yes	# MONTHS	○ No ○ Yes
134.	birth control patches?	○ No	○ Yes	# MONTHS	○ No ○ Yes
135.	a hormonal IUD (intrauterine device)?	○ No	○ Yes	# MONTHS	○ No ○ Yes
136.	a Norplant implant?	○ No	○ Yes	# MONTHS	○ No ○ Yes
137.	a Nuva Ring?	○ No	○ Yes	# MONTHS	○ No ○ Yes
138.	Depo Provera?	○ No	○ Yes	# MONTHS	○ No ○ Yes
139.	any other hormonal birth control?	○ No	○ Yes	# MONTHS	○ No ○ Yes

140. Have you **ever** tried for more than one year to become pregnant and did not get pregnant?

○ No

○ Yes

141. Since January 1, 2009, have you visited a doctor, clinic, or hospital to seek help for you to become pregnant?

○ No

○ Yes

142. Since January 1, 2009, have you used <u>any fertility medications</u>?

○ No → **GO TO QUESTION 145**

○ Yes

Since January 1, 2009, have you taken…		NO	YES	a. If yes, how many months or menstrual cycles in all have you used this since January 1, 2009?
143.	Clomiphene, Clomid, or Serophene?	○ No	○ Yes	# MONTHS/CYCLES
144.	drugs that contain follicle-stimulating hormones (FSH) — Follistim, Puregon, Gonal-F, Urofollitropin, Metrodin, Fertinex, Bravelle, human menopausal gonadotropin (hMG), menotropin, Pergonal, Humegon, or Repronex?	○ No	○ Yes	# MONTHS/CYCLES

145. Have you **ever** conceived a pregnancy in a menstrual cycle where you were treated with the fertility drug Clomiphene, Clomid, or Serophene?

○ No → **GO TO THE NEXT PAGE, QUESTION 146**

○ Yes

145a. How many times? # TIMES

145b. When did the first such pregnancy end? MONTH / DAY / YEAR

145c. When did the last such pregnancy end? MONTH / DAY / YEAR

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146. Have you **ever** conceived a pregnancy in a menstrual cycle where you were treated with drugs that contain follicle-stimulating hormone (FSH) (Metrodin, human menopausal gonadotropin (hMG), Pergonal, menotropin, Follistim, Puregon, Gonal-F, Urofollitropin, Fertinex, Bravelle, Repronex, Humegon)?

○ No → **GO TO QUESTION 147**

○ Yes

146a. How many times? # TIMES

146b. When did the first such pregnancy end? MONTH / DAY / YEAR

146c. When did the last such pregnancy end? MONTH / DAY / YEAR

147. Has a doctor or other health professional ever told you that you had mastitis while you were breastfeeding (postnatal or lactational mastitis)?

○ No → **GO TO THE NEXT PAGE, QUESTION 148**

○ Yes

147a. How many times have you had this? # TIMES

147b. What was the month and year of your most recent mastitis? MONTH / YEAR

147c. Were you ever given antibiotics to treat mastitis? ○ No ○ Yes

147d. Were you ever given pain medication to treat mastitis? ○ No ○ Yes

147e. Did you ever stop breastfeeding sooner than planned because of mastitis? ○ No ○ Yes

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

Since January 1, 2009, have you used…		NO	YES	a. If yes, how many months in all have you used this since January 1, 2009?	b. Do you currently use this female hormone product(s)?
148.	a combined pill containing both estrogen and progesterone (such as Prempro)?	○ No	○ Yes	# MONTHS	○ No ○ Yes
149.	an estrogen-only pill (such as Premarin) with no additional progesterone in any form?	○ No	○ Yes	# MONTHS	○ No ○ Yes
150.	an estrogen pill (such as Premarin) **and** a separate progesterone pill (such as Provera) or progesterone shot?	○ No	○ Yes	# MONTHS	○ No ○ Yes
151.	an estrogen-only patch with no additional progesterone in any form?	○ No	○ Yes	# MONTHS	○ No ○ Yes
152.	a patch containing both estrogen and progesterone (such as Combipatch)?	○ No	○ Yes	# MONTHS	○ No ○ Yes
153.	an estrogen-only patch **and** a separate progesterone pill or progesterone shot?	○ No	○ Yes	# MONTHS	○ No ○ Yes
154.	progesterone alone (not for birth control)?	○ No	○ Yes	# MONTHS	○ No ○ Yes

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Since January 1, 2009, have you used…	NO	YES	If yes, how many months in all have you used this since January 1, 2009?
155. vaginal estrogen creams, rings, or suppositories?	○ No	○ Yes	a. ☐☐ # MONTHS b. Do you currently use this female hormone product(s)? ○ No ○ Yes c. Does this product also contain progesterone? ○ No ○ Yes ○ Don't know d. Did you also take progesterone in another form (e.g., patch, pill) during the time you were using vaginal estrogen creams, rings, or suppositories? ○ No ○ Yes
156. any other estrogen products, including "natural" estrogens?	○ No	○ Yes	a. ☐☐ # MONTHS b. Do you currently use this female hormone product(s)? ○ No ○ Yes c. Which of the following products have you used since January 1, 2009? *(Please mark all that apply.)* ○ Capsules ○ Gel or cream applied to the skin ○ Injection ○ Liquid ○ Troche or lozenge (dissolved under the tongue) ○ Other

Since January 1, 2009, have you used…	NO	YES	a. If yes, how many months in all have you used this since January 1, 2009?	b. Do you currently use this?
157. tamoxifen or Nolvadex?	○ No	○ Yes	# MONTHS	○ No ○ Yes
158. raloxifene or Evista?	○ No	○ Yes	# MONTHS	○ No ○ Yes
159. Herceptin?	○ No	○ Yes	# MONTHS	○ No ○ Yes
Aromatase inhibitors:				
160a. anasterozole or Arimidex?	○ No	○ Yes	# MONTHS	○ No ○ Yes
160b. exemestane or Aromasin?	○ No	○ Yes	# MONTHS	○ No ○ Yes
160c. letrozole or Femara?	○ No	○ Yes	# MONTHS	○ No ○ Yes
160d. other aromatase inhibitor? Please specify:	○ No	○ Yes	# MONTHS	○ No ○ Yes
161. testosterone supplements?	○ No	○ Yes	# MONTHS	○ No ○ Yes
162. Estratest?	○ No	○ Yes	# MONTHS	○ No ○ Yes

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Since January 1, 2009, have you had…	NEVER OR BEFORE 1/1/2009	HAD PROCEDURE 1/1/2009 OR LATER	If you had this procedure January 1, 2009 or later, what was the month and year?
163. a hysterectomy (surgical removal of the uterus)?	○ Never had procedure ○ Had procedure before January 1, 2009	○ Had procedure January 1, 2009 or later	a. MONTH/YEAR HAD PROCEDURE [ ][ ] / 2 0 [ ][ ] MONTH YEAR b. Did you have all or part of either of your ovaries removed at the same time you had the hysterectomy? ○ No → **GO TO QUESTION 164** ○ Yes c. Did you have… ○ both ovaries completely removed? ○ one ovary and part of the other ovary removed? ○ one ovary removed? ○ part of one or part of both ovaries removed? d. Did you have all or part of either ovary left after this surgery? ○ No ○ Yes
164. a separate surgery to remove part or all of one or both ovaries (but not your uterus)?	○ Never had procedure ○ Had procedure before January 1, 2009	○ Had procedure January 1, 2009 or later	a. MONTH/YEAR HAD PROCEDURE [ ][ ] / 2 0 [ ][ ] MONTH YEAR b. Did you have… ○ both ovaries completely removed? ○ one ovary and part of the other ovary removed? ○ one ovary removed? ○ part of one or part of both ovaries removed? c. Did you have all or part of either ovary left after this surgery? ○ No ○ Yes

SYMPTOMS OF MENOPAUSE OR PRE-MENOPAUSE

Have you **ever** experienced any of the following menopausal symptoms?		NO	YES	a. On average, how would you rate the severity of your symptom?	b. Have you experienced any symptoms in the **past 12 months?**
165.	Hot flashes	○ No	○ Yes	○ Mild ○ Moderate ○ Severe How often did/do these occur in a typical week? ○ 1 time or less ○ 2-3 times ○ 4 or more times ○ Don't know For about how many total months or years did you have hot flashes? ○ Less than 3 months ○ 3 to less than 6 months ○ 6 months to less than 1 year ○ 1 to less than 2 years ○ 2 to less than 3 years ○ 3 or more years	○ No ○ Yes
166.	Night sweats	○ No	○ Yes	○ Mild ○ Moderate ○ Severe	○ No ○ Yes
167.	Other excessive sweating	○ No	○ Yes	○ Mild ○ Moderate ○ Severe	○ No ○ Yes
168.	Vaginal dryness	○ No	○ Yes	○ Mild ○ Moderate ○ Severe	○ No ○ Yes
169.	Pain with intercourse	○ No	○ Yes	○ Mild ○ Moderate ○ Severe	○ No ○ Yes
170.	Irregular menstrual bleeding	○ No	○ Yes	○ Mild ○ Moderate ○ Severe	○ No ○ Yes

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Have you **ever** experienced any of the following menopausal symptoms?		NO	YES	a. On average, how would you rate the severity of your symptom?	b. Have you experienced any symptoms in the **past 12 months?**
171.	Bladder problems	○ No	○ Yes	○ Mild ○ Moderate ○ Severe	○ No ○ Yes
172.	Depression, anxiety, or emotional distress	○ No	○ Yes	○ Mild ○ Moderate ○ Severe	○ No ○ Yes
173.	Insomnia	○ No	○ Yes	○ Mild ○ Moderate ○ Severe	○ No ○ Yes

SURGERIES

Since January 1, 2009, have you had…		NEVER OR BEFORE 1/1/2009	HAD PROCEDURE 1/1/2009 OR LATER	a. If you had this procedure January 1, 2009 or later, what was the month and year?
174.	gallbladder surgery?	○ Never had procedure ○ Had procedure before January 1, 2009	○ Had procedure January 1, 2009 or later	☐☐ / 2 0 ☐☐ MONTH YEAR
175.	angioplasty or coronary artery stent?	○ Never had procedure ○ Had procedure before January 1, 2009	○ Had procedure January 1, 2009 or later	☐☐ / 2 0 ☐☐ MONTH YEAR
176.	coronary artery bypass graft surgery?	○ Never had procedure ○ Had procedure before January 1, 2009	○ Had procedure January 1, 2009 or later	☐☐ / 2 0 ☐☐ MONTH YEAR

MEDICATIONS

Since January 1, 2009, have you used any prescription medicines to treat or to prevent…		NO	YES	a. If yes, are you currently taking this?
177.	hypertension (high blood pressure)?	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed
178.	high cholesterol?	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed

MEDICATIONS

Since January 1, 2009, have you used any prescription medicines to treat or to prevent…		NO	YES	a. If yes, are you currently taking this?
179.	cardiac arrhythmia (irregular heartbeat)?	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed
180.	congestive heart failure?	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed
181.	diabetes?	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed
182.	thyroid disease?	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed
183.	osteoporosis (bone loss, or bone thinning)? Do not count calcium or vitamin D.	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed
184.	rheumatoid arthritis?	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed
185.	osteoarthritis?	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed
186.	migraines?	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed
187.	depression?	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed
188.	asthma?	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed
189.	Parkinson's disease?	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed
190.	anxiety?	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed

Please use a ballpoint pen for this form

Since January 1, 2009, have you regularly (at least once a week for at least three months in a row) taken...		NO	YES	a. If yes, for about how long have you taken this regularly (at least once a week for at least three months in a row) since January 1, 2009?	
191.	acetaminophen (Tylenol)?	○ No	○ Yes	○ Less than 12 months ○ 1 year ○ 2 years	○ 3 years ○ 4 years ○ More than 4 years
192.	"baby aspirin" or low-dose aspirin (100mg/tablet or less)?	○ No	○ Yes	○ Less than 12 months ○ 1 year ○ 2 years	○ 3 years ○ 4 years ○ More than 4 years
193.	aspirin or other aspirin containing products (325 mg/tablet or more)?	○ No	○ Yes	○ Less than 12 months ○ 1 year ○ 2 years	○ 3 years ○ 4 years ○ More than 4 years
194.	ibuprofen (such as Advil, Motrin, Nuprin, etc.)?	○ No	○ Yes	○ Less than 12 months ○ 1 year ○ 2 years	○ 3 years ○ 4 years ○ More than 4 years
195.	Celebrex or other COX-2 inhibitors?	○ No	○ Yes	○ Less than 12 months ○ 1 year ○ 2 years	○ 3 years ○ 4 years ○ More than 4 years
196.	Aleve or Naprosyn?	○ No	○ Yes	○ Less than 12 months ○ 1 year ○ 2 years	○ 3 years ○ 4 years ○ More than 4 years
197.	Relafen, Ketoprofen, Anaprox, or other non-steroidal anti-inflammatories?	○ No	○ Yes	○ Less than 12 months ○ 1 year ○ 2 years	○ 3 years ○ 4 years ○ More than 4 years
198.	antibiotics?	○ No	○ Yes	○ Less than 12 months ○ 1 year ○ 2 years	○ 3 years ○ 4 years ○ More than 4 years

b. On average, how many days per week have you taken this?	c. On days when you take it, how many times do you take it?	d. Are you currently taking this?
○ 1 day per week ○ 2-3 days per week ○ 4-5 days per week ○ 6-7 days per week	○ 1 time per day ○ 2 times per day ○ 3 times per day ○ 4 times per day ○ 5 or more times per day	○ No ○ Yes
○ 1 day per week ○ 2-3 days per week ○ 4-5 days per week ○ 6-7 days per week	○ 1 time per day ○ 2 times per day ○ 3 times per day ○ 4 times per day ○ 5 or more times per day	○ No ○ Yes
○ 1 day per week ○ 2-3 days per week ○ 4-5 days per week ○ 6-7 days per week	○ 1 time per day ○ 2 times per day ○ 3 times per day ○ 4 times per day ○ 5 or more times per day	○ No ○ Yes
○ 1 day per week ○ 2-3 days per week ○ 4-5 days per week ○ 6-7 days per week	○ 1 time per day ○ 2 times per day ○ 3 times per day ○ 4 times per day ○ 5 or more times per day	○ No ○ Yes
○ 1 day per week ○ 2-3 days per week ○ 4-5 days per week ○ 6-7 days per week	○ 1 time per day ○ 2 times per day ○ 3 times per day ○ 4 times per day ○ 5 or more times per day	○ No ○ Yes
○ 1 day per week ○ 2-3 days per week ○ 4-5 days per week ○ 6-7 days per week	○ 1 time per day ○ 2 times per day ○ 3 times per day ○ 4 times per day ○ 5 or more times per day	○ No ○ Yes
○ 1 day per week ○ 2-3 days per week ○ 4-5 days per week ○ 6-7 days per week	○ 1 time per day ○ 2 times per day ○ 3 times per day ○ 4 times per day ○ 5 or more times per day	○ No ○ Yes
○ 1 day per week ○ 2-3 days per week ○ 4-5 days per week ○ 6-7 days per week	○ 1 time per day ○ 2 times per day ○ 3 times per day ○ 4 times per day ○ 5 or more times per day	○ No ○ Yes

Please use a ballpoint pen for this form

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

Do not include:

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

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

○ No → **GO TO END, PAGE 51**

○ Yes

TOTAL # ☐☐

a. What is/are the name(s) of the prescription or non-prescription medication(s) that you **currently take regularly?**	b. For how long have you used this regularly?
1.	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
2.	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
3.	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
4.	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
5.	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years

c. How often do you take it?	d. On days when you take it, how many times do you take it?	e. In what form did you take this? *(Please mark all that apply.)*
○ Once a month or less ○ Less than once a week ○ Once a week ○ 2-3 days a week ○ 4-5 days a week ○ 6-7 days a week	○ 1 time per day ○ 2 times per day ○ 3 times per day ○ 4 times per day ○ 5 or more times per day	○ Pill ○ Patch ○ Inhaler ○ Spray ○ Cream ○ Shot ○ Liquid ○ Other
○ Once a month or less ○ Less than once a week ○ Once a week ○ 2-3 days a week ○ 4-5 days a week ○ 6-7 days a week	○ 1 time per day ○ 2 times per day ○ 3 times per day ○ 4 times per day ○ 5 or more times per day	○ Pill ○ Patch ○ Inhaler ○ Spray ○ Cream ○ Shot ○ Liquid ○ Other
○ Once a month or less ○ Less than once a week ○ Once a week ○ 2-3 days a week ○ 4-5 days a week ○ 6-7 days a week	○ 1 time per day ○ 2 times per day ○ 3 times per day ○ 4 times per day ○ 5 or more times per day	○ Pill ○ Patch ○ Inhaler ○ Spray ○ Cream ○ Shot ○ Liquid ○ Other
○ Once a month or less ○ Less than once a week ○ Once a week ○ 2-3 days a week ○ 4-5 days a week ○ 6-7 days a week	○ 1 time per day ○ 2 times per day ○ 3 times per day ○ 4 times per day ○ 5 or more times per day	○ Pill ○ Patch ○ Inhaler ○ Spray ○ Cream ○ Shot ○ Liquid ○ Other
○ Once a month or less ○ Less than once a week ○ Once a week ○ 2-3 days a week ○ 4-5 days a week ○ 6-7 days a week	○ 1 time per day ○ 2 times per day ○ 3 times per day ○ 4 times per day ○ 5 or more times per day	○ Pill ○ Patch ○ Inhaler ○ Spray ○ Cream ○ Shot ○ Liquid ○ Other

Please use a ballpoint pen for this form

Draft

a. What is/are the name(s) of the prescription or non-prescription medication(s) that you **currently take regularly?** (If you need more space, answer the same questions for each medication and record it on a separate sheet.)	b. For how long have you used this regularly?
6.	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
7.	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
8.	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
9.	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
10.	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
11.	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
12.	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years

c. How often do you take it?	d. On days when you take it, how many times do you take it?	e. In what form did you take this? *(Please mark all that apply.)*	
○ Once a month or less ○ Less than once a week ○ Once a week ○ 2-3 days a week ○ 4-5 days a week ○ 6-7 days a week	○ 1 time per day ○ 2 times per day ○ 3 times per day ○ 4 times per day ○ 5 or more times per day	○ Pill ○ Inhaler ○ Cream ○ Liquid	○ Patch ○ Spray ○ Shot ○ Other
○ Once a month or less ○ Less than once a week ○ Once a week ○ 2-3 days a week ○ 4-5 days a week ○ 6-7 days a week	○ 1 time per day ○ 2 times per day ○ 3 times per day ○ 4 times per day ○ 5 or more times per day	○ Pill ○ Inhaler ○ Cream ○ Liquid	○ Patch ○ Spray ○ Shot ○ Other
○ Once a month or less ○ Less than once a week ○ Once a week ○ 2-3 days a week ○ 4-5 days a week ○ 6-7 days a week	○ 1 time per day ○ 2 times per day ○ 3 times per day ○ 4 times per day ○ 5 or more times per day	○ Pill ○ Inhaler ○ Cream ○ Liquid	○ Patch ○ Spray ○ Shot ○ Other
○ Once a month or less ○ Less than once a week ○ Once a week ○ 2-3 days a week ○ 4-5 days a week ○ 6-7 days a week	○ 1 time per day ○ 2 times per day ○ 3 times per day ○ 4 times per day ○ 5 or more times per day	○ Pill ○ Inhaler ○ Cream ○ Liquid	○ Patch ○ Spray ○ Shot ○ Other
○ Once a month or less ○ Less than once a week ○ Once a week ○ 2-3 days a week ○ 4-5 days a week ○ 6-7 days a week	○ 1 time per day ○ 2 times per day ○ 3 times per day ○ 4 times per day ○ 5 or more times per day	○ Pill ○ Inhaler ○ Cream ○ Liquid	○ Patch ○ Spray ○ Shot ○ Other
○ Once a month or less ○ Less than once a week ○ Once a week ○ 2-3 days a week ○ 4-5 days a week ○ 6-7 days a week	○ 1 time per day ○ 2 times per day ○ 3 times per day ○ 4 times per day ○ 5 or more times per day	○ Pill ○ Inhaler ○ Cream ○ Liquid	○ Patch ○ Spray ○ Shot ○ Other
○ Once a month or less ○ Less than once a week ○ Once a week ○ 2-3 days a week ○ 4-5 days a week ○ 6-7 days a week	○ 1 time per day ○ 2 times per day ○ 3 times per day ○ 4 times per day ○ 5 or more times per day	○ Pill ○ Inhaler ○ Cream ○ Liquid	○ Patch ○ Spray ○ Shot ○ Other

Please use a ballpoint pen for this form

Draft

Please check to see that all questions are answered.

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

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

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

If you have a pathology report from a cyst aspiration, cyst removal, needle biopsy, surgical biopsy, lumpectomy, or mastectomy that you are willing to share with us, please include a copy with your completed questionnaire.

Thank you!

The Sister Study
Lifestyle
Version 2

Instructions:

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

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

Like this: ● Not like this: ⊘ ✓

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

Like this: ● ~~YES~~ Not like this: ● YES

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

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

1	2	3	4	5	6	7	8	9	0

When writing dates, please follow this example.

EXAMPLE: June 7, 2011 = 0 6 / 0 7 / 2 0 1 1
(month) (day) (year)

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

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

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

- ○ Never married
- ○ Widowed
- ○ Divorced
- ○ Separated

GO TO QUESTION 2

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

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

☐☐ # YEARS OR ○ Less than 1 year

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

- ○ Man
- ○ Woman

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

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

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

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

4. Did you smoke at least 10 cigarettes since January 1, 2009?

○ No → **GO TO QUESTION 5**

○ Yes

4a.	When did you **first** start smoking?	○ Before 2009 ○ 2009 ○ 2010 ○ 2011 ○ 2012 ○ 2013
4b.	When did you **last** smoke cigarettes?	○ I am a current smoker ○ I last smoked in 2013 ○ I last smoked in 2012 ○ I last smoked in 2011 ○ I last smoked in 2010 ○ I last smoked in 2009
4c.	During the years you smoked since January 1, 2009, how many days per week do/did you smoke?	○ Less than one day per week ○ 1-3 days per week ○ 4-6 days per week ○ Every day
4d.	During the years you smoked since January 1, 2009, how many cigarettes do/did you usually smoke per day on the days that you smoked?	☐☐☐ # CIGARETTES

Please use a ballpoint pen for this form

5. Since January 1, 2009, how many regular smokers have you lived with (not counting yourself, if you smoke)?

○ None
○ 1
○ 2
○ 3-4
○ 5 or more

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

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

Since January 1, 2009...	**NO**	**YES**	a. IF YES, in which years since January 1, 2009 did you drink alcohol? *(Please mark all that apply.)*	b. About how often did you drink alcohol?	c. On average, how many drinks did you have on the days that you drank alcohol?
7. have you drunk **beer or other malt beverages?**	○ No	○ Yes	○ 2009 ○ 2010 ○ 2011 ○ 2012 ○ 2013	○ Every day ○ 5-6 times per week ○ 3-4 times per week ○ 2 times per week ○ Once per week ○ 2-3 times per month ○ Once per month ○ A few times per year	○ 7 or more ○ 6 ○ 5 ○ 4 ○ 3 ○ 2 ○ 1
8. have you drunk **white wine or white wine coolers?**	○ No	○ Yes	○ 2009 ○ 2010 ○ 2011 ○ 2012 ○ 2013	○ Every day ○ 5-6 times per week ○ 3-4 times per week ○ 2 times per week ○ Once per week ○ 2-3 times per month ○ Once per month ○ A few times per year	○ 7 or more ○ 6 ○ 5 ○ 4 ○ 3 ○ 2 ○ 1
9. have you drunk **red wine or red wine coolers?**	○ No	○ Yes	○ 2009 ○ 2010 ○ 2011 ○ 2012 ○ 2013	○ Every day ○ 5-6 times per week ○ 3-4 times per week ○ 2 times per week ○ Once per week ○ 2-3 times per month ○ Once per month ○ A few times per year	○ 7 or more ○ 6 ○ 5 ○ 4 ○ 3 ○ 2 ○ 1
10. have you drunk **liquor?**	○ No	○ Yes	○ 2009 ○ 2010 ○ 2011 ○ 2012 ○ 2013	○ Every day ○ 5-6 times per week ○ 3-4 times per week ○ 2 times per week ○ Once per week ○ 2-3 times per month ○ Once per month ○ A few times per year	○ 7 or more ○ 6 ○ 5 ○ 4 ○ 3 ○ 2 ○ 1

11. Since January 1, 2009, did you ever drink four or more alcoholic beverages in a row, in one sitting?

○ No → **GO TO QUESTION 12**

○ Yes

11a. How often has this happened since January 1, 2009?

- ○ More than once a week
- ○ Once a week
- ○ More than once a month but less than once a week
- ○ Once a month
- ○ 7-11 times a year
- ○ 4-6 times a year
- ○ 2-3 times a year
- ○ Once a year
- ○ Once or twice

12. Since January 1, 2009, has a doctor or other health professional told you that your drinking was hurting your health?

○ No

○ Yes

Please use a ballpoint pen for this form

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

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

During the **past 7 days,** how much time did you…	
16. usually spend **sitting** on a **weekday**? This includes sitting while at work, at home, while doing course work, and during leisure time. This may include time spent sitting at a desk, visiting friends, reading, or sitting or lying down to watch television.	☐☐ HOURS PER DAY **AND** ☐☐ MINUTES PER DAY *(up to 59)* ○ Not sure
17. usually spend **standing** on a **weekday**? This includes standing while at work, at home, and during leisure time.	☐☐ HOURS PER DAY **AND** ☐☐ MINUTES PER DAY *(up to 59)* ○ Not sure

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

○ Less than usual
○ About the same
○ More than usual

19. In the past year, did you swim in a pool during summer (June-August)?

○ No → **GO TO QUESTION 20**

○ Yes

19a.	How many times per week?	○ Less than 1 ○ 1-2 times ○ 3-4 times ○ 5 or more times
19b.	On average, how many minutes per time?	○ Less than 15 minutes ○ 15-30 minutes ○ 31-45 minutes ○ 46-60 minutes ○ More than 60 minutes
19c.	How often did you swim in an **INDOOR** pool during June-August?	○ Never ○ Seldom ○ Half the time ○ Often ○ Almost always

Please use a ballpoint pen for this form

20. In the past year, did you swim in a pool during the rest of the year (September-May)?

○ No → **GO TO QUESTION 21**

○ Yes

20a.	How many times per week?	○ Less than 1 ○ 1-2 times ○ 3-4 times ○ 5 or more times
20b.	On average, how many minutes per time?	○ Less than 15 minutes ○ 15-30 minutes ○ 31-45 minutes ○ 46-60 minutes ○ More than 60 minutes
20c.	How often did you swim in an **INDOOR** pool during September-May?	○ Never ○ Seldom ○ Half the time ○ Often ○ Almost always

21. Since January 1, 2009, have you done any of the following **hobbies** at least 5 hours per week for at least 6 weeks? *(Please mark all that apply.)*

○ Oil painting or other artistic painting
○ Developing photographs chemically
○ Woodworking
○ Refinishing furniture
○ Ceramics or pottery making
○ Glass blowing
○ Etching
○ Hobbies that involve soldering such as stained glass or jewelry making
○ Hobbies that involve welding
○ Leather crafting
○ Print making or silk screening
○ Auto or engine repair
○ Gardening
○ I have not done any of these hobbies

22. Since January 1, 2009, have you used **hair dye** to color your hair?

○ No → **GO TO NEXT PAGE, QUESTION 23**

○ Yes

22a. In what years did you do this? *(Please mark all that apply.)*

- ○ 2009
- ○ 2010
- ○ 2011
- ○ 2012
- ○ 2013

22b. What color did you **usually** use?

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

22c. What type of hair dye do you use most often?

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

Please use a ballpoint pen for this form

23. Since January 1, 2009, about how often have you used **chemical insect repellents on your skin, hair, or clothing in the summer?** Please do not include products that contain only citronella.

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

24. Since January 1, 2009, about how often have you used **chemical insect repellents on your skin, hair, or clothing the rest of the year?** Please do not include products that contain only citronella.

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

25. Since January 1, 2009, about how often have you used an over-the-counter or prescription **lice control product** on yourself, or applied it to someone else's skin, hair, or clothing?

- ○ Never
- ○ Once
- ○ Twice
- ○ Three times
- ○ Four or more times

	Since January 1, 2009, about how many hours per day do you usually spend outdoors in daylight…	a. During this time, about how often did you use sunscreen or wear protective clothing such as hats or long sleeves?
26. <u>on weekend or vacation days</u> **in the summer?**	○ Less than 1 hour per day ○ 1-2 hours per day ○ 3-4 hours per day ○ 5-8 hours per day ○ 9-12 hours per day ○ More than 12 hours per day	○ Never ○ Rarely ○ Sometimes ○ Usually ○ Always
27. <u>on other days</u> **in the summer?**	○ Less than 1 hour per day ○ 1-2 hours per day ○ 3-4 hours per day ○ 5-8 hours per day ○ 9-12 hours per day ○ More than 12 hours per day	○ Never ○ Rarely ○ Sometimes ○ Usually ○ Always
28. <u>on weekend or vacation days</u> **the rest of the year?**	○ Less than 1 hour per day ○ 1-2 hours per day ○ 3-4 hours per day ○ 5-8 hours per day ○ 9-12 hours per day ○ More than 12 hours per day	○ Never ○ Rarely ○ Sometimes ○ Usually ○ Always
29. <u>on other days</u> **the rest of the year?**	○ Less than 1 hour per day ○ 1-2 hours per day ○ 3-4 hours per day ○ 5-8 hours per day ○ 9-12 hours per day ○ More than 12 hours per day	○ Never ○ Rarely ○ Sometimes ○ Usually ○ Always

Please use a ballpoint pen for this form

30. Have you moved since January 1, 2009?

○ No → **GO TO QUESTION 31**

○ Yes

30a. What month and year did you move into your current residence?

MONTH | YEAR (2 0 _ _)

30b. Please write down your current address.

STREET #

STREET NAME

APT #

CITY OR TOWN

STATE

ZIP CODE

COUNTY

30c. Please write down the name of the nearest cross street (the street that intersects with the street where you live):

NAME OF NEAREST CROSS STREET

31. How many lanes of traffic in total does the street where you live have?

LANES

32. Which best describes the traffic condition during rush hour on the road where you live?

○ Little or no traffic
○ Light traffic, moving at or above the speed limit
○ Heavy traffic, moving below the speed limit
○ Congested or "stop and go"
○ Heavy traffic, moving at or above the speed limit

33. Since January 1, 2009, about how often has your residence been treated with insecticides or pesticides to control insects, rodents, or other pests, either inside or around the foundation?

○ Never → **GO TO THE NEXT PAGE, QUESTION 34**

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

33a. For what kinds of pests were pest control chemicals used at your residence? *(Please mark all that apply.)*

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

33b. When pest control chemicals were applied since January 1, 2009, about how often did you **personally** apply them?

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

Please use a ballpoint pen for this form

34. Since January 1, 2009, about how often was the garden or yard around this residence treated with weed killers or insecticides, including those labeled organic such as pyrethrum or rotenone?

- ○ Never
- ○ Not applicable

→ **GO TO QUESTION 35**

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

34a. When weed killers or insecticides were used in the garden or yard since January 1, 2009, about how often did you **personally** apply them?

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

35. Since January 1, 2009, about how often have you used household cleaning solutions other than dish washing and laundry detergents?

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

36. Do you currently have any household pets?

- ○ No → **GO TO THE NEXT PAGE, QUESTION 37**
- ○ Yes

How many of each of the following do you have?

		None	1	2	3-4	5 or more
36a.	Dogs	○	○	○	○	○
36b.	Birds	○	○	○	○	○
36c.	Cats	○	○	○	○	○
36d.	Other furry animals	○	○	○	○	○

37. Since January 1, 2009, have you regularly used air fresheners in your home? Please include air fresheners that plug in, hang, sit on a shelf, or stick on the wall, as well as sprays that are used at least three times a week.

○ No → **GO TO QUESTION 38**

○ Yes

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

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

38. Since January 1, 2009, have you regularly used air fresheners in your car? Please include the hanging types, as well as those that plug in, and sprays that are used at least three times a week.

○ No → **GO TO QUESTION 39**

○ Yes

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

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

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

○ Never → **GO TO THE NEXT PAGE, QUESTION 40**

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

39a. What is the traffic condition that best describes your travel time (by car, van, truck, or bus) **on most days?**

- ○ Little or no traffic
- ○ Light traffic, moving at or above the speed limit
- ○ Heavy traffic, moving below the speed limit
- ○ Congested or "stop and go"
- ○ Heavy traffic, moving at or above the speed limit

Please use a ballpoint pen for this form

40. How much time per day do you spend traveling by bicycle or motorcycle **on most days?**

○ Never → **GO TO QUESTION 41**

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

40a. What is the traffic condition that best describes your travel time by bicycle or motorcycle **on most days?**

○ Little or no traffic
○ Light traffic, moving at or above the speed limit
○ Heavy traffic, moving below the speed limit
○ Congested or "stop and go"
○ Heavy traffic, moving at or above the speed limit

41. How much time per day do you spend traveling by foot **on most days?**

○ Never → **GO TO QUESTION 42**

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

41a. What is the traffic condition that best describes your travel time by foot **on most days?**

○ Little or no traffic
○ Light traffic, moving at or above the speed limit
○ Heavy traffic, moving below the speed limit
○ Congested or "stop and go"
○ Heavy traffic, moving at or above the speed limit

42. Since January 1, 2009 have you had a full-time or part-time job other than homemaking that you held for at least 12 months (at least 9 months if it was a teaching job)?

○ No

42a. Which of the following **best** describes your current situation?

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

GO TO THE END

○ Yes → **GO TO THE NEXT PAGE, QUESTION 43**

43. How many different jobs have you had since January 1, 2009? ☐☐ # OF JOBS

Please tell us about the jobs you have had since January 1, 2009, starting with the most recent and working backwards.

	JOB 1	JOB 2
44. When did you first start this job?	○ Before 2009 ○ 2009 ○ 2010 ○ 2011 ○ 2012 ○ 2013	○ Before 2009 ○ 2009 ○ 2010 ○ 2011 ○ 2012 ○ 2013
45. When did you last have this job?	○ 2009 ○ 2010 ○ 2011 ○ 2012 ○ 2013 ○ I still work there	○ 2009 ○ 2010 ○ 2011 ○ 2012 ○ 2013 ○ I still work there
46. Where did you work? Please write down the name of the company you worked for and the **full street address** of this workplace.	NAME OF COMPANY/PLACE OF WORK STREET # STREET NAME APT # CITY OR TOWN STATE ZIP CODE COUNTY	NAME OF COMPANY/PLACE OF WORK STREET # STREET NAME APT # CITY OR TOWN STATE ZIP CODE COUNTY

Knowing the name and addresses of the places you work will allow us to evaluate the impact of air pollution and other factors in the general environment on your health. We will never use this information for any other purpose and will never contact your employer.

Please use a ballpoint pen for this form

SPACE IS PROVIDED FOR TWO JOBS. IF YOU HAVE HAD MORE THAN TWO JOBS LASTING 12 MONTHS OR MORE SINCE JANUARY 1, 2009, PLEASE ANSWER THE SAME QUESTIONS FOR EACH JOB AND RECORD YOUR ANSWERS ON A SEPARATE SHEET OF PAPER.

		JOB 1	JOB 2
47.	On a scale from 1 to 5, how **physically demanding** was this job?	○ 1 Not demanding ○ 2 ○ 3 ○ 4 ○ 5 Extremely demanding	○ 1 Not demanding ○ 2 ○ 3 ○ 4 ○ 5 Extremely demanding
48.	On a scale from 1 to 5, how **emotionally demanding** was this job?	○ 1 Not demanding ○ 2 ○ 3 ○ 4 ○ 5 Extremely demanding	○ 1 Not demanding ○ 2 ○ 3 ○ 4 ○ 5 Extremely demanding
49.	What was/is your job title?	JOB TITLE	JOB TITLE
50.	What type of company or organization do/did you work for? (What do they make or what services do they provide?)	INDUSTRY	INDUSTRY
51.	What are the specific tasks that you usually do/did in your job?	JOB DUTIES	JOB DUTIES

		JOB 1	JOB 2
52.	How many hours per week do/did you usually work at this job?	○ Less than 10 ○ 11-20 ○ 21-30 ○ 31-40 ○ More than 40	○ Less than 10 ○ 11-20 ○ 21-30 ○ 31-40 ○ More than 40
53.	What hours of the day do/did you usually work at this job?	START TIME: (mark one) ○ AM ○ PM (hr) : (min) STOP TIME: (mark one) ○ AM ○ PM (hr) : (min) **OR** ○ I work(ed) irregular hours ○ I work(ed) rotating shifts	START TIME: (mark one) ○ AM ○ PM (hr) : (min) STOP TIME: (mark one) ○ AM ○ PM (hr) : (min) **OR** ○ I work(ed) irregular hours ○ I work(ed) rotating shifts
54.	How many times per month do/did you work at night? "Work at night" means any shift that includes at least one hour between midnight and 2:00 AM.	○ Never ○ 1-2 times/month ○ 3-5 times/month ○ 6-10 times/month ○ 11-15 times/month ○ More than 15 times per month	○ Never ○ 1-2 times/month ○ 3-5 times/month ○ 6-10 times/month ○ 11-15 times/month ○ More than 15 times per month

Please use a ballpoint pen for this form

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

Please check to see that all questions are answered.

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

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

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

The Sister Study
Quality of Life and Special Topics
Version 2

Instructions:

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

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

Like this: ● Not like this: ⊗ ✓

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

Like this: ● ~~YES~~ Not like this: ● YES

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

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

1	2	3	4	5	6	7	8	9	0

When writing dates, please follow this example.

EXAMPLE: June 7, 2011 = 0 6 / 0 7 / 2 0 1 1
(month) (day) (year)

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

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

Today's Date: ☐☐ / ☐☐ / 2 0 ☐☐

MONTH DAY YEAR

Please respond to each item by marking one answer per row.

	Excellent	Very good	Good	Fair	Poor
1. In general, would you say your health is...	○	○	○	○	○
2. In general, would you say your quality of life is...	○	○	○	○	○
3. In general, how would you rate your physical health?	○	○	○	○	○
4. In general, how would you rate your mental health, including your mood and your ability to think?	○	○	○	○	○
5. In general, how would you rate your satisfaction with your social activities and relationships?	○	○	○	○	○
6. In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)	○	○	○	○	○

7. To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?

○ Completely
○ Mostly
○ Moderately
○ A little
○ Not at all

8. In the **past 7 days,** how often have you been bothered by emotional problems such as feeling anxious, depressed, or irritable?

- ○ Never
- ○ Rarely
- ○ Sometimes
- ○ Often
- ○ Always

9. In the **past 7 days,** how would you rate your fatigue on average?

- ○ None
- ○ Mild
- ○ Moderate
- ○ Severe
- ○ Extremely severe

10. In the **past 7 days,** how would you rate your pain on average?

No pain										**Worst imaginable pain**
○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10

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

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

Please use a ballpoint pen for this form

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

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
a. I can count on someone to provide me with emotional support (someone to confide in about myself or a problem or who will listen to me when I need to talk).	○	○	○	○	○
b. I can count on someone if I need help (for example, to take me to the doctor or help with daily chores if I am sick).	○	○	○	○	○
c. There is someone in my immediate family who believes in me and wants me to succeed.	○	○	○	○	○
d. There is someone in my immediate family who makes me feel important or special.	○	○	○	○	○

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

○ None
○ 1-2
○ 3-5
○ 6-9
○ 10 or more

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

○ None → **GO TO QUESTION 15**

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

14a. How stressful would you say it is to provide care for these children or grandchildren?

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

14b. During the **past 12 months,** for whom did you provide such care? *(Please mark all that apply.)*

○ My children
○ My grandchildren
○ Other children

15. During the **past 12 months,** about how many hours **per week** on average did you provide care for an ill or disabled person? This might be a parent, child, sibling, spouse, partner, other relative, or personal friend.

○ None → **GO TO THE NEXT PAGE, QUESTION 16**

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

15a. How stressful would you say it is to provide care for these disabled or ill individuals?

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

15b. During the **past 12 months,** for whom did you provide such care? *(Please mark all that apply.)*

○ Parent
○ Child
○ Sibling
○ Spouse
○ Partner
○ Other relative
○ Friend

Please use a ballpoint pen for this form

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

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

Since **January 1, 2009,** have you experienced the death of…	**NO**	**YES**	a. Regardless of when this happened, how much distress or anxiety has this caused you in the **past 4 weeks?**
17. your spouse or partner?	○ No	○ Yes	○ None ○ A little ○ A moderate amount ○ A lot
18. your sister with breast cancer?	○ No	○ Yes	○ None ○ A little ○ A moderate amount ○ A lot
19. another sibling?	○ No	○ Yes	○ None ○ A little ○ A moderate amount ○ A lot
20. a child?	○ No	○ Yes	○ None ○ A little ○ A moderate amount ○ A lot
21. a parent?	○ No	○ Yes	○ None ○ A little ○ A moderate amount ○ A lot
22. a close personal friend?	○ No	○ Yes	○ None ○ A little ○ A moderate amount ○ A lot

Please use a ballpoint pen for this form

Since **January 1, 2009,** have you experienced…	**NO**	**YES**	a. Regardless of when this happened, how much distress or anxiety has this caused you in the **past 4 weeks?**
23. a major illness that was life threatening or severely disabling to you?	○ No	○ Yes	○ None ○ A little ○ A moderate amount ○ A lot
24. the recurrence or worsening of your sister's breast cancer?	○ No	○ Yes	○ None ○ A little ○ A moderate amount ○ A lot
25. any other close relative's diagnosis of breast cancer?	○ No	○ Yes	○ None ○ A little ○ A moderate amount ○ A lot
26. a major change in, or serious difficulty with a personal relationship (such as a divorce, or child custody issues)?	○ No	○ Yes	○ None ○ A little ○ A moderate amount ○ A lot
27. serious financial or legal troubles such as arrest or bankruptcy (either you or another family member whose troubles would directly affect you)?	○ No	○ Yes	○ None ○ A little ○ A moderate amount ○ A lot

28. In the **past 12 months,** have you had to quit, reduce your hours, or change your job because of your health or to meet the needs of your family?

- ○ No
- ○ Not applicable
- ○ Yes

28a. Why did you have to do this? *(Please mark all that apply.)*
- ○ Because of my health
- ○ To meet the needs of my family

29. In the **past 12 months,** have you been forced to leave your job, reduce your hours, or change your job for other reasons such as the economy?

- ○ No
- ○ Not applicable
- ○ Yes

30a. Are you currently unemployed and looking for work?

- ○ No
- ○ Yes

30b. Are you currently unemployed and **not** looking for work?

- ○ No
- ○ Yes

Please use a ballpoint pen for this form

As people age, some begin to worry about their ability to think clearly, make decisions and remember things.

In the last several years…	No	Yes	Don't Know	Not applicable
31. have you noticed that your judgment (e.g., ability to make decisions and think clearly) is not as good as it used to be?	○	○	○	○
32. has your interest in hobbies or activities decreased?	○	○	○	○
33. have you noticed that you tend to repeat things over and over (questions, stories, or statements) more often than you used to?	○	○	○	○
34. has it become harder to learn how to use a new tool, appliance or gadget (e.g., computer, microwave, remote control)?	○	○	○	○
35. have you noticed more problems remembering the month or year?	○	○	○	○
36. have you had more problems handling complicated financial affairs (e.g., balancing checkbook, preparing income taxes, paying bills) than you used to?	○	○	○	○
37. has it become more difficult to remember appointments?	○	○	○	○
38. do you notice more daily problems with thinking and/or memory?	○	○	○	○

Please answer the following questions about sleep.

39. To feel your best, how many hours of sleep do you need?

HOURS

40. In the **past year,** how many hours of sleep per night on average did you typically get?

HOURS

41. In the **past month,** how many hours of sleep per night on average did you typically get?

☐☐ # HOURS

42. Do you have difficulty falling asleep or staying asleep on a regular basis?

○ No → **GO TO QUESTION 43**

○ Yes

42a. How many nights in a typical month do you have trouble sleeping? ☐☐ # NIGHTS

43. Do you **ever** feel excessively sleepy during the day, even after getting your usual sleep?

○ No → **GO TO QUESTION 44**

○ Yes

43a. In the **past month,** about how often did you feel excessively sleepy during the day?

- ○ Less than once a week
- ○ 1 - 2 days per week
- ○ 3 - 5 days per week
- ○ 6 days per week or daily

44. Have you **ever** been told, or suspected yourself, that you seem to "act out your dreams" while asleep, for example, punching or flailing arms in the air, making running movements, shouting, or screaming?

○ No → **GO TO NEXT PAGE, QUESTION 45**

○ Yes

44a. How often do you do this?

- ○ Less than 3 times in total
- ○ Less than once a month
- ○ 1 - 3 times a month
- ○ Once a week
- ○ More than once a week

44b. How old were you when you first knew you did this? ☐☐ AGE

Please use a ballpoint pen for this form

45. Has a doctor or other health professional **ever** told you that you have restless leg syndrome?

- ○ No
- ○ Yes

		No	Yes
46.	Do you have, or have you had, recurrent uncomfortable feelings or sensations in your legs while you are sitting or lying down?	○	○
47.	Do you have, or have you had, a recurrent need or urge to move your legs while you were sitting or lying down?	○	○

IF YOU ANSWERED NO TO *BOTH*, GO TO QUESTION 58, PAGE 15

IF YOU ANSWERED YES TO *EITHER* OF THE ABOVE, GO TO QUESTION 48

If you answered *Yes* to either 46 or 47:

48. Are you more likely to have these feelings when you are resting (either sitting or lying down) or when you are physically active?

- ○ Resting
- ○ Active

49. If you get up or move around when you have these feelings do these feelings get any better while you actually keep moving?

- ○ No
- ○ Yes
- ○ Don't know

50. Which times of day are these feelings in your legs **most** likely to occur?
(Please mark all that apply.)

- ○ Morning
- ○ Mid-day
- ○ Afternoon
- ○ Evening
- ○ Night
- ○ About equal at all times

51. Will simply changing leg position by itself **once** without continuing to move usually relieve these feelings?

- ○ Usually relieves
- ○ Does not usually relieve
- ○ Don't know

52. Are these feelings **ever** due to muscle cramps?

- ○ No
- ○ Don't know

GO TO QUESTION 53

- ○ Yes

52a. Are they **always** due to muscle cramps?

- ○ No
- ○ Yes
- ○ Don't know

53. Do these feelings occur when sitting or when lying down?

- ○ Only when sitting
- ○ Only when lying down
- ○ Both when sitting and when lying down
- ○ Neither

Please use a ballpoint pen for this form

54. When you experience the feelings in your legs, how **distressing** are they?

- ○ Not at all distressing
- ○ A little bit
- ○ Moderately
- ○ Extremely distressing

55. In the **past 12 months,** how often did you experience these feelings in your legs? *(Please mark the best single answer.)*

- ○ 6 times per week or daily
- ○ 4 - 5 days per week
- ○ 2 - 3 days per week
- ○ 1 day per week
- ○ 2 - 3 days per month
- ○ 1 day per month or less
- ○ Never

56. Approximately how old were you when you **first** noticed these feelings in your legs? *(Please write age.)*

AGE

57. Did you **first** notice these feelings during a pregnancy?

- ○ No
- ○ Never been pregnant

} **GO TO NEXT PAGE, QUESTION 58**

- ○ Yes

57a. Other than pregnancy, about how old were you when you **first** noticed these feelings in your legs?

AGE

- ○ Never felt this outside of pregnancy

58. During the **past 12 months,** have you taken any vitamins or minerals regularly, at least once a month?

○ No, not regularly → **GO TO PAGE 21, QUESTION 79**

○ Yes, fairly regularly

During the **past 12 months,** have you taken...	NO	YES	a. How often?	b. For how many years in all have you taken this?	c. Did you usually take types that...
Multiple Vitamins 59. One A Day, Centrum, or Thera type multiple vitamins?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	○ contain minerals, iron, zinc, etc.? ○ do not contain minerals? ○ Don't know
60. Stress-tabs or B-Complex type multiple vitamins?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	
61. Antioxidant combination-type multiple vitamins?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	

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During the **past 12 months,** have you taken...	NO	YES	a. How often?	b. For how many years in all have you taken this?	c. How much did you usually take on the days you took it?
Single Vitamins and Minerals (not part of multiple vitamins)					
62. Vitamin A (not beta-carotene)?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	○ Less than 8000 IU ○ 8000 IU ○ More than 8000 IU
63. Beta-carotene?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	
64. Thiamin (B1)?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	○ Less than 100 mg ○ 100-250 mg ○ More than 250 mg
65. Niacin (B3)?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	○ Less than 500 mg ○ 500 mg ○ More than 500 mg

During the **past 12 months,** have you taken...	NO	YES	a. How often?	b. For how many years in all have you taken this?	c. How much did you usually take on the days you took it?
Single Vitamins and Minerals (not part of multiple vitamins)					
66. Vitamin B6?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	○ Less than 100 mg ○ 100 mg ○ More than 100 mg
67. Vitamin B12?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	○ Less than 500 mcg ○ 500 mcg ○ 1000 mcg ○ 2000 mcg ○ More than 2000 mcg
68. Vitamin C?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	○ Less than 500 mg ○ 500 mg ○ 1000 mg ○ More than 1000 mg
69. Vitamin D alone?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	○ Less than 2000 IU ○ 2000 IU ○ More than 2000 IU

Please use a ballpoint pen for this form

During the **past 12 months,** have you taken...	**NO**	**YES**	a. How often?	b. For how many years in all have you taken this?	c. How much did you usually take on the days you took it?
Single Vitamins and Minerals (not part of multiple vitamins)					
70. Vitamin E?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	○ Less than 400 IU ○ 400 IU ○ More than 400 IU
71. Folic acid, folate?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	○ Less than 400 mcg ○ 400 mcg ○ More than 400 mcg
72. Calcium plus vitamin D?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	
73. Calcium without vitamin D?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	○ Less than 600 mg ○ 600 mg ○ More than 600 mg

During the **past 12 months,** have you taken...	NO	YES	a. How often?	b. For how many years in all have you taken this?	c. How much did you usually take on the days you took it?
Single Vitamins and Minerals (not part of multiple vitamins)					
74. Chromium?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	○ Less than 200 mcg ○ 200 - 1000 mcg ○ More than 1000 mcg
75. Iron?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	○ Less than 65 mg ○ 65 mg ○ More than 65 mg
76. Magnesium?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	○ Less than 250 mg ○ 250 mg ○ More than 250 mg
77. Selenium?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	○ Less than 200 mcg ○ 200 mcg ○ More than 200 mcg

Please use a ballpoint pen for this form

During the **past 12 months,** have you taken...	NO	YES	a. How often?	b. For how many years in all have you taken this?	c. How much did you usually take on the days you took it?
Single Vitamins and Minerals (not part of multiple vitamins)					
78. Zinc, alone or combined with something else?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	○ Less than 50 mg ○ 50 mg ○ More than 50 mg

In the **past 12 months,** did you take any of these supplements at least once a month?	**NO**	**YES**	a. How frequently did you take this?	b. For how many years in all have you taken this?
79. Black cohosh	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
80. Chamomile	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
81. Co-enzyme Q10 (CoQ10)	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
82. Cod liver oil	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
83. Cranberry pills	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
84. DHEA	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years

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In the **past 12 months,** did you take any of these supplements at least once a month?	**NO**	**YES**	a. How frequently did you take this?	b. For how many years in all have you taken this?
85. Echinacea	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
86. Evening primrose oil	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
87. Fiber supplement	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
88. Fish oil (EPA)	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
89. Flax seed/flax seed oil	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
90. Garlic pills	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years

In the **past 12 months,** did you take any of these supplements at least once a month?	**NO**	**YES**	a. How frequently did you take this?	b. For how many years in all have you taken this?
91. Ginger	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
92. Ginkgo	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
93. Ginseng	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
94. Glucosamine/Chondroitin	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
95. Kava Kava	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
96. Lecithin	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years

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In the **past 12 months,** did you take any of these supplements at least once a month?		**NO**	**YES**	a. How frequently did you take this?	b. For how many years in all have you taken this?
97.	Lutein	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
98.	Melatonin	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
99.	Milk thistle	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
100.	Mixed carotenoids	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
101.	Omega-3 or omega-3 fatty acids	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
102.	Probiotics/acidophilus	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years

In the **past 12 months,** did you take any of these supplements at least once a month?		**NO**	**YES**	a. How frequently did you take this?	b. For how many years in all have you taken this?
103.	Soy isoflavones	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
104.	St. John's Wort	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
105.	Turmeric capsules	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
106.	Valerian	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
107.	Something else	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years

Please use a ballpoint pen for this form

Have you used any of the following complementary or alternative practices within the **past 12 months?**		**NO**	**YES**	a. How frequently?	b. For how many years in all?
108.	Juicing	○ No	○ Yes	○ Less than once a month ○ 1-4 times a month ○ More than 4 times a month	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
109.	Acupuncture	○ No	○ Yes	○ Less than once a month ○ 1-4 times a month ○ More than 4 times a month	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
110.	Yoga	○ No	○ Yes	○ Less than once a month ○ 1-4 times a month ○ More than 4 times a month	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
111.	Spirituality, meditation, prayer	○ No	○ Yes	○ Less than once a month ○ 1-4 times a month ○ More than 4 times a month	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
112.	Therapeutic touch/massage	○ No	○ Yes	○ Less than once a month ○ 1-4 times a month ○ More than 4 times a month	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
113.	Tai chi	○ No	○ Yes	○ Less than once a month ○ 1-4 times a month ○ More than 4 times a month	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years

Have you used any of the following complementary or alternative practices within the **past 12 months?**		**NO**	**YES**	a. How frequently?	b. For how many years in all?
114.	Qi gong	○ No	○ Yes	○ Less than once a month ○ 1-4 times a month ○ More than 4 times a month	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
115.	Chiropractic	○ No	○ Yes	○ Less than once a month ○ 1-4 times a month ○ More than 4 times a month	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
116.	Reiki	○ No	○ Yes	○ Less than once a month ○ 1-4 times a month ○ More than 4 times a month	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
117.	Biofeedback	○ No	○ Yes	○ Less than once a month ○ 1-4 times a month ○ More than 4 times a month	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
118.	Homeopathy	○ No	○ Yes	○ Less than once a month ○ 1-4 times a month ○ More than 4 times a month	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
119.	Visualization/guided imagery	○ No	○ Yes	○ Less than once a month ○ 1-4 times a month ○ More than 4 times a month	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years

Please use a ballpoint pen for this form

Have you used any of the following complementary or alternative practices within the **past 12 months?**	**NO**	**YES**	a. How frequently?	b. For how many years in all?
120. Deep breathing exercises	○ No	○ Yes	○ Less than once a month ○ 1-4 times a month ○ More than 4 times a month	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years

121. Typically, how often do you have bowel movements?

○ Less than once every other day
○ Once every other day
○ Once per day
○ 2 or more times per day

122. How often do you use laxatives, not including fiber or fiber tabs?

○ Never
○ Less than once a month
○ 1 - 3 times per month
○ 1 - 3 times per week
○ 4 - 6 times per week
○ Daily or more

Some people follow special diets as part of their lifestyle. Others change their diet when there is a change in their life or when they are trying to achieve a goal like losing weight.

Since **January 1, 2009,** which (if any) of these special diets have you followed for longer than a month, other than during pregnancy?		**NO**	**YES**	a. How long did you follow this diet?	b. Have you followed this diet for **at least a month in the past year?**
123.	High fiber	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ Yes ○ No
124.	Low fat	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ Yes ○ No
125.	Restricted calories	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ Yes ○ No
126.	Liquid/juice	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ Yes ○ No
127.	Vegetarian	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ Yes ○ No
128.	Low salt	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ Yes ○ No
129.	Macrobiotic	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ Yes ○ No
130.	Diabetic diet	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ Yes ○ No
131.	Atkins	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ Yes ○ No
132.	Zone (Barry Sears)	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ Yes ○ No

Please use a ballpoint pen for this form

Since **January 1, 2009,** which (if any) of these special diets have you followed for longer than a month, other than during pregnancy?		**NO**	**YES**	a. How long did you follow this diet?	b. Have you followed this diet for **at least a month in the past year?**
133.	Weight Watchers	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ Yes ○ No
134.	Tried to gain weight	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ Yes ○ No
135.	Diet with pre-prepared meals	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ Yes ○ No
136.	Physician-based diet with special supplements such as puddings, beverages or vitamins	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ Yes ○ No
137.	South Beach diet	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ Yes ○ No
138.	Raw food diet	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ Yes ○ No
139.	HCG diet	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ Yes ○ No
140.	Other diet, please specify:	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ Yes ○ No

Have you **ever** had any of the following weight loss procedures?		**NO**	**YES**	a. What age did you have this?
141.	Lap band	○ No	○ Yes	☐☐ AGE
142.	Bariatric surgery	○ No	○ Yes	☐☐ AGE

Draft

143. Do you have, or have you **ever** had, a food allergy?

○ No
○ Don't know } **GO TO PAGE 33, QUESTION 156**

○ Yes

Do you have, or have you **ever** had, an allergy to the following foods?	NO	YES	b. Have you eaten this item in the past year?	c. Are you still allergic to this food?
144. Milk	○ No	○ Yes, it started before age 18 ○ Yes, it started age 18 or later → a. Age it started ☐☐ AGE	○ No ○ Yes	○ No ○ Yes ○ Don't know
145. Egg	○ No	○ Yes, it started before age 18 ○ Yes, it started age 18 or later → a. Age it started ☐☐ AGE	○ No ○ Yes	○ No ○ Yes ○ Don't know
146. Peanuts	○ No	○ Yes, it started before age 18 ○ Yes, it started age 18 or later → a. Age it started ☐☐ AGE	○ No ○ Yes	○ No ○ Yes ○ Don't know
147. Other nuts	○ No	○ Yes, it started before age 18 ○ Yes, it started age 18 or later → a. Age it started ☐☐ AGE	○ No ○ Yes	○ No ○ Yes ○ Don't know

Please use a ballpoint pen for this form

Do you have, or have you **ever** had, an allergy to the following foods?	NO	YES	b. Have you eaten this item in the past year?	c. Are you still allergic to this food?
148. Shellfish	○ No	○ Yes, it started before age 18 ○ Yes, it started age 18 or later → a. Age it started ☐☐ AGE	○ No ○ Yes	○ No ○ Yes ○ Don't know
149. Fish	○ No	○ Yes, it started before age 18 ○ Yes, it started age 18 or later → a. Age it started ☐☐ AGE	○ No ○ Yes	○ No ○ Yes ○ Don't know
150. Any kind of fruit	○ No	○ Yes, it started before age 18 ○ Yes, it started age 18 or later → a. Age it started ☐☐ AGE	○ No ○ Yes	○ No ○ Yes ○ Don't know
151. Wheat	○ No	○ Yes, it started before age 18 ○ Yes, it started age 18 or later → a. Age it started ☐☐ AGE	○ No ○ Yes	○ No ○ Yes ○ Don't know
152. Soy	○ No	○ Yes, it started before age 18 ○ Yes, it started age 18 or later → a. Age it started ☐☐ AGE	○ No ○ Yes	○ No ○ Yes ○ Don't know

Do you have, or have you **ever** had, an allergy to the following foods?	NO	YES	b. Have you eaten this item in the past year?	c. Are you still allergic to this food?
153. Rye	○ No	○ Yes, it started before age 18 ○ Yes, it started age 18 or later → a. Age it started ☐☐ AGE	○ No ○ Yes	○ No ○ Yes ○ Don't know
154. Vegetable(s)	○ No	○ Yes, it started before age 18 ○ Yes, it started age 18 or later → a. Age it started ☐☐ AGE	○ No ○ Yes	○ No ○ Yes ○ Don't know
155. Other food, specify: ☐	○ No	○ Yes, it started before age 18 ○ Yes, it started age 18 or later → a. Age it started ☐☐ AGE	○ No ○ Yes	○ No ○ Yes ○ Don't know

Please use a ballpoint pen for this form

156. Do you have lactose intolerance?

○ No
○ Don't know

GO TO NEXT PAGE, QUESTION 157

○ Yes

156a. Do you consume any type of dairy products on most days?
○ No
○ Yes

157. During the past month, did you eat any **hot or cold cereals?**

○ No → **GO TO NEXT PAGE, QUESTION 158**

○ Yes

157a. During the past month, how often did you eat **hot or cold cereals?** You can report per day, per week, or per month.

TIMES

○ Per day
○ Per week
○ Per month

157b. During the past month, what kind of cereal did you usually eat? *Please record the name using the enclosed card. If your cereal is not listed, please enter the cereal name.*

FIRST CEREAL

157c. Was there another cereal that you usually ate?

○ No → **GO TO NEXT PAGE, QUESTION 158**

○ Yes

157d. During the past month, what second kind of cereal did you usually eat? *Please record the name using the enclosed card. If your cereal is not listed, please enter the cereal name.*

SECOND CEREAL

158. During the past month, did you have any **milk** (either to drink or on cereal)? Include regular milks, chocolate or other flavored milks, lactose-free milk, buttermilk. Do **not** include soy milk or small amounts of milk in coffee or tea.

○ No
○ Don't know

GO TO NEXT PAGE, QUESTION 159

○ Yes

158a. During the past month, how often did you have any **milk** (either to drink or on cereal)? You can report per day, per week, or per month.

TIMES

○ Per day
○ Per week
○ Per month

158b. During the past month, what kind of milk did you usually drink? Pick one.

○ Whole or regular milk
○ Fat-free, skim, or non-fat milk
○ 2% fat or reduced-fat milk
○ Soy milk
○ 1%, ½%, or low-fat milk
○ Other, specify:

Please use a ballpoint pen for this form

Draft

During the past month, did you…		NO	YES	a. How often?
159.	drink any **regular soda or pop** that contains sugar? Do **not** include diet soda.	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month
160.	drink any **100% pure fruit juices** such as orange, mango, apple, grape and pineapple juices? Do **not** include fruit-flavored drinks with added sugar or fruit juice you made at home and added sugar to.	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month
161.	drink any **coffee or tea** that had **sugar or honey** added to it? Include coffee and tea you sweetened yourself and presweetened tea and coffee drinks such as Arizona Iced Tea and Frappuccino. Do **not** include artificially sweetened coffee or diet tea.	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month
162.	drink any **sweetened** fruit drinks, sports or energy drinks, such as Kool-aid, lemonade, Hi-C, cranberry drink, Gatorade, Red Bull, or Vitamin Water? Include fruit juices you made at home and added sugar to. Do **not** include diet drinks or artificially sweetened drinks.	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month
163.	eat any **fruit?** Include fresh, frozen, or canned fruit. Do **not** include juices.	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month
164.	eat a green leafy or lettuce **salad**, with or without other vegetables?	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month
165.	eat any kind of **fried potatoes** including french fries, home fries, or hash brown potatoes?	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month
166.	eat **any other kind of potatoes,** such as baked, boiled, mashed potatoes, sweet potatoes, or potato salad?	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month
167.	eat any **refried beans, baked beans, beans in soup, pork and beans or other cooked dried beans?** Do **not** include green beans.	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month
168.	eat any **brown rice** or other cooked whole grains, such as bulgur, cracked wheat, or millet? Do **not** include white rice.	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month

During the past month, did you…		NO	YES	a. How often?
169.	eat **any other vegetables?** Do **not** include green salads, potatoes, and cooked dried beans.	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month
170.	eat any Mexican-type **salsa** made with tomato?	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month
171.	eat any **pizza?** Include frozen pizza, fast food pizza, and homemade pizza.	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month
172.	have any **tomato sauces** such as with spaghetti or noodles or mixed into foods such as lasagna? Do **not** count tomato sauce on pizza.	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month
173.	eat any kind of **cheese?** Include cheese as a snack, cheese on burgers, sandwiches, and cheese in foods such as lasagna, quesadillas, or casseroles. Do **not** include cheese on pizza.	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month
174.	eat any **red meat,** such as beef, pork, ham, or sausage? Do **not** include chicken, turkey or seafood. Include red meat you had in sandwiches, lasagna, stew, and other mixtures. Red meats may also include veal, lamb, and any lunch meats made with these meats.	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month
175.	eat any **processed meat,** such as bacon, lunch meats, or hot dogs? Include processed meats you had in sandwiches, soups, pizza, casseroles, and other mixtures. Processed meats are those preserved by smoking, curing, or salting, or by the addition of preservatives. Examples are: ham, bacon, pastrami, salami, sausages, bratwursts, frankfurters, hot dogs, and spam.	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month
176.	eat any **whole grain bread** including toast, rolls and in sandwiches? Whole grain breads include whole wheat, rye, oatmeal and pumpernickel. Do **not** include white bread.	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month
177.	eat any **chocolate** or any other types of **candy?** Do **not** include sugar-free candy.	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month

Please use a ballpoint pen for this form

During the past month, did you…		NO	YES	a. How often?
178.	eat any **doughnuts,** sweet rolls, Danish, muffins, *pan dulce* or pop-tarts? Do **not** include sugar-free items.	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month
179.	eat any **cookies, cake, pie, or brownies?** Do **not** include sugar-free kinds.	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month
180.	eat any ice cream or other **frozen desserts?** Do **not** include sugar-free kinds.	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month
181.	eat any **popcorn?**	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month

Please check to see that all questions are answered.

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

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

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

The Sister Study

Quality of Life and Special Topics

Cereal Card

#

100% Bran

100% Low Fat Natural Granola

100% Natural Cereal

100% Natural Cereal, with oats, honey and raisins

100% Natural Granola, Oats & Honey

100% Natural Wholegrain Cereal with raisins, lowfat

A

All-Bran

All-Bran Bran Buds

All-Bran with Extra Fiber

Alpen

Alpha-Bits

Alpha-Bits with marshmallows

Amaranth Flakes

Apple Jacks

Apple Zaps

Apple Zings, Malt-O-Meal

B

Banana Nut Crunch Cereal

Barley

Basic 4

Berry Colossal Crunch, Malt-O-Meal

Blueberry Morning

Booberry

Bran

Bran Buds

Bran flakes

Bran, Nabisco

Branola

Brown Sugar Bliss

Buckwheat groats

Bulgur

C

Cap'n Crunch

Cap'n Crunch's Christmas Crunch

Cap'n Crunch's Crunch Berries

Cap'n Crunch's Oops! ChocoDonuts

Cap'n Crunch's Peanut Butter Crunch

Cheerios

Cheerios, Apple Cinnamon

Cheerios, Berry Burst

Cheerios, Berry Burst Strawberry

Cheerios, Berry Burst Triple Berry

Cheerios, Berry Burst, Cherry Vanilla

Cheerios, Berry Burst, Strawberry Banana

Cheerios, Frosted

Cheerios, Honey Nut

Cheerios, Multi Grain

Cheerios, Team

Cheerios, Yogurt Burst, Strawberry

Cheerios, Yogurt Burst, Vanilla

Cheese grits

Chex

Chex Morning Mix Banana Nut

Chex Morning Mix Cinnamon

Chex Morning Mix Fruit & Nut

Chex Morning Mix Honey Nut

Chex, Bran

Chex, Corn

Chex, Honey Nut

Chex, Multi-Bran

Chex, Rice

Chex, Wheat

Chocolate frosted cereal

Cinnamon Cluster Raisin Bran

Cinnamon Crunch Crispix

Cinnamon Grahams Cereal

Cinnamon Marshmallow Scooby Doo!

Cinnamon Toast Crunch

Cinnamon Toast Crunch, Reduced Sugar

Coco-Roos, Malt-O-Meal

Cocoa Blasts

Cocoa Comets

Cocoa Dyno Bites, Malt-O-Meal

Cocoa Krispies

Cocoa Pebbles

Cocoa Puffs

Cocoa Puffs, Reduced Sugar

Cocoa Wheats

Complete Bran Flakes

Complete Oat Bran Flakes

Complete Wheat Bran Flakes

Cookie-Crisp (all flavors)

Corn Bursts, Malt-O-Meal

Corn Flakes, Kellogg's

Corn Pops

Corn Puffs

Corn flakes

Corn flakes, low sodium

Cornmeal mush

Count Chocula

Cracklin' Oat Bran

Cranberry Almond Crunch Cereal

Cream of Rice

Cream of Rye

Cream of Wheat

Crisp Crunch

Crispix

Crispy Brown Rice Cereal

Crispy Rice

Crispy Rice, Malt-O-Meal

Crispy Wheats 'N Raisins

Crunchy Corn Bran

D

Disney Cereal

Disney Hunny B's

Disney Mickey's Magix

Disney Mud & Bugs

E

Ener-G Pure Rice Bran

F

Familia

Farina

Fiber 7 Flakes

Fiber One

Frankenberry

French Toast Crunch

Froot Loops

Frosted Flakes, Kellogg's

Frosted Flakes, Malt-O-Meal

Frosted Fruit Rings

Frosted Mini Spooners, Malt-O-Meal

Frosted Mini Wheats

Frosted Shredded Wheat

Frosted Wheat Bites

Frosted cereal, with marshmallows

Frosted corn flakes

Frosted flakes

Frosted rice

Frosty O's

Fruit & Fibre (fiber)

Fruit & Fibre (fiber) with Dates, Raisins and Walnuts

Fruit & Fibre (fiber) with Peaches, Raisins, Almonds, and Oat Clusters

Fruit Harvest

Fruit Harvest Apple Cinnamon

Fruit Harvest Strawberry Blueberry

Fruit Loops

Fruit Rings

Fruit Whirls

Fruit and Cream Oatmeal

Fruity Dyno Bites, Malt-O-Meal

Fruity Pebbles

G

Golden Crisp

Golden Grahams

Golden Puffs, Malt-O-Meal

Granola

Granola, homemade

Granola, lowfat

Granola, lowfat, Kellogg's

Granola, lowfat, with Raisins, Kellogg's

Grape Nut O's

Grape-Nuts

Grape-Nuts Flakes

Great Grains Crunchy Pecan Whole Grain Cereal

Great Grains, Raisins, Dates, and Pecans Whole Grain Cereal

Grits

H

Harina de maize con leche

Harmony Vanilla Almond Oats

Healthy Choice

Honey Bunches of Oat Honey Roasted

Honey Bunches of Oat with Strawberry

Honey Bunches of Oats

Honey Bunches of Oats with Almonds

Honey Buzzers, Malt-O-Meal

Honey Crisp Corn Flakes

Honey Crunch Corn Flakes

Honey Graham Squares, Malt-O-Meal

Honey Nut Clusters

Honey Nut Heaven

Honey Nut Shredded Wheat

Honey Smacks

Honeycomb

Honeycomb, strawberry

I

Instant Grits, all flavors

J

Jenny O's

Just Right

Just Right with Fruit & Nut

K

Kaboom

Kasha

Kashi

Kashi GOLEAN

Kashi Good Friends

Kashi Good Friends Cinna-Raisin Crunch

Kashi Heart to Heart Cereal

Kashi Honey Puffed

Kashi Medley

Kashi Organic Promise

Kashi Pilaf

Kashi Pillows

Kashi Seven in the Morning

Kashi, Puffed

Kix

Kix, Berry Berry

L

Life (plain and cinnamon)

Lucky Charms

Lucky Charms, Berry

Lucky Charms, Chocolate

M

Magic Stars

Malt-O-Meal

Malt-O-Meal, chocolate

Maltex

Marshmallow Mateys, Malt-O-Meal

Marshmallow Safari

Masa harina

Maypo

Millet

Millet, puffed

Mini-Wheats

Mini-Wheats Frosted Bite Size

Mini-Wheats Frosted Original

Mini-Wheats Frosted Raisin

Mini-Wheats Frosted Strawberry

Mother's Natural Foods Cereal, Quaker

Muesli

Muesli(x)

Multigrain Oatmeal

Multigrain cereal

N

Natural Bran Flakes

Nature Valley Granola

Nature Valley Granola, with fruit and nuts

Nesquik

Nestum

Nu System Cuisine Toasted Grain Circles

Nutri-Grain

Nutri-Grain Golden Wheat and Raisin

Nutty Nuggets

O

OS

Oat Bran Cereal, Quaker

Oat Bran Flakes, Health Valley

Oat bran cereal

Oat bran uncooked

Oat cereal

Oat flakes

Oatmeal

Oatmeal Crisp

Oatmeal Crisp with Almonds

Oatmeal Crisp, Apple Cinnamon

Oatmeal Crisp, Raisin

Oatmeal Squares

Oatmeal Swirlers

Oats, raw

Oh's

Oh's, Apple Cinnamon

Oh's, Fruitangy

Oh's, Honey Graham

Old Wessex Irish Style Oatmeal

Optimum Slim, Nature's Path

Optimum, Nature's Path

Oreo O's Cereal

P

Peanut Butter Toast Crunch

Polenta

Product 19

Puffed Rice, Malt-O-Meal

Puffed Wheat, Malt-O-Meal

Q

Quaker Dinosaur Eggs oatmeal

Quaker Fruit and Cream Oatmeal

Quaker Instant Grits, all flavors

Quaker Multigrain Oatmeal

Quaker Oatmeal Express

Quaker Oatmeal Nutrition for Women

Quaker Oatmeal Squares

Quisp

R

Raisin Bran Crunch

Raisin Bran, Kellogg's

Raisin Bran, Post

Raisin Nut Bran

Raisin bran

Reese's Peanut Butter Puffs

Rice Krispies

Rice Krispies, Frosted

Rice Krispies, Treats Cereal

Rice bran, uncooked

Rice cereal

Rice flakes

Rice polishings

Rice, puffed

Roman Meal

S

Seven-grain Cereal

Seven-grain cereal

Shredded Wheat

Shredded Wheat 'N Bran

Shredded Wheat Spoon Size

Shredded Wheat, 100%

Shredded Wheat, Original

Smacks

Smart Start

Smorz

Special K

Special K Fruit & Yogurt

Special K Low Carb Lifestyle Protein Plus

Special K Red Berries

Special K Vanilla Almond

Strawberry Squares

Sun Country 100% Natural Granola, with Almonds

Sweet Crunch

Sweet Puffs

T

Tasteeos

Toasted Cinnamon Twists, Malt-O-Meal

Toasted Oatmeal Cereal

Toasted Oatmeal, Honey Nut

Toasted oat cereal

Toasties

Toasty O's, Apple Cinnamon, Malt-O-Meal

Toasty O's, Honey and Nut, Malt-O-Meal

Toasty O's, Malt-O-Meal

Tony's Cinnamon Crunchers

Tootie Fruities, Malt-O-Meal

Total

Total Brown Sugar & Oats

Total Corn Flakes

Total Instant Oatmeal

Total Raisin Bran

Trix

Trix, Reduced Sugar

U

Uncle Sam's Hi Fiber Cereal

Under Cover Bears

W

Waffle Crisp

Weetabix Whole Wheat Cereal

Wheat Hearts

Wheat bran, unprocessed (miller's bran)

Wheat cereal

Wheat germ

Wheat germ, with sugar and honey

Wheat, puffed

Wheat, puffed, presweetened with sugar

Wheatena

Wheaties

Wheaties Energy Crunch

Wheaties Raisin Bran

Whole wheat cereal

Whole wheat, cracked

Z

Zoom

Contact Information Update Form

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

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

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

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

Name and Primary Address	**Update or Correction**
Name: «FirstName»	
«MiddleInitial»	
«LastName»	

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

Street Address: «Address1»	
«Address2»	
«City», «State»	,
«Zip»	-

If you have moved, what was the date of your move? OR,
If you are moving in 2-3 months, what date will you move? __ / __ / 2 0 __ __ (month) (day) (year)

Mailing Address: ☐ Same as street address

«Address1»	
«Address2»	
«City», «State»	,
«Zip»	-

Telephone Numbers We Can Use to Reach You:

Home phone: «HomePhoneNumber»	( ) -
Work phone: «WorkPhoneNumber» «WorkPhoneExt»	( ) - ext.
Cell phone: «OtherPhoneNumber»	( ) -

Email Address We Can Use to Reach You:

Email: «Email1» __ @ __ . __

PAGE ONE - PLEASE CONTINUE TO NEXT PAGE

ID#: SIS

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

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

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

First Contact — **Update / Correction / New Contact**

Name: «FirstName»
«LastName»

Relationship to you: «Relationship»

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

Phone Number: «PhoneNumber» ( ) -

What is the reason for the changes you made?

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

Second Contact — **Update / Correction / New Contact**

Name: «FirstName»
«LastName»

Relationship to you: «Relationship»

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

Phone Number: «PhoneNumber» ( ) -

What is the reason for the changes you made?

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

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

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