



# 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
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When writing dates, please follow this example.

EXAMPLE: June 7, 2011 = 

0	6
---	---

 / 

0	7
---	---

 / 

2	0	1	1
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(month) (day) (year)

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



Your continued participation in the Sister Study is completely voluntary and greatly appreciated. If you are not comfortable answering a question, just skip it and go 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?	<input type="radio"/>	<input type="radio"/>
b. been to a dentist for a routine check-up or cleaning?	<input type="radio"/>	<input type="radio"/>
c. had a Pap smear?	<input type="radio"/>	<input type="radio"/>
d. had a breast exam by a doctor or other health professional?	<input type="radio"/>	<input type="radio"/>
e. had a screening mammogram?	<input type="radio"/>	<input type="radio"/>
f. had a screening ultrasound of the breast?	<input type="radio"/>	<input type="radio"/>
g. had a screening MRI of the breast?	<input type="radio"/>	<input type="radio"/>
h. had a bone density scan or osteoporosis screening?	<input type="radio"/>	<input type="radio"/>
i. had a screening colonoscopy or sigmoidoscopy exam?	<input type="radio"/>	<input type="radio"/>
j. had an ultrasound of the uterus?	<input type="radio"/>	<input type="radio"/>



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



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

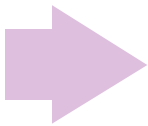
14. Since January 1, 2009, were **any** of your sisters diagnosed with breast cancer **for the first time**?

- 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



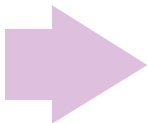
15a. What is/are the relative(s)' relationship to you?  
*(Please mark all that apply.)*

- 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.)*

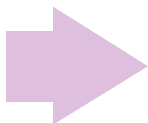
- Sister
- Mother
- Daughter
- Grandmother
- Other relative related to you by blood

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



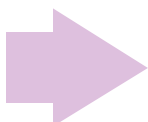
17a. What is/are the relative(s)' relationship to you?  
*(Please mark all that apply.)*

- 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



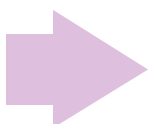
18a. What is/are the relative(s)' relationship to you?  
*(Please mark all that apply.)*

- 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.)*

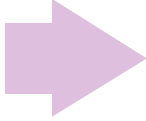
- Mother
- Father
- Sister
- Brother
- Daughter
- Son
- Other relative related to you by blood



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

No → GO TO QUESTION 21

Yes



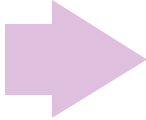
20a. What is/are the relative(s)' relationship to you?  
*(Please mark all that apply.)*

- 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

Please use a ballpoint pen for this form

## 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 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?
22. breast cancer? Please do <b>not</b> include in situ cancer.	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">             MONTH           </div> <div style="font-size: 2em; margin: 0 5px;">/</div> <div style="display: flex; gap: 5px;"> <div style="border: 1px solid black; padding: 2px;">2</div> <div style="border: 1px solid black; padding: 2px;">0</div> <div style="border: 1px solid black; padding: 2px;">             YEAR           </div> </div> </div>
23. ductal (breast) carcinoma in situ (DCIS)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">             MONTH           </div> <div style="font-size: 2em; margin: 0 5px;">/</div> <div style="display: flex; gap: 5px;"> <div style="border: 1px solid black; padding: 2px;">2</div> <div style="border: 1px solid black; padding: 2px;">0</div> <div style="border: 1px solid black; padding: 2px;">             YEAR           </div> </div> </div>
24. lobular (breast) carcinoma in situ (LCIS)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">             MONTH           </div> <div style="font-size: 2em; margin: 0 5px;">/</div> <div style="display: flex; gap: 5px;"> <div style="border: 1px solid black; padding: 2px;">2</div> <div style="border: 1px solid black; padding: 2px;">0</div> <div style="border: 1px solid black; padding: 2px;">             YEAR           </div> </div> </div>
25. lung cancer?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">             MONTH           </div> <div style="font-size: 2em; margin: 0 5px;">/</div> <div style="display: flex; gap: 5px;"> <div style="border: 1px solid black; padding: 2px;">2</div> <div style="border: 1px solid black; padding: 2px;">0</div> <div style="border: 1px solid black; padding: 2px;">             YEAR           </div> </div> </div>
26. ovarian cancer?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">             MONTH           </div> <div style="font-size: 2em; margin: 0 5px;">/</div> <div style="display: flex; gap: 5px;"> <div style="border: 1px solid black; padding: 2px;">2</div> <div style="border: 1px solid black; padding: 2px;">0</div> <div style="border: 1px solid black; padding: 2px;">             YEAR           </div> </div> </div>
27. cancer of the uterus or endometrium?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">             MONTH           </div> <div style="font-size: 2em; margin: 0 5px;">/</div> <div style="display: flex; gap: 5px;"> <div style="border: 1px solid black; padding: 2px;">2</div> <div style="border: 1px solid black; padding: 2px;">0</div> <div style="border: 1px solid black; padding: 2px;">             YEAR           </div> </div> </div>
28. cancer of the colon or rectum?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">             MONTH           </div> <div style="font-size: 2em; margin: 0 5px;">/</div> <div style="display: flex; gap: 5px;"> <div style="border: 1px solid black; padding: 2px;">2</div> <div style="border: 1px solid black; padding: 2px;">0</div> <div style="border: 1px solid black; padding: 2px;">             YEAR           </div> </div> </div>
29. Hodgkin's disease or Hodgkin's lymphoma?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">             MONTH           </div> <div style="font-size: 2em; margin: 0 5px;">/</div> <div style="display: flex; gap: 5px;"> <div style="border: 1px solid black; padding: 2px;">2</div> <div style="border: 1px solid black; padding: 2px;">0</div> <div style="border: 1px solid black; padding: 2px;">             YEAR           </div> </div> </div>
30. non-Hodgkin's lymphoma?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">             MONTH           </div> <div style="font-size: 2em; margin: 0 5px;">/</div> <div style="display: flex; gap: 5px;"> <div style="border: 1px solid black; padding: 2px;">2</div> <div style="border: 1px solid black; padding: 2px;">0</div> <div style="border: 1px solid black; padding: 2px;">             YEAR           </div> </div> </div>
31. leukemia?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">             MONTH           </div> <div style="font-size: 2em; margin: 0 5px;">/</div> <div style="display: flex; gap: 5px;"> <div style="border: 1px solid black; padding: 2px;">2</div> <div style="border: 1px solid black; padding: 2px;">0</div> <div style="border: 1px solid black; padding: 2px;">             YEAR           </div> </div> </div>





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?
32. malignant melanoma?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>
33. skin cancer (not malignant melanoma)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<p>a. MONTH/YEAR DIAGNOSED</p> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div> <p>b. Was it... (Please mark all that apply.)</p> <p><input type="radio"/> basal cell?</p> <p><input type="radio"/> squamous cell?</p> <p><input type="radio"/> other?</p>
34. any other type of cancer not already listed?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<p>a. MONTH/YEAR DIAGNOSED</p> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div> <p>b. Please specify what type of cancer:</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p>c. If you were diagnosed with a second <b>other</b> type of cancer January 1, 2009 or later, what month and year were you diagnosed?</p> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div> <p>d. Please specify what type of cancer:</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Please use a ballpoint pen for this form



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?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first</u> diagnosed <u>before</u> January 1, 2009 <input type="radio"/> Yes, <u>first</u> diagnosed January 1, 2009 or later → <div style="border: 1px solid black; padding: 5px; display: inline-block;">           a. What month and year were you diagnosed?  <div style="display: flex; align-items: center; gap: 10px;"> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px;"> </div> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px;"> </div> <span style="font-size: 1.5em;">/</span> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px; text-align: center;">2</div> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px; text-align: center;">0</div> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px;"> </div> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px;"> </div> </div> <div style="display: flex; justify-content: space-around; font-size: 0.8em;"> <span>MONTH</span> <span>YEAR</span> </div> </div>	<input type="radio"/> No <input type="radio"/> Yes
36. angina?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first</u> diagnosed <u>before</u> January 1, 2009 <input type="radio"/> Yes, <u>first</u> diagnosed January 1, 2009 or later → <div style="border: 1px solid black; padding: 5px; display: inline-block;">           a. What month and year were you diagnosed?  <div style="display: flex; align-items: center; gap: 10px;"> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px;"> </div> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px;"> </div> <span style="font-size: 1.5em;">/</span> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px; text-align: center;">2</div> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px; text-align: center;">0</div> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px;"> </div> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px;"> </div> </div> <div style="display: flex; justify-content: space-around; font-size: 0.8em;"> <span>MONTH</span> <span>YEAR</span> </div> </div>	<input type="radio"/> No <input type="radio"/> Yes
37. cardiac arrhythmia (irregular heartbeat)?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first</u> diagnosed <u>before</u> January 1, 2009 <input type="radio"/> Yes, <u>first</u> diagnosed January 1, 2009 or later → <div style="border: 1px solid black; padding: 5px; display: inline-block;">           a. What month and year were you diagnosed?  <div style="display: flex; align-items: center; gap: 10px;"> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px;"> </div> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px;"> </div> <span style="font-size: 1.5em;">/</span> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px; text-align: center;">2</div> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px; text-align: center;">0</div> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px;"> </div> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px;"> </div> </div> <div style="display: flex; justify-content: space-around; font-size: 0.8em;"> <span>MONTH</span> <span>YEAR</span> </div> </div>	<input type="radio"/> No <input type="radio"/> Yes
38. congestive heart failure?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first</u> diagnosed <u>before</u> January 1, 2009 <input type="radio"/> Yes, <u>first</u> diagnosed January 1, 2009 or later → <div style="border: 1px solid black; padding: 5px; display: inline-block;">           a. What month and year were you diagnosed?  <div style="display: flex; align-items: center; gap: 10px;"> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px;"> </div> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px;"> </div> <span style="font-size: 1.5em;">/</span> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px; text-align: center;">2</div> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px; text-align: center;">0</div> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px;"> </div> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px;"> </div> </div> <div style="display: flex; justify-content: space-around; font-size: 0.8em;"> <span>MONTH</span> <span>YEAR</span> </div> </div>	<input type="radio"/> No <input type="radio"/> 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?	<input type="radio"/> No	<input type="radio"/> Yes, my <u>first</u> heart attack was <u>before</u> January 1, 2009  <input type="radio"/> Yes, my <u>first</u> heart attack was January 1, 2009 or later ↓ <div style="border: 1px solid black; padding: 5px; margin: 5px 0;">           a. What month and year was your first heart attack?  <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-around; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div> </div>	<input type="radio"/> No  <input type="radio"/> Yes ↓ <div style="border: 1px solid black; padding: 5px; margin: 5px 0;">           c. What month and year was your most recent heart attack?  <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-around; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div> </div>
40. a stroke (this does not include TIA or "mini-stroke")?	<input type="radio"/> No	<input type="radio"/> Yes, my <u>first</u> stroke was <u>before</u> January 1, 2009  <input type="radio"/> Yes, my <u>first</u> stroke was January 1, 2009 or later ↓ <div style="border: 1px solid black; padding: 5px; margin: 5px 0;">           a. What month and year was your first stroke?  <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-around; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div> </div>	<input type="radio"/> No  <input type="radio"/> Yes ↓ <div style="border: 1px solid black; padding: 5px; margin: 5px 0;">           c. What month and year was your most recent stroke?  <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-around; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div> </div>
41. a mini-stroke or TIA (transient ischemic attack)?	<input type="radio"/> No	<input type="radio"/> Yes, my <u>first</u> mini-stroke was <u>before</u> January 1, 2009  <input type="radio"/> Yes, my <u>first</u> mini-stroke was January 1, 2009 or later ↓ <div style="border: 1px solid black; padding: 5px; margin: 5px 0;">           a. What month and year was your first mini-stroke?  <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-around; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div> </div>	<input type="radio"/> No  <input type="radio"/> Yes ↓ <div style="border: 1px solid black; padding: 5px; margin: 5px 0;">           c. What month and year was your most recent mini-stroke?  <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-around; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div> </div>

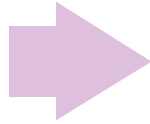
Please use a ballpoint pen for this form



Since January 1, 2009, have you had...	NEVER OR BEFORE 1/1/2009	1/1/2009 OR LATER	a. 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?	<input type="radio"/> Never <input type="radio"/> Before January 1, 2009	<input type="radio"/> January 1, 2009 or later	<input type="text"/> # TIMES	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
43. a wrist fracture?	<input type="radio"/> Never <input type="radio"/> Before January 1, 2009	<input type="radio"/> January 1, 2009 or later	<input type="text"/> # TIMES	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR

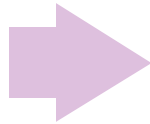
44. Since January 1, 2009, have you had any other broken bones?

- 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 YEAR

44b.   
FIRST BROKEN BONE

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

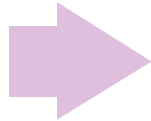
44d.   
SECOND BROKEN BONE

		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?	<input type="radio"/> No	<input type="radio"/> Yes <input type="text"/> # TIMES	<input type="text"/> <input type="text"/> AGE	<input type="text"/> <input type="text"/> AGE

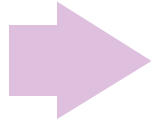


46. Since January 1, 2009, have you had any other major injury that required hospitalization?

- Never
- Yes, before January 1, 2009
- Yes, January 1, 2009 or later



**GO TO QUESTION 47**



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?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first</u> diagnosed <u>before</u> January 1, 2009 <input type="radio"/> Yes, <u>first</u> diagnosed January 1, 2009 or later →	<div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;">           a. What month and year were you diagnosed?  <input type="text"/> <input type="text"/> / 2 0 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>  <small>MONTH YEAR</small> </div> b. Do you still have this condition? <input type="radio"/> No <input type="radio"/> Yes  c. Do you currently take insulin for diabetes? <input type="radio"/> No → GO TO THE NEXT PAGE, QUESTION 48 <input type="radio"/> Yes  d. If yes, when did you <b>first</b> use insulin? <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>MONTH YEAR</small>



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?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first</u> diagnosed <u>before</u> January 1, 2009 <input type="radio"/> Yes, <u>first</u> diagnosed January 1, 2009 or later → a. What month and year were you diagnosed? <div style="border: 1px solid black; padding: 5px; display: inline-block;"> <table style="border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: none; padding: 0 5px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">2</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center; font-size: 8px;">MONTH</td> <td></td> <td colspan="4" style="text-align: center; font-size: 8px;">YEAR</td> </tr> </table> </div>			/	2	0			MONTH			YEAR				<input type="radio"/> No <input type="radio"/> Yes
		/	2	0													
MONTH			YEAR														
49. asthma?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first</u> diagnosed <u>before</u> January 1, 2009 <input type="radio"/> Yes, <u>first</u> diagnosed January 1, 2009 or later → a. What month and year were you diagnosed? <div style="border: 1px solid black; padding: 5px; display: inline-block;"> <table style="border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: none; padding: 0 5px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">2</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center; font-size: 8px;">MONTH</td> <td></td> <td colspan="4" style="text-align: center; font-size: 8px;">YEAR</td> </tr> </table> </div>			/	2	0			MONTH			YEAR				<input type="radio"/> No <input type="radio"/> Yes
		/	2	0													
MONTH			YEAR														
50. depression?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first</u> diagnosed <u>before</u> January 1, 2009 <input type="radio"/> Yes, <u>first</u> diagnosed January 1, 2009 or later → a. What month and year were you diagnosed? <div style="border: 1px solid black; padding: 5px; display: inline-block;"> <table style="border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: none; padding: 0 5px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">2</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center; font-size: 8px;">MONTH</td> <td></td> <td colspan="4" style="text-align: center; font-size: 8px;">YEAR</td> </tr> </table> </div>			/	2	0			MONTH			YEAR				<input type="radio"/> No <input type="radio"/> Yes
		/	2	0													
MONTH			YEAR														
51. periodontal (gum) disease?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first</u> diagnosed <u>before</u> January 1, 2009 <input type="radio"/> Yes, <u>first</u> diagnosed January 1, 2009 or later → a. What month and year were you diagnosed? <div style="border: 1px solid black; padding: 5px; display: inline-block;"> <table style="border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: none; padding: 0 5px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">2</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center; font-size: 8px;">MONTH</td> <td></td> <td colspan="4" style="text-align: center; font-size: 8px;">YEAR</td> </tr> </table> </div>			/	2	0			MONTH			YEAR				<input type="radio"/> No <input type="radio"/> Yes
		/	2	0													
MONTH			YEAR														



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?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> </div> <div style="display: flex; justify-content: space-between; width: 100%;"> <span>MONTH</span> <span>YEAR</span> </div>
53. emphysema?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> </div> <div style="display: flex; justify-content: space-between; width: 100%;"> <span>MONTH</span> <span>YEAR</span> </div>
54. chronic obstructive pulmonary disease (COPD)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> </div> <div style="display: flex; justify-content: space-between; width: 100%;"> <span>MONTH</span> <span>YEAR</span> </div>
55. Graves' disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> </div> <div style="display: flex; justify-content: space-between; width: 100%;"> <span>MONTH</span> <span>YEAR</span> </div>
56. other hyperthyroidism (overactive thyroid)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> </div> <div style="display: flex; justify-content: space-between; width: 100%;"> <span>MONTH</span> <span>YEAR</span> </div>
57. Hashimoto's thyroiditis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> </div> <div style="display: flex; justify-content: space-between; width: 100%;"> <span>MONTH</span> <span>YEAR</span> </div>
58. other hypothyroidism (underactive thyroid)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> </div> <div style="display: flex; justify-content: space-between; width: 100%;"> <span>MONTH</span> <span>YEAR</span> </div>
59. an enlarged thyroid or goiter?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> </div> <div style="display: flex; justify-content: space-between; width: 100%;"> <span>MONTH</span> <span>YEAR</span> </div>
60. thyroid nodules?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> </div> <div style="display: flex; justify-content: space-between; width: 100%;"> <span>MONTH</span> <span>YEAR</span> </div>
61. another thyroid problem? Please do <b>not</b> include thyroid cancer.	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> </div> <div style="display: flex; justify-content: space-between; width: 100%;"> <span>MONTH</span> <span>YEAR</span> </div> <p>b. Please specify the problem:</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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





<p>Has a doctor or other health professional ever told you that you had...</p>	<p>NO</p>	<p>YES</p>														
<p>74. migraine headaches?</p>	<p><input type="radio"/> No</p>	<p><input type="radio"/> Yes, <u>first</u> diagnosed <u>before</u> January 1, 2009</p> <p><input type="radio"/> Yes, <u>first</u> diagnosed January 1, 2009 or later →</p> <div data-bbox="1101 527 1474 737" style="border: 1px solid black; padding: 5px;"> <p>a. What month and year were you diagnosed?</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: none; text-align: center; padding: 0 5px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">2</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center; font-size: 8px;">MONTH</td> <td colspan="5" style="text-align: center; font-size: 8px;">YEAR</td> </tr> </table> </div> <p>b. Was the diagnosis of migraine made by a... (Please mark all that apply.)</p> <ul style="list-style-type: none"> <li><input type="radio"/> Headache specialist</li> <li><input type="radio"/> Neurologist</li> <li><input type="radio"/> Other physician</li> <li><input type="radio"/> Other health professional</li> </ul> <p>c. Which kind of migraines do you get?</p> <ul style="list-style-type: none"> <li><input type="radio"/> With visual aura</li> <li><input type="radio"/> Without visual aura</li> <li><input type="radio"/> Both types with similar frequency</li> </ul> <p>d. During the past 12 months, how often have you had a migraine?</p> <ul style="list-style-type: none"> <li><input type="radio"/> Never</li> <li><input type="radio"/> Monthly or less</li> <li><input type="radio"/> Biweekly</li> <li><input type="radio"/> Weekly</li> <li><input type="radio"/> Daily</li> </ul> <p>e. During the past 12 months, how long on average have your migraines usually lasted?</p> <ul style="list-style-type: none"> <li><input type="radio"/> A few hours or less</li> <li><input type="radio"/> About half a day</li> <li><input type="radio"/> A day</li> <li><input type="radio"/> Several days</li> <li><input type="radio"/> One week or longer</li> </ul>			/	2	0			MONTH		YEAR				
		/	2	0												
MONTH		YEAR														

Please use a ballpoint pen for this form

Has a doctor or other health professional told you that you had...	NEVER OR BEFORE 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?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/>              MONTH                      YEAR           </div>
76. polycystic ovarian syndrome or PCOS?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/>              MONTH                      YEAR           </div>
77. ovarian cysts?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/>              MONTH                      YEAR           </div>
78. endometriosis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/>              MONTH                      YEAR           </div>
79. uterine fibroids or fibroid tumors?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/>              MONTH                      YEAR           </div>
80. gallstones or gallbladder disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/>              MONTH                      YEAR           </div>
81. Parkinson's disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/>              MONTH                      YEAR           </div>
82. Alzheimer's disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/>              MONTH                      YEAR           </div>
83. mild cognitive impairment?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/>              MONTH                      YEAR           </div>
84. kidney failure requiring dialysis or transplant?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/>              MONTH                      YEAR           </div>
85. kidney stones?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/>              MONTH                      YEAR           </div>
86. other kidney disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/>              MONTH                      YEAR           </div>



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?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
88. cataracts?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
89. glaucoma?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
90. macular degeneration?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
91. hearing loss?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR

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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?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> YEAR
91c. deep vein thrombosis, DVT, or deep vein blood clots in your legs or somewhere else?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> YEAR



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

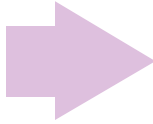
	No	Yes
a. swelling in your wrist, finger, elbow, or knee joints lasting six or more weeks?	<input type="radio"/>	<input type="radio"/>
b. joint stiffness in the mornings, lasting at least one hour, and for more than six weeks (do not include stiffness related or due to an injury or surgery)?	<input type="radio"/>	<input type="radio"/>
c. daily, persistent, troublesome dry eyes 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?	<input type="radio"/>	<input type="radio"/>
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?	<input type="radio"/>	<input type="radio"/>
e. a tremor or trembling in either of your hands?	<input type="radio"/>	<input type="radio"/>
f. walking or other movements getting noticeably slower?	<input type="radio"/>	<input type="radio"/>
g. handwriting getting noticeably smaller?	<input type="radio"/>	<input type="radio"/>
h. difficulty getting started when walking or making other movements?	<input type="radio"/>	<input type="radio"/>
i. wheezing or whistling in your chest?	<input type="radio"/>	<input type="radio"/>
j. shortness of breath when hurrying on level ground, or when walking up a slight hill, or when climbing a flight of stairs at your usual pace?	<input type="radio"/>	<input type="radio"/>
k. shortness of breath when at rest?	<input type="radio"/>	<input type="radio"/>
l. shortness of breath when lying down?	<input type="radio"/>	<input type="radio"/>
m. shortness of breath when walking?	<input type="radio"/>	<input type="radio"/>
n. swelling (or edema) in your legs?	<input type="radio"/>	<input type="radio"/>
o. excessive sweating other than due to menopause?	<input type="radio"/>	<input type="radio"/>
p. unexplained and unintentional weight loss of 10 or more pounds?	<input type="radio"/>	<input type="radio"/>



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?	<table border="1" style="margin: auto;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table> AGE		
93b.	Are there any reasons (such as head injury) that explain the decrease in your sense of smell?  <input type="radio"/> No <input type="radio"/> Yes, specify:  <div style="border: 1px solid black; height: 20px; width: 100%;"></div>			

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?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> 1 year <input type="radio"/> 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)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> 1 year <input type="radio"/> 2 or more years

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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

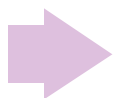
97g. Were you told this test showed any of the following? (Please mark all that apply.)  
 Breast cysts  
 Fibrocystic breasts  
 Breast calcifications  
 Dense breasts  
 Uneven or one-sided densities  
 Fibroadenoma  
 Other  
 Don't know



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

No → GO TO QUESTION 99

Yes

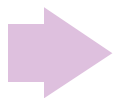


98a. On how many occasions have you had this since January 1, 2009?	<input type="text"/> <input type="text"/> # OCCASIONS
98b. What was the month and year of your most recent procedure?	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
98c. On which breast was the most recent cyst aspiration or removal performed?	<input type="radio"/> Left breast <input type="radio"/> Right breast <input type="radio"/> Both breasts
98d. Following the most recent procedure, what was the doctors' recommendation? Did they tell you to...	<input type="radio"/> Come back in 12 months or more for usual follow-up <input type="radio"/> Come back in 6-11 months <input type="radio"/> Come back in 3-5 months <input type="radio"/> Come back in less than 3 months <input type="radio"/> Have a breast biopsy, surgery, or other treatment <input type="radio"/> Don't know

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?	<input type="text"/> <input type="text"/> # OCCASIONS
99b. What was the month and year of your most recent procedure?	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
99c. On which breast was the most recent needle biopsy performed?	<input type="radio"/> Left breast <input type="radio"/> Right breast <input type="radio"/> Both breasts
99d. Following the most recent procedure, what was the doctors' recommendation? Did they tell you to...	<input type="radio"/> Come back in 12 months or more for usual follow-up <input type="radio"/> Come back in 6-11 months <input type="radio"/> Come back in 3-5 months <input type="radio"/> Come back in less than 3 months <input type="radio"/> Have a different type of breast biopsy, surgery, or other treatment <input type="radio"/> Don't know

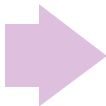
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100. Since January 1, 2009, have you had a surgical biopsy or a biopsy other than a needle biopsy to diagnose or rule out a breast condition?

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

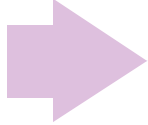




101. Since January 1, 2009, have you had a breast lump or lumps removed (lumpectomy or excisional biopsy)?

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?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2009	<input type="radio"/> Yes, January 1, 2009 or later	<input type="radio"/> To treat breast cancer <input type="radio"/> To prevent breast cancer <input type="radio"/> Both	<input type="text"/> <input type="text"/> / 2 0 <input type="text"/> <input type="text"/> MONTH YEAR
103. a mastectomy of your right breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2009	<input type="radio"/> Yes, January 1, 2009 or later	<input type="radio"/> To treat breast cancer <input type="radio"/> To prevent breast cancer <input type="radio"/> Both	<input type="text"/> <input type="text"/> / 2 0 <input type="text"/> <input type="text"/> MONTH YEAR



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.	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2009	<input type="radio"/> Yes, January 1, 2009 or later	<div style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/>              MONTH YEAR           </div>
105. fibroadenoma?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2009	<input type="radio"/> Yes, January 1, 2009 or later	<div style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/>              MONTH YEAR           </div> <p>b. What type?</p> <input type="radio"/> Simple fibroadenoma <input type="radio"/> Complex fibroadenoma <input type="radio"/> Both <input type="radio"/> Don't know
106. proliferation without atypia? For example, sclerosing adenosis, intraductal papilloma, moderate hyperplasia, suspicious calcifications, etc.	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2009	<input type="radio"/> Yes, January 1, 2009 or later	<div style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/>              MONTH YEAR           </div>
107. atypical hyperplasia?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2009	<input type="radio"/> Yes, January 1, 2009 or later	<div style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/>              MONTH YEAR           </div> <p>b. What type?</p> <input type="radio"/> Atypical ductal hyperplasia <input type="radio"/> Atypical lobular hyperplasia <input type="radio"/> Both <input type="radio"/> Don't know
108. ductal carcinoma in situ (DCIS)?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2009	<input type="radio"/> Yes, January 1, 2009 or later	<div style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/>              MONTH YEAR           </div>
109. lobular carcinoma in situ (LCIS)?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2009	<input type="radio"/> Yes, January 1, 2009 or later	<div style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/>              MONTH YEAR           </div>
110. breast cancer?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2009	<input type="radio"/> Yes, January 1, 2009 or later	<div style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/>              MONTH YEAR           </div>
111. other changes?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2009	<input type="radio"/> Yes, January 1, 2009 or later	<div style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/>              MONTH YEAR           </div>



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 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?
114. breast reduction surgery on your left breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2009	<input type="radio"/> Yes, January 1, 2009 or later	<div style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/>              MONTH                      YEAR           </div>
115. breast reduction surgery on your right breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2009	<input type="radio"/> Yes, January 1, 2009 or later	<div style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/>              MONTH                      YEAR           </div>

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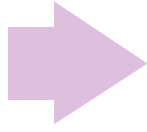
Since January 1, 2009, have you had...	NEVER OR BEFORE 1/1/2009	1/1/2009 OR LATER	a. If you had this procedure January 1, 2009 or later, what was the month and year?	b. Did you have a silicone gel implant?
116. breast reconstruction surgery on your left breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2009	<input type="radio"/> Yes, January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>	<input type="radio"/> No <input type="radio"/> Yes
117. breast reconstruction surgery on your right breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2009	<input type="radio"/> Yes, January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>	<input type="radio"/> No <input type="radio"/> Yes
118. breast enlargement surgery on your left breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2009	<input type="radio"/> Yes, January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>	<input type="radio"/> No <input type="radio"/> Yes
119. breast enlargement surgery on your right breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2009	<input type="radio"/> Yes, January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>	<input type="radio"/> No <input type="radio"/> 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?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2009	<input type="radio"/> Yes, January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>	<input type="radio"/> No <input type="radio"/> Yes
121. a breast implant surgically removed from your right breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2009	<input type="radio"/> Yes, January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>	<input type="radio"/> No <input type="radio"/> Yes



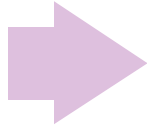
122. Since January 1, 2009, have you had any other major health condition?

- Never diagnosed
- Diagnosed before 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?

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

124e. What statement best describes you?

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

OR

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

GO TO PAGE 32,  
QUESTION 125

124f. 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:

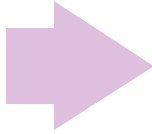
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REPRODUCTIVE HISTORY AND HORMONES

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

No → GO TO PAGE 34, QUESTION 132

Yes



125a. Are you currently pregnant?	<input type="radio"/> No <input type="radio"/> Yes
125b. How many times have you been pregnant since January 1, 2009 (including your current pregnancy, if you are pregnant now)?	<input type="text"/> # 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?	<input type="radio"/> Still pregnant now <input type="radio"/> Single live birth <input type="radio"/> Twins, live births <input type="radio"/> Other multiple live births → <input type="text"/> # BABIES <input type="radio"/> Stillbirth(s) <input type="radio"/> Miscarriage <input type="radio"/> Induced abortion <input type="radio"/> Molar or ectopic pregnancy	<input type="radio"/> Still pregnant now <input type="radio"/> Single live birth <input type="radio"/> Twins, live births <input type="radio"/> Other multiple live births → <input type="text"/> # BABIES <input type="radio"/> Stillbirth(s) <input type="radio"/> Miscarriage <input type="radio"/> Induced abortion <input type="radio"/> Molar or ectopic pregnancy
127. How many weeks did this pregnancy last (or has it lasted so far, if now pregnant)?	<input type="radio"/> Less than 8 weeks <input type="radio"/> 8 to 12 weeks <input type="radio"/> 13 to 16 weeks <input type="radio"/> 17 to 24 weeks <input type="radio"/> 25 to 36 weeks <input type="radio"/> 37 to 41 weeks <input type="radio"/> 42 weeks or more	<input type="radio"/> Less than 8 weeks <input type="radio"/> 8 to 12 weeks <input type="radio"/> 13 to 16 weeks <input type="radio"/> 17 to 24 weeks <input type="radio"/> 25 to 36 weeks <input type="radio"/> 37 to 41 weeks <input type="radio"/> 42 weeks or more
128. What month and year did this pregnancy end?	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> <input type="text"/> MONTH YEAR OR <input type="radio"/> Still pregnant now	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> <input type="text"/> MONTH YEAR OR <input type="radio"/> Still pregnant now
129. What was the sex of the baby or babies?	<input type="radio"/> Single male <input type="radio"/> Single female <input type="radio"/> Multiple → <input type="text"/> # MALES <input type="text"/> # FEMALES <input type="radio"/> Don't know	<input type="radio"/> Single male <input type="radio"/> Single female <input type="radio"/> Multiple → <input type="text"/> # MALES <input type="text"/> # FEMALES <input type="radio"/> Don't know
130. How long did you breastfeed (or have you been breastfeeding)?	<input type="radio"/> Less than one month <input type="radio"/> 1-3 months <input type="radio"/> 4-6 months <input type="radio"/> 7-12 months <input type="radio"/> 13-24 months <input type="radio"/> More than 24 months } GO TO 131 <input type="radio"/> Did not breastfeed/ not applicable → GO TO NEXT PREGNANCY OR QUESTION 132	<input type="radio"/> Less than one month <input type="radio"/> 1-3 months <input type="radio"/> 4-6 months <input type="radio"/> 7-12 months <input type="radio"/> 13-24 months <input type="radio"/> More than 24 months } GO TO 131 <input type="radio"/> Did not breastfeed/ not applicable → GO TO NEXT PREGNANCY OR QUESTION 132
131. Are you still breastfeeding?	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes

Please use a ballpoint pen for this form

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.



132. Since January 1, 2009, have you used any hormonal birth control?

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?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
134. birth control patches?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
135. a hormonal IUD (intrauterine device)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
136. a Norplant implant?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
137. a Nuva Ring?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
138. Depo Provera?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
139. any other hormonal birth control?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> 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 any fertility medications?

No → GO TO QUESTION 145

Yes



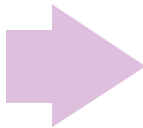
Since January 1, 2009, have you taken...	NO	YES	a. If yes, how many months or menstrual cycles in all have you used this since January 1, 2009?
143. Clomiphene, Clomid, or Serophene?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS/CYCLES
144. drugs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

Please use a ballpoint pen for this form

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



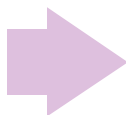
145a. How many times?	<input type="text"/> <input type="text"/> # TIMES
145b. When did the first such pregnancy end?	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH DAY YEAR
145c. When did the last such pregnancy end?	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH DAY YEAR



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

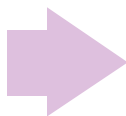


146a. How many times?	<input type="text"/> <input type="text"/>
	# TIMES
146b. When did the first such pregnancy end?	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	MONTH DAY YEAR
146c. When did the last such pregnancy end?	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	MONTH DAY YEAR

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?	<input type="text"/> <input type="text"/>
	# TIMES
147b. What was the month and year of your most recent mastitis?	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	MONTH YEAR
147c. Were you ever given antibiotics to treat mastitis?	<input type="radio"/> No <input type="radio"/> Yes
147d. Were you ever given pain medication to treat mastitis?	<input type="radio"/> No <input type="radio"/> Yes
147e. Did you ever stop breastfeeding sooner than planned because of mastitis?	<input type="radio"/> No <input type="radio"/> 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)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
149.	an estrogen-only pill (such as Premarin) with no additional progesterone in any form?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
150.	an estrogen pill (such as Premarin) <b>and</b> a separate progesterone pill (such as Provera) or progesterone shot?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
151.	an estrogen-only patch with no additional progesterone in any form?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
152.	a patch containing both estrogen and progesterone (such as Combipatch)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
153.	an estrogen-only patch <b>and</b> a separate progesterone pill or progesterone shot?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
154.	progesterone alone (not for birth control)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes

Please use a ballpoint pen for this form



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



Since 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?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
158.	raloxifene or Evista?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
159.	Herceptin?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
<b>Aromatase inhibitors:</b>					
160a.	anastrozole or Arimidex?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
160b.	exemestane or Aromasin?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
160c.	letrozole or Femara?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
160d.	other aromatase inhibitor? Please specify: <input type="text"/>	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
161.	testosterone supplements?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
162.	Estratest?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes

Please use a ballpoint pen for this form

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)?	<input type="radio"/> Never had procedure <input type="radio"/> Had procedure <u>before</u> January 1, 2009	<input type="radio"/> Had procedure January 1, 2009 or later	a. MONTH/YEAR HAD PROCEDURE <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-around; width: 100%; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div> b. Did you have all or part of either of your ovaries removed at the same time you had the hysterectomy? <input type="radio"/> No → GO TO QUESTION 164 <input type="radio"/> Yes c. Did you have... <input type="radio"/> both ovaries completely removed? <input type="radio"/> one ovary and part of the other ovary removed? <input type="radio"/> one ovary removed? <input type="radio"/> part of one or part of both ovaries removed? d. Did you have all or part of either ovary left after this surgery? <input type="radio"/> No <input type="radio"/> Yes
164. a separate surgery to remove part or all of one or both ovaries (but not your uterus)?	<input type="radio"/> Never had procedure <input type="radio"/> Had procedure <u>before</u> January 1, 2009	<input type="radio"/> Had procedure January 1, 2009 or later	a. MONTH/YEAR HAD PROCEDURE <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-around; width: 100%; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div> b. Did you have... <input type="radio"/> both ovaries completely removed? <input type="radio"/> one ovary and part of the other ovary removed? <input type="radio"/> one ovary removed? <input type="radio"/> part of one or part of both ovaries removed? c. Did you have all or part of either ovary left after this surgery? <input type="radio"/> No <input type="radio"/> Yes





## 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	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe  How often did/do these occur in a typical week? <input type="radio"/> 1 time or less <input type="radio"/> 2-3 times <input type="radio"/> 4 or more times <input type="radio"/> Don't know  For about how many total months or years did you have hot flashes? <input type="radio"/> Less than 3 months <input type="radio"/> 3 to less than 6 months <input type="radio"/> 6 months to less than 1 year <input type="radio"/> 1 to less than 2 years <input type="radio"/> 2 to less than 3 years <input type="radio"/> 3 or more years	<input type="radio"/> No <input type="radio"/> Yes
166.	Night sweats	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> No <input type="radio"/> Yes
167.	Other excessive sweating	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> No <input type="radio"/> Yes
168.	Vaginal dryness	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> No <input type="radio"/> Yes
169.	Pain with intercourse	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> No <input type="radio"/> Yes
170.	Irregular menstrual bleeding	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> No <input type="radio"/> Yes

Please use a ballpoint pen for this form

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	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> No <input type="radio"/> Yes
172.	Depression, anxiety, or emotional distress	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> No <input type="radio"/> Yes
173.	Insomnia	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> No <input type="radio"/> 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?	<input type="radio"/> Never had procedure <input type="radio"/> Had procedure <u>before</u> January 1, 2009	<input type="radio"/> Had procedure January 1, 2009 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> <input type="text"/> MONTH YEAR
175. angioplasty or coronary artery stent?	<input type="radio"/> Never had procedure <input type="radio"/> Had procedure <u>before</u> January 1, 2009	<input type="radio"/> Had procedure January 1, 2009 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> <input type="text"/> MONTH YEAR
176. coronary artery bypass graft surgery?	<input type="radio"/> Never had procedure <input type="radio"/> Had procedure <u>before</u> January 1, 2009	<input type="radio"/> Had procedure January 1, 2009 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> <input type="text"/> 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)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
178. high cholesterol?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> 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)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
180.	congestive heart failure?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
181.	diabetes?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
182.	thyroid disease?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
183.	osteoporosis (bone loss, or bone thinning)? Do not count calcium or vitamin D.	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
184.	rheumatoid arthritis?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
185.	osteoarthritis?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
186.	migraines?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
187.	depression?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
188.	asthma?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
189.	Parkinson's disease?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
190.	anxiety?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> 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)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 12 months <input type="radio"/> 1 year <input type="radio"/> 2 years	<input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> More than 4 years
192.	"baby aspirin" or low-dose aspirin (100mg/tablet or less)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 12 months <input type="radio"/> 1 year <input type="radio"/> 2 years	<input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> More than 4 years
193.	aspirin or other aspirin containing products (325 mg/tablet or more)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 12 months <input type="radio"/> 1 year <input type="radio"/> 2 years	<input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> More than 4 years
194.	ibuprofen (such as Advil, Motrin, Nuprin, etc.)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 12 months <input type="radio"/> 1 year <input type="radio"/> 2 years	<input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> More than 4 years
195.	Celebrex or other COX-2 inhibitors?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 12 months <input type="radio"/> 1 year <input type="radio"/> 2 years	<input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> More than 4 years
196.	Aleve or Naprosyn?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 12 months <input type="radio"/> 1 year <input type="radio"/> 2 years	<input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> More than 4 years
197.	Relafen, Ketoprofen, Anaprox, or other non-steroidal anti-inflammatories?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 12 months <input type="radio"/> 1 year <input type="radio"/> 2 years	<input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> More than 4 years
198.	antibiotics?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 12 months <input type="radio"/> 1 year <input type="radio"/> 2 years	<input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> More than 4 years



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



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



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







c. How often do you take it?	d. On days when you take it, how many times do you take it?	e. In what form did you take this? <i>(Please mark all that apply.)</i>	
<input type="radio"/> Once a month or less <input type="radio"/> Less than once a week <input type="radio"/> Once a week <input type="radio"/> 2-3 days a week <input type="radio"/> 4-5 days a week <input type="radio"/> 6-7 days a week	<input type="radio"/> 1 time per day <input type="radio"/> 2 times per day <input type="radio"/> 3 times per day <input type="radio"/> 4 times per day <input type="radio"/> 5 or more times per day	<input type="radio"/> Pill <input type="radio"/> Inhaler <input type="radio"/> Cream <input type="radio"/> Liquid	<input type="radio"/> Patch <input type="radio"/> Spray <input type="radio"/> Shot <input type="radio"/> Other
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<input type="radio"/> Once a month or less <input type="radio"/> Less than once a week <input type="radio"/> Once a week <input type="radio"/> 2-3 days a week <input type="radio"/> 4-5 days a week <input type="radio"/> 6-7 days a week	<input type="radio"/> 1 time per day <input type="radio"/> 2 times per day <input type="radio"/> 3 times per day <input type="radio"/> 4 times per day <input type="radio"/> 5 or more times per day	<input type="radio"/> Pill <input type="radio"/> Inhaler <input type="radio"/> Cream <input type="radio"/> Liquid	<input type="radio"/> Patch <input type="radio"/> Spray <input type="radio"/> Shot <input type="radio"/> Other
<input type="radio"/> Once a month or less <input type="radio"/> Less than once a week <input type="radio"/> Once a week <input type="radio"/> 2-3 days a week <input type="radio"/> 4-5 days a week <input type="radio"/> 6-7 days a week	<input type="radio"/> 1 time per day <input type="radio"/> 2 times per day <input type="radio"/> 3 times per day <input type="radio"/> 4 times per day <input type="radio"/> 5 or more times per day	<input type="radio"/> Pill <input type="radio"/> Inhaler <input type="radio"/> Cream <input type="radio"/> Liquid	<input type="radio"/> Patch <input type="radio"/> Spray <input type="radio"/> Shot <input type="radio"/> Other
<input type="radio"/> Once a month or less <input type="radio"/> Less than once a week <input type="radio"/> Once a week <input type="radio"/> 2-3 days a week <input type="radio"/> 4-5 days a week <input type="radio"/> 6-7 days a week	<input type="radio"/> 1 time per day <input type="radio"/> 2 times per day <input type="radio"/> 3 times per day <input type="radio"/> 4 times per day <input type="radio"/> 5 or more times per day	<input type="radio"/> Pill <input type="radio"/> Inhaler <input type="radio"/> Cream <input type="radio"/> Liquid	<input type="radio"/> Patch <input type="radio"/> Spray <input type="radio"/> Shot <input type="radio"/> Other
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Please check to see that all questions are answered.

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

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

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

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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.

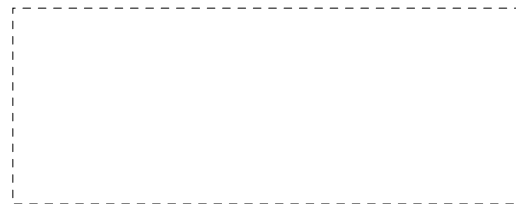
*Thank you!*







# 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
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 / 

0	7
---	---

 / 

2	0	1	1
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(month) (day) (year)

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

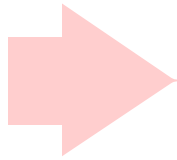


Your continued participation in the Sister Study is completely voluntary and greatly appreciated. If you are not comfortable answering a question, just skip it and go to the next one. All information you share will be kept confidential.

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

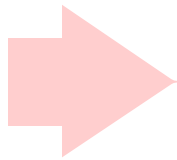
1. Which of the following best describes your current marital status?

- 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

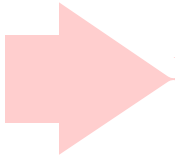
Draft



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?	<input type="radio"/> Before 2009 <input type="radio"/> 2009 <input type="radio"/> 2010 <input type="radio"/> 2011 <input type="radio"/> 2012 <input type="radio"/> 2013			
4b.	When did you last smoke cigarettes?	<input type="radio"/> I am a current smoker <input type="radio"/> I last smoked in 2013 <input type="radio"/> I last smoked in 2012 <input type="radio"/> I last smoked in 2011 <input type="radio"/> I last smoked in 2010 <input type="radio"/> I last smoked in 2009			
4c.	During the years you smoked since January 1, 2009, how many days per week do/did you smoke?	<input type="radio"/> Less than one day per week <input type="radio"/> 1-3 days per week <input type="radio"/> 4-6 days per week <input type="radio"/> Every day			
4d.	During the years you smoked since January 1, 2009, how many cigarettes do/did you usually smoke per day on the days that you smoked?	<table border="1"><tr><td> </td><td> </td><td> </td></tr></table> # CIGARETTES			

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

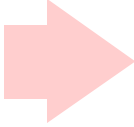
Since January 1, 2009...		NO	YES	a. IF YES, in which years since January 1, 2009 did you drink alcohol? (Please mark all that apply.)	b. About how often did you drink alcohol?	c. On average, how many drinks did you have on the days that you drank alcohol?
7.	have you drunk beer or other malt beverages?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> 2009 <input type="radio"/> 2010 <input type="radio"/> 2011 <input type="radio"/> 2012 <input type="radio"/> 2013	<input type="radio"/> Every day <input type="radio"/> 5-6 times per week <input type="radio"/> 3-4 times per week <input type="radio"/> 2 times per week <input type="radio"/> Once per week <input type="radio"/> 2-3 times per month <input type="radio"/> Once per month <input type="radio"/> A few times per year	<input type="radio"/> 7 or more <input type="radio"/> 6 <input type="radio"/> 5 <input type="radio"/> 4 <input type="radio"/> 3 <input type="radio"/> 2 <input type="radio"/> 1
8.	have you drunk white wine or white wine coolers?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> 2009 <input type="radio"/> 2010 <input type="radio"/> 2011 <input type="radio"/> 2012 <input type="radio"/> 2013	<input type="radio"/> Every day <input type="radio"/> 5-6 times per week <input type="radio"/> 3-4 times per week <input type="radio"/> 2 times per week <input type="radio"/> Once per week <input type="radio"/> 2-3 times per month <input type="radio"/> Once per month <input type="radio"/> A few times per year	<input type="radio"/> 7 or more <input type="radio"/> 6 <input type="radio"/> 5 <input type="radio"/> 4 <input type="radio"/> 3 <input type="radio"/> 2 <input type="radio"/> 1
9.	have you drunk red wine or red wine coolers?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> 2009 <input type="radio"/> 2010 <input type="radio"/> 2011 <input type="radio"/> 2012 <input type="radio"/> 2013	<input type="radio"/> Every day <input type="radio"/> 5-6 times per week <input type="radio"/> 3-4 times per week <input type="radio"/> 2 times per week <input type="radio"/> Once per week <input type="radio"/> 2-3 times per month <input type="radio"/> Once per month <input type="radio"/> A few times per year	<input type="radio"/> 7 or more <input type="radio"/> 6 <input type="radio"/> 5 <input type="radio"/> 4 <input type="radio"/> 3 <input type="radio"/> 2 <input type="radio"/> 1
10.	have you drunk liquor?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> 2009 <input type="radio"/> 2010 <input type="radio"/> 2011 <input type="radio"/> 2012 <input type="radio"/> 2013	<input type="radio"/> Every day <input type="radio"/> 5-6 times per week <input type="radio"/> 3-4 times per week <input type="radio"/> 2 times per week <input type="radio"/> Once per week <input type="radio"/> 2-3 times per month <input type="radio"/> Once per month <input type="radio"/> A few times per year	<input type="radio"/> 7 or more <input type="radio"/> 6 <input type="radio"/> 5 <input type="radio"/> 4 <input type="radio"/> 3 <input type="radio"/> 2 <input type="radio"/> 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 <b>vigorous</b> physical activities? These take hard physical effort and make you breathe much harder than normal, for example running or swimming at a fast pace. Think only about activities that you did for at least 10 minutes at a time.	<input type="text"/> → # DAYS OR <input type="radio"/> No vigorous physical activity  <input type="text"/> AND <input type="text"/> HOURS PER DAY MINUTES PER DAY (up to 59) <input type="radio"/> Not sure
14. do <b>moderate</b> physical activities? These take moderate physical effort and make you breathe somewhat harder than normal, for example dancing or doing yard work. Think only about those physical activities that you did for at least 10 minutes at a time. Do not include walking.	<input type="text"/> → # DAYS OR <input type="radio"/> No moderate physical activity  <input type="text"/> AND <input type="text"/> HOURS PER DAY MINUTES PER DAY (up to 59) <input type="radio"/> Not sure
15. <b>walk</b> for at least 10 minutes at a time? This includes walking at work and at home, walking to travel from place to place, and any other walking you might do solely for recreation, sport, exercise, or leisure.	<input type="text"/> → # DAYS OR <input type="radio"/> No walking for at least 10 mins  <input type="text"/> AND <input type="text"/> HOURS PER DAY MINUTES PER DAY (up to 59) <input type="radio"/> Not sure

During the past 7 days, how much time did you...	
16. usually spend <b>sitting</b> on a <b>weekday</b> ? 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.	<input type="text"/> AND <input type="text"/> HOURS PER DAY MINUTES PER DAY (up to 59) <input type="radio"/> Not sure
17. usually spend <b>standing</b> on a <b>weekday</b> ? This includes standing while at work, at home, and during leisure time.	<input type="text"/> AND <input type="text"/> HOURS PER DAY MINUTES PER DAY (up to 59) <input type="radio"/> Not sure

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

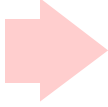
- Less than usual
- About the same
- More than usual



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

No → GO TO QUESTION 20

Yes



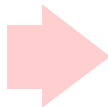
19a. How many times per week?	<input type="radio"/> Less than 1 <input type="radio"/> 1-2 times <input type="radio"/> 3-4 times <input type="radio"/> 5 or more times
19b. On average, how many minutes per time?	<input type="radio"/> Less than 15 minutes <input type="radio"/> 15-30 minutes <input type="radio"/>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

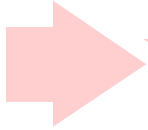
21. Since January 1, 2009, have you done any of the following **hobbies** at least 5 hours per week for at least 6 weeks? *(Please mark all that apply.)*

- 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. on weekend or vacation days in the summer?

- Less than 1 hour per day
- 1-2 hours per day
- 3-4 hours per day
- 5-8 hours per day
- 9-12 hours per day
- More than 12 hours per day

- Never
- Rarely
- Sometimes
- Usually
- Always

27. on other days in the summer?

- Less than 1 hour per day
- 1-2 hours per day
- 3-4 hours per day
- 5-8 hours per day
- 9-12 hours per day
- More than 12 hours per day

- Never
- Rarely
- Sometimes
- Usually
- Always

28. on weekend or vacation days the rest of the year?

- Less than 1 hour per day
- 1-2 hours per day
- 3-4 hours per day
- 5-8 hours per day
- 9-12 hours per day
- More than 12 hours per day

- Never
- Rarely
- Sometimes
- Usually
- Always

29. on other days the rest of the year?

- Less than 1 hour per day
- 1-2 hours per day
- 3-4 hours per day
- 5-8 hours per day
- 9-12 hours per day
- More than 12 hours per day

- Never
- Rarely
- Sometimes
- Usually
- Always

Please use a ballpoint pen for this form

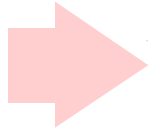




33. Since January 1, 2009, about how often has your residence been treated with insecticides or pesticides to control insects, rodents, or other pests, either inside or around the foundation?

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

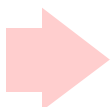
35. Since January 1, 2009, about how often have you used household cleaning solutions other than dish washing and laundry detergents?

- 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?

	<u>None</u>	<u>1</u>	<u>2</u>	<u>3-4</u>	<u>5 or more</u>
36a. Dogs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
36b. Birds	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
36c. Cats	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
36d. Other furry animals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



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



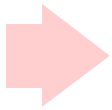
37a. What types of air fresheners do you use at home? *(Please mark all that apply.)*

- 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



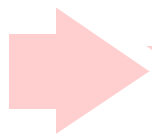
38a. What types of air fresheners do you use in your car? *(Please mark all that apply.)*

- 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

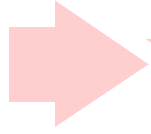
Please use a ballpoint pen for this form



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



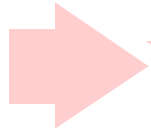
40a. What is the traffic condition that best describes your travel time by bicycle or motorcycle on most days?

- 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

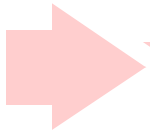


41a. What is the traffic condition that best describes your travel time by foot on most days?

- 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?	<input type="radio"/> Before 2009 <input type="radio"/> 2009 <input type="radio"/> 2010 <input type="radio"/> 2011 <input type="radio"/> 2012 <input type="radio"/> 2013	<input type="radio"/> Before 2009 <input type="radio"/> 2009 <input type="radio"/> 2010 <input type="radio"/> 2011 <input type="radio"/> 2012 <input type="radio"/> 2013								
45. When did you last have this job?	<input type="radio"/> 2009 <input type="radio"/> 2010 <input type="radio"/> 2011 <input type="radio"/> 2012 <input type="radio"/> 2013 <input type="radio"/> I still work there	<input type="radio"/> 2009 <input type="radio"/> 2010 <input type="radio"/> 2011 <input type="radio"/> 2012 <input type="radio"/> 2013 <input type="radio"/> 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.  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.	<div style="border: 1px solid black; height: 30px; margin-bottom: 5px;"></div> NAME OF COMPANY/PLACE OF WORK <div style="border: 1px solid black; height: 30px; margin-bottom: 5px;"></div> STREET # <div style="border: 1px solid black; height: 30px; margin-bottom: 5px;"></div> STREET NAME <div style="border: 1px solid black; height: 30px; margin-bottom: 5px;"></div> APT # <div style="border: 1px solid black; height: 30px; margin-bottom: 5px;"></div> CITY OR TOWN <table style="width: 100%; border: none;"> <tr> <td style="border: 1px solid black; width: 30px; height: 20px; margin-right: 10px;"></td> <td style="border: 1px solid black; width: 150px; height: 20px;"></td> </tr> <tr> <td style="text-align: center;">STATE</td> <td style="text-align: center;">ZIP CODE</td> </tr> </table> <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div> COUNTY			STATE	ZIP CODE	<div style="border: 1px solid black; height: 30px; margin-bottom: 5px;"></div> NAME OF COMPANY/PLACE OF WORK <div style="border: 1px solid black; height: 30px; margin-bottom: 5px;"></div> STREET # <div style="border: 1px solid black; height: 30px; margin-bottom: 5px;"></div> STREET NAME <div style="border: 1px solid black; height: 30px; margin-bottom: 5px;"></div> APT # <div style="border: 1px solid black; height: 30px; margin-bottom: 5px;"></div> CITY OR TOWN <table style="width: 100%; border: none;"> <tr> <td style="border: 1px solid black; width: 30px; height: 20px; margin-right: 10px;"></td> <td style="border: 1px solid black; width: 150px; height: 20px;"></td> </tr> <tr> <td style="text-align: center;">STATE</td> <td style="text-align: center;">ZIP CODE</td> </tr> </table> <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div> COUNTY			STATE	ZIP CODE
STATE	ZIP CODE									
STATE	ZIP CODE									

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.

Draft



	JOB 1	JOB 2
47. On a scale from 1 to 5, how <b>physically demanding</b> was this job?	<input type="radio"/> 1 Not demanding <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 Extremely demanding	<input type="radio"/> 1 Not demanding <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 Extremely demanding
48. On a scale from 1 to 5, how <b>emotionally demanding</b> was this job?	<input type="radio"/> 1 Not demanding <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 Extremely demanding	<input type="radio"/> 1 Not demanding <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 Extremely demanding
49. What was/is your job title?	<div style="border: 1px solid black; height: 30px; width: 100%;"></div> JOB TITLE	<div style="border: 1px solid black; height: 30px; width: 100%;"></div> JOB TITLE
50. What type of company or organization do/did you work for? (What do they make or what services do they provide?)	<div style="border: 1px solid black; height: 80px; width: 100%;"></div> INDUSTRY	<div style="border: 1px solid black; height: 80px; width: 100%;"></div> INDUSTRY
51. What are the specific tasks that you usually do/did in your job?	<div style="border: 1px solid black; height: 150px; width: 100%;"></div> JOB DUTIES	<div style="border: 1px solid black; height: 150px; width: 100%;"></div> JOB DUTIES



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)*

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

AM  
 PM

START TIME: *(mark one)*

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

AM  
 PM

STOP TIME: *(mark one)*

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

AM  
 PM

STOP TIME: *(mark one)*

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

AM  
 PM

OR

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

OR

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

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?	<input type="radio"/>	<input type="radio"/>	a. work in dusty conditions?	<input type="radio"/>	<input type="radio"/>
		b. breathe in chemical vapors or fumes?	<input type="radio"/>	<input type="radio"/>	b. breathe in chemical vapors or fumes?	<input type="radio"/>	<input type="radio"/>
		c. get chemicals or oils on your skin or clothing?	<input type="radio"/>	<input type="radio"/>	c. get chemicals or oils on your skin or clothing?	<input type="radio"/>	<input type="radio"/>
		d. come in contact with solvents or degreasers?	<input type="radio"/>	<input type="radio"/>	d. come in contact with solvents or degreasers?	<input type="radio"/>	<input type="radio"/>
		e. come in contact with metal chips, dust, or fumes?	<input type="radio"/>	<input type="radio"/>	e. come in contact with metal chips, dust, or fumes?	<input type="radio"/>	<input type="radio"/>
		f. come in contact with pesticides?	<input type="radio"/>	<input type="radio"/>	f. come in contact with pesticides?	<input type="radio"/>	<input type="radio"/>
		g. use cleaning solutions (not counting dish or laundry detergents)?	<input type="radio"/>	<input type="radio"/>	g. use cleaning solutions (not counting dish or laundry detergents)?	<input type="radio"/>	<input type="radio"/>
		h. travel in a vehicle?	<input type="radio"/>	<input type="radio"/>	h. travel in a vehicle?	<input type="radio"/>	<input type="radio"/>

Please check to see that all questions are answered.

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

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

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







# The Sister Study 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)

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



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

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...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. In general, would you say your quality of life is...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. In general, how would you rate your physical health?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. In general, how would you rate your mental health, including your mood and your ability to think?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. In general, how would you rate your satisfaction with your social activities and relationships?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. felt confident about your ability to handle your personal problems?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. felt that things were going your way?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. felt difficulties were piling up so high that you could not overcome them?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



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).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. I can count on someone if I need help (for example, to take me to the doctor or help with daily chores if I am sick).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. There is someone in my immediate family who believes in me and wants me to succeed.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. There is someone in my immediate family who makes me feel important or special.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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)?

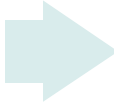
- None
- 1-2
- 3-5
- 6-9
- 10 or more



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

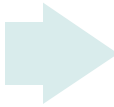


14a. How stressful would you say it is to provide care for these children or grandchildren?	<input type="radio"/> Not at all <input type="radio"/> A little <input type="radio"/> A moderate amount <input type="radio"/> A lot
14b. During the <b>past 12 months</b> , for whom did you provide such care? <i>(Please mark all that apply.)</i>	<input type="radio"/> My children <input type="radio"/> My grandchildren <input type="radio"/> Other children

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?	<input type="radio"/> Not at all <input type="radio"/> A little <input type="radio"/> A moderate amount <input type="radio"/> A lot
15b. During the <b>past 12 months</b> , for whom did you provide such care? <i>(Please mark all that apply.)</i>	<input type="radio"/> Parent <input type="radio"/> Child <input type="radio"/> Sibling <input type="radio"/> Spouse <input type="radio"/> Partner <input type="radio"/> Other relative <input type="radio"/> 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.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. I had trouble keeping my mind on what I was doing.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. I felt depressed.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. I felt that everything I did was an effort.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. I felt hopeful about the future.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. I felt fearful.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. My sleep was restless.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. I was happy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. I felt lonely.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. I could not "get going."	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



Since <b>January 1, 2009</b> , 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?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> None <input type="radio"/> A little <input type="radio"/> A moderate amount <input type="radio"/> A lot
18. your sister with breast cancer?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> None <input type="radio"/> A little <input type="radio"/> A moderate amount <input type="radio"/> A lot
19. another sibling?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> None <input type="radio"/> A little <input type="radio"/> A moderate amount <input type="radio"/> A lot
20. a child?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> None <input type="radio"/> A little <input type="radio"/> A moderate amount <input type="radio"/> A lot
21. a parent?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> None <input type="radio"/> A little <input type="radio"/> A moderate amount <input type="radio"/> A lot
22. a close personal friend?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> None <input type="radio"/> A little <input type="radio"/> A moderate amount <input type="radio"/> A lot

Please use a ballpoint pen for this form



Since <b>January 1, 2009</b> , 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?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> None <input type="radio"/> A little <input type="radio"/> A moderate amount <input type="radio"/> A lot
24. the recurrence or worsening of your sister's breast cancer?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> None <input type="radio"/> A little <input type="radio"/> A moderate amount <input type="radio"/> A lot
25. any other close relative's diagnosis of breast cancer?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> None <input type="radio"/> A little <input type="radio"/> A moderate amount <input type="radio"/> A lot
26. a major change in, or serious difficulty with a personal relationship (such as a divorce, or child custody issues)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> None <input type="radio"/> A little <input type="radio"/> A moderate amount <input type="radio"/> 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)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> None <input type="radio"/> A little <input type="radio"/> A moderate amount <input type="radio"/> 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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
32. has your interest in hobbies or activities decreased?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
33. have you noticed that you tend to repeat things over and over (questions, stories, or statements) more often than you used to?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
34. has it become harder to learn how to use a new tool, appliance or gadget (e.g., computer, microwave, remote control)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
35. have you noticed more problems remembering the month or year?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
36. have you had more problems handling complicated financial affairs (e.g., balancing checkbook, preparing income taxes, paying bills) than you used to?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
37. has it become more difficult to remember appointments?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
38. do you notice more daily problems with thinking and/or memory?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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?

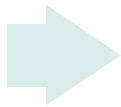
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# NIGHTS

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

No → GO TO QUESTION 44

Yes



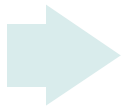
43a. In the past month, about how often did you feel excessively sleepy during the day?

- 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?	<input type="radio"/>	<input type="radio"/>
47. Do you have, or have you had, a recurrent need or urge to move your legs while you were sitting or lying down?	<input type="radio"/>	<input type="radio"/>



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



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.)

--	--

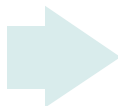
AGE

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 <b>past 12 months</b> , 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...
<b>Multiple Vitamins</b> 59. One A Day, Centrum, or Thera type multiple vitamins?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	<input type="radio"/> contain minerals, iron, zinc, etc.? <input type="radio"/> do not contain minerals? <input type="radio"/> Don't know
60. Stress-tabs or B-Complex type multiple vitamins?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	
61. Antioxidant combination-type multiple vitamins?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	

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?
<b>Single Vitamins and Minerals (not part of multiple vitamins)</b>  62. Vitamin A (not beta-carotene)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	<input type="radio"/> Less than 8000 IU <input type="radio"/> 8000 IU <input type="radio"/> More than 8000 IU
63. Beta-carotene?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	
64. Thiamin (B1)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	<input type="radio"/> Less than 100 mg <input type="radio"/> 100-250 mg <input type="radio"/> More than 250 mg
65. Niacin (B3)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	<input type="radio"/> Less than 500 mg <input type="radio"/> 500 mg <input type="radio"/> 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?
<b>Single Vitamins and Minerals (not part of multiple vitamins)</b>					
66. Vitamin B6?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	<input type="radio"/> Less than 100 mg <input type="radio"/> 100 mg <input type="radio"/> More than 100 mg
67. Vitamin B12?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	<input type="radio"/> Less than 500 mcg <input type="radio"/> 500 mcg <input type="radio"/> 1000 mcg <input type="radio"/> 2000 mcg <input type="radio"/> More than 2000 mcg
68. Vitamin C?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	<input type="radio"/> Less than 500 mg <input type="radio"/> 500 mg <input type="radio"/> 1000 mg <input type="radio"/> More than 1000 mg
69. Vitamin D alone?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	<input type="radio"/> Less than 2000 IU <input type="radio"/> 2000 IU <input type="radio"/> More than 2000 IU



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?
<b>Single Vitamins and Minerals (not part of multiple vitamins)</b>					
70. Vitamin E?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	<input type="radio"/> Less than 400 IU <input type="radio"/> 400 IU <input type="radio"/> More than 400 IU
71. Folic acid, folate?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	<input type="radio"/> Less than 400 mcg <input type="radio"/> 400 mcg <input type="radio"/> More than 400 mcg
72. Calcium plus vitamin D?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	
73. Calcium without vitamin D?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	<input type="radio"/> Less than 600 mg <input type="radio"/> 600 mg <input type="radio"/> 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?
<b>Single Vitamins and Minerals (not part of multiple vitamins)</b>					
74. Chromium?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	<input type="radio"/> Less than 200 mcg <input type="radio"/> 200 - 1000 mcg <input type="radio"/> More than 1000 mcg
75. Iron?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	<input type="radio"/> Less than 65 mg <input type="radio"/> 65 mg <input type="radio"/> More than 65 mg
76. Magnesium?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	<input type="radio"/> Less than 250 mg <input type="radio"/> 250 mg <input type="radio"/> More than 250 mg
77. Selenium?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	<input type="radio"/> Less than 200 mcg <input type="radio"/> 200 mcg <input type="radio"/> More than 200 mcg



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?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	<input type="radio"/> Less than 50 mg <input type="radio"/> 50 mg <input type="radio"/> 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	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
80. Chamomile	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
81. Co-enzyme Q10 (CoQ10)	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
82. Cod liver oil	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
83. Cranberry pills	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
84. DHEA	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 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?
85. Echinacea	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
86. Evening primrose oil	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
87. Fiber supplement	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
88. Fish oil (EPA)	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
89. Flax seed/flax seed oil	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
90. Garlic pills	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 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	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
92. Ginkgo	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
93. Ginseng	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
94. Glucosamine/Chondroitin	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
95. Kava Kava	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
96. Lecithin	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 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?
97.	Lutein	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
98.	Melatonin	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
99.	Milk thistle	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
100.	Mixed carotenoids	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
101.	Omega-3 or omega-3 fatty acids	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
102.	Probiotics/acidophilus	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 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	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
104.	St. John's Wort	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
105.	Turmeric capsules	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
106.	Valerian	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
107.	Something else	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 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	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than once a month <input type="radio"/> 1-4 times a month <input type="radio"/> More than 4 times a month	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
109.	Acupuncture	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than once a month <input type="radio"/> 1-4 times a month <input type="radio"/> More than 4 times a month	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
110.	Yoga	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than once a month <input type="radio"/> 1-4 times a month <input type="radio"/> More than 4 times a month	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
111.	Spirituality, meditation, prayer	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than once a month <input type="radio"/> 1-4 times a month <input type="radio"/> More than 4 times a month	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
112.	Therapeutic touch/massage	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than once a month <input type="radio"/> 1-4 times a month <input type="radio"/> More than 4 times a month	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
113.	Tai chi	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than once a month <input type="radio"/> 1-4 times a month <input type="radio"/> More than 4 times a month	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 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	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than once a month <input type="radio"/> 1-4 times a month <input type="radio"/> More than 4 times a month	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
115.	Chiropractic	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than once a month <input type="radio"/> 1-4 times a month <input type="radio"/> More than 4 times a month	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
116.	Reiki	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than once a month <input type="radio"/> 1-4 times a month <input type="radio"/> More than 4 times a month	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
117.	Biofeedback	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than once a month <input type="radio"/> 1-4 times a month <input type="radio"/> More than 4 times a month	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
118.	Homeopathy	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than once a month <input type="radio"/> 1-4 times a month <input type="radio"/> More than 4 times a month	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
119.	Visualization/guided imagery	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than once a month <input type="radio"/> 1-4 times a month <input type="radio"/> More than 4 times a month	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 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	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than once a month <input type="radio"/> 1-4 times a month <input type="radio"/> More than 4 times a month	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 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 <b>January 1, 2009</b> , 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	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 8 weeks <input type="radio"/> 8 weeks - 1 year <input type="radio"/> More than 1 year	<input type="radio"/> Yes <input type="radio"/> No
124.	Low fat	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 8 weeks <input type="radio"/> 8 weeks - 1 year <input type="radio"/> More than 1 year	<input type="radio"/> Yes <input type="radio"/> No
125.	Restricted calories	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 8 weeks <input type="radio"/> 8 weeks - 1 year <input type="radio"/> More than 1 year	<input type="radio"/> Yes <input type="radio"/> No
126.	Liquid/juice	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 8 weeks <input type="radio"/> 8 weeks - 1 year <input type="radio"/> More than 1 year	<input type="radio"/> Yes <input type="radio"/> No
127.	Vegetarian	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 8 weeks <input type="radio"/> 8 weeks - 1 year <input type="radio"/> More than 1 year	<input type="radio"/> Yes <input type="radio"/> No
128.	Low salt	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 8 weeks <input type="radio"/> 8 weeks - 1 year <input type="radio"/> More than 1 year	<input type="radio"/> Yes <input type="radio"/> No
129.	Macrobiotic	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 8 weeks <input type="radio"/> 8 weeks - 1 year <input type="radio"/> More than 1 year	<input type="radio"/> Yes <input type="radio"/> No
130.	Diabetic diet	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 8 weeks <input type="radio"/> 8 weeks - 1 year <input type="radio"/> More than 1 year	<input type="radio"/> Yes <input type="radio"/> No
131.	Atkins	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 8 weeks <input type="radio"/> 8 weeks - 1 year <input type="radio"/> More than 1 year	<input type="radio"/> Yes <input type="radio"/> No
132.	Zone (Barry Sears)	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 8 weeks <input type="radio"/> 8 weeks - 1 year <input type="radio"/> More than 1 year	<input type="radio"/> Yes <input type="radio"/> No

Please use a ballpoint pen for this form



Since <b>January 1, 2009</b> , 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	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 8 weeks <input type="radio"/> 8 weeks - 1 year <input type="radio"/> More than 1 year	<input type="radio"/> Yes <input type="radio"/> No
134.	Tried to gain weight	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 8 weeks <input type="radio"/> 8 weeks - 1 year <input type="radio"/> More than 1 year	<input type="radio"/> Yes <input type="radio"/> No
135.	Diet with pre-prepared meals	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 8 weeks <input type="radio"/> 8 weeks - 1 year <input type="radio"/> More than 1 year	<input type="radio"/> Yes <input type="radio"/> No
136.	Physician-based diet with special supplements such as puddings, beverages or vitamins	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 8 weeks <input type="radio"/> 8 weeks - 1 year <input type="radio"/> More than 1 year	<input type="radio"/> Yes <input type="radio"/> No
137.	South Beach diet	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 8 weeks <input type="radio"/> 8 weeks - 1 year <input type="radio"/> More than 1 year	<input type="radio"/> Yes <input type="radio"/> No
138.	Raw food diet	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 8 weeks <input type="radio"/> 8 weeks - 1 year <input type="radio"/> More than 1 year	<input type="radio"/> Yes <input type="radio"/> No
139.	HCG diet	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 8 weeks <input type="radio"/> 8 weeks - 1 year <input type="radio"/> More than 1 year	<input type="radio"/> Yes <input type="radio"/> No
140.	Other diet, please specify: <input type="text"/>	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 8 weeks <input type="radio"/> 8 weeks - 1 year <input type="radio"/> More than 1 year	<input type="radio"/> Yes <input type="radio"/> No

Have you ever had any of the following weight loss procedures?		NO	YES	a. What age did you have this?
141.	Lap band	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> AGE
142.	Bariatric surgery	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> AGE



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	<input type="radio"/> No	<input type="radio"/> Yes, it started <u>before</u> age 18 <input type="radio"/> Yes, it started age 18 or later → a. Age it started <div style="border: 1px solid black; width: 100px; height: 30px; margin: 5px auto; display: flex; justify-content: space-around;"> <span style="border: 1px solid black; width: 20px; height: 20px;"></span> <span style="border: 1px solid black; width: 20px; height: 20px;"></span> </div> <div style="text-align: center; margin-top: 5px;">AGE</div>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't know
145. Egg	<input type="radio"/> No	<input type="radio"/> Yes, it started <u>before</u> age 18 <input type="radio"/> Yes, it started age 18 or later → a. Age it started <div style="border: 1px solid black; width: 100px; height: 30px; margin: 5px auto; display: flex; justify-content: space-around;"> <span style="border: 1px solid black; width: 20px; height: 20px;"></span> <span style="border: 1px solid black; width: 20px; height: 20px;"></span> </div> <div style="text-align: center; margin-top: 5px;">AGE</div>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't know
146. Peanuts	<input type="radio"/> No	<input type="radio"/> Yes, it started <u>before</u> age 18 <input type="radio"/> Yes, it started age 18 or later → a. Age it started <div style="border: 1px solid black; width: 100px; height: 30px; margin: 5px auto; display: flex; justify-content: space-around;"> <span style="border: 1px solid black; width: 20px; height: 20px;"></span> <span style="border: 1px solid black; width: 20px; height: 20px;"></span> </div> <div style="text-align: center; margin-top: 5px;">AGE</div>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't know
147. Other nuts	<input type="radio"/> No	<input type="radio"/> Yes, it started <u>before</u> age 18 <input type="radio"/> Yes, it started age 18 or later → a. Age it started <div style="border: 1px solid black; width: 100px; height: 30px; margin: 5px auto; display: flex; justify-content: space-around;"> <span style="border: 1px solid black; width: 20px; height: 20px;"></span> <span style="border: 1px solid black; width: 20px; height: 20px;"></span> </div> <div style="text-align: center; margin-top: 5px;">AGE</div>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> 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	<input type="radio"/> No	<input type="radio"/> Yes, it started <u>before</u> age 18 <input type="radio"/> Yes, it started age 18 or later → a. Age it started <div style="border: 1px solid black; width: 100px; height: 30px; margin: 5px auto; display: flex; justify-content: space-between;"><div style="width: 45%;"></div><div style="width: 45%;"></div></div> <div style="text-align: center; margin-top: 5px;">AGE</div>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't know
149. Fish	<input type="radio"/> No	<input type="radio"/> Yes, it started <u>before</u> age 18 <input type="radio"/> Yes, it started age 18 or later → a. Age it started <div style="border: 1px solid black; width: 100px; height: 30px; margin: 5px auto; display: flex; justify-content: space-between;"><div style="width: 45%;"></div><div style="width: 45%;"></div></div> <div style="text-align: center; margin-top: 5px;">AGE</div>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't know
150. Any kind of fruit	<input type="radio"/> No	<input type="radio"/> Yes, it started <u>before</u> age 18 <input type="radio"/> Yes, it started age 18 or later → a. Age it started <div style="border: 1px solid black; width: 100px; height: 30px; margin: 5px auto; display: flex; justify-content: space-between;"><div style="width: 45%;"></div><div style="width: 45%;"></div></div> <div style="text-align: center; margin-top: 5px;">AGE</div>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't know
151. Wheat	<input type="radio"/> No	<input type="radio"/> Yes, it started <u>before</u> age 18 <input type="radio"/> Yes, it started age 18 or later → a. Age it started <div style="border: 1px solid black; width: 100px; height: 30px; margin: 5px auto; display: flex; justify-content: space-between;"><div style="width: 45%;"></div><div style="width: 45%;"></div></div> <div style="text-align: center; margin-top: 5px;">AGE</div>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't know
152. Soy	<input type="radio"/> No	<input type="radio"/> Yes, it started <u>before</u> age 18 <input type="radio"/> Yes, it started age 18 or later → a. Age it started <div style="border: 1px solid black; width: 100px; height: 30px; margin: 5px auto; display: flex; justify-content: space-between;"><div style="width: 45%;"></div><div style="width: 45%;"></div></div> <div style="text-align: center; margin-top: 5px;">AGE</div>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> 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	<input type="radio"/> No	<input type="radio"/> Yes, it started <u>before</u> age 18 <input type="radio"/> Yes, it started age 18 or later → a. Age it started <div style="border: 1px solid black; width: 60px; height: 20px; margin: 5px auto; display: flex; justify-content: space-around;"><span> </span><span> </span></div> <p style="text-align: center; margin: 0;">AGE</p>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't know
154. Vegetable(s)	<input type="radio"/> No	<input type="radio"/> Yes, it started <u>before</u> age 18 <input type="radio"/> Yes, it started age 18 or later → a. Age it started <div style="border: 1px solid black; width: 60px; height: 20px; margin: 5px auto; display: flex; justify-content: space-around;"><span> </span><span> </span></div> <p style="text-align: center; margin: 0;">AGE</p>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't know
155. Other food, specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	<input type="radio"/> No	<input type="radio"/> Yes, it started <u>before</u> age 18 <input type="radio"/> Yes, it started age 18 or later → a. Age it started <div style="border: 1px solid black; width: 60px; height: 20px; margin: 5px auto; display: flex; justify-content: space-around;"><span> </span><span> </span></div> <p style="text-align: center; margin: 0;">AGE</p>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't know

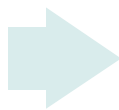
156. Do you have lactose intolerance?

- 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





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

During the past month, did you...	NO	YES	a. How often?
169. eat <b>any other vegetables</b> ? Do <b>not</b> include green salads, potatoes, and cooked dried beans.	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # TIMES <input type="radio"/> Per day <input type="radio"/> Per week <input type="radio"/> Per month
170. eat any Mexican-type salsa made with tomato?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # TIMES <input type="radio"/> Per day <input type="radio"/> Per week <input type="radio"/> Per month
171. eat any <b>pizza</b> ? Include frozen pizza, fast food pizza, and homemade pizza.	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # TIMES <input type="radio"/> Per day <input type="radio"/> Per week <input type="radio"/> Per month
172. have any <b>tomato sauces</b> such as with spaghetti or noodles or mixed into foods such as lasagna? Do <b>not</b> count tomato sauce on pizza.	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # TIMES <input type="radio"/> Per day <input type="radio"/> Per week <input type="radio"/> Per month
173. eat any kind of <b>cheese</b> ? Include cheese as a snack, cheese on burgers, sandwiches, and cheese in foods such as lasagna, quesadillas, or casseroles. Do <b>not</b> include cheese on pizza.	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # TIMES <input type="radio"/> Per day <input type="radio"/> Per week <input type="radio"/> Per month
174. eat any <b>red meat</b> , such as beef, pork, ham, or sausage? Do <b>not</b> 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.	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # TIMES <input type="radio"/> Per day <input type="radio"/> Per week <input type="radio"/> Per month
175. eat any <b>processed meat</b> , 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.	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # TIMES <input type="radio"/> Per day <input type="radio"/> Per week <input type="radio"/> Per month
176. eat any <b>whole grain bread</b> including toast, rolls and in sandwiches? Whole grain breads include whole wheat, rye, oatmeal and pumpernickel. Do <b>not</b> include white bread.	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # TIMES <input type="radio"/> Per day <input type="radio"/> Per week <input type="radio"/> Per month
177. eat any <b>chocolate</b> or any other types of <b>candy</b> ? Do <b>not</b> include sugar-free candy.	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # TIMES <input type="radio"/> Per day <input type="radio"/> Per week <input type="radio"/> Per month



During the past month, did you...	NO	YES	a. How often?
178. eat any <b>doughnuts</b> , sweet rolls, Danish, muffins, <i>pan dulce</i> or pop-tarts? Do <b>not</b> include sugar-free items.	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # TIMES <input type="radio"/> Per day <input type="radio"/> Per week <input type="radio"/> Per month
179. eat any <b>cookies</b> , <b>cake</b> , <b>pie</b> , or <b>brownies</b> ? Do <b>not</b> include sugar-free kinds.	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # TIMES <input type="radio"/> Per day <input type="radio"/> Per week <input type="radio"/> Per month
180. eat any ice cream or other <b>frozen desserts</b> ? Do <b>not</b> include sugar-free kinds.	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # TIMES <input type="radio"/> Per day <input type="radio"/> Per week <input type="radio"/> Per month
181. eat any <b>popcorn</b> ?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # TIMES <input type="radio"/> Per day <input type="radio"/> Per week <input type="radio"/> Per month





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Please check to see that all questions are answered.

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

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

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

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# 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:  /  / 20  
(month) (day) (year)

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

### Name and Primary Address

### 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?

 /  / 20  
(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»

Grid for name input

Relationship to you: «Relationship»

Grid for relationship input

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

Grid for address input

Phone Number: «PhoneNumber»

Grid for phone number input

What is the reason for the changes you made?

Reason for changes checkboxes: 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»

Grid for name input

Relationship to you: «Relationship»

Grid for relationship input

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

Grid for address input

Phone Number: «PhoneNumber»

Grid for phone number input

What is the reason for the changes you made?

Reason for changes checkboxes: 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