



# The Sister Study

## Health and Medical History

### A-Version 1

**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: ⊗ ⊙

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, 2012 = 

0	6
---	---

 / 

0	7
---	---

 / 

2	0	1	2
---	---	---	---

  
(month)      (day)      (year)

Public reporting burden for this collection of information is estimated to average 40 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"/>
k. had an ultrasound of the ovaries?	<input type="radio"/>	<input type="radio"/>
l. had a flu vaccination (either a flu shot or nasal spray)?	<input type="radio"/>	<input type="radio"/>
m. had a vaccination for shingles (herpes zoster)?	<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, 2012, 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? Please round to the nearest inch.

--	--	--

FEET      INCHES

8. Since January 1, 2012, 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



## FAMILY MEDICAL HISTORY

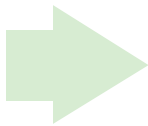
9. Since January 1, 2012, were **any** of your sisters diagnosed with breast cancer **for the first time**?
- No
  - Yes

9a. In all, how many of your full or half sisters have ever been diagnosed with breast cancer?

- 1
- 2
- 3
- 4
- 5 or more

10. Since January 1, 2012, have any **other** close blood relatives of yours been diagnosed with breast cancer **for the first time**?
- No → GO TO QUESTION 11

Yes



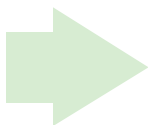
10a. What is/are the relative(s)' relationship to you?  
(Please mark all that apply.)

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

11. Since January 1, 2012, have **any** close blood relatives of yours been diagnosed with ovarian cancer **for the first time**?

No → GO TO THE NEXT PAGE, QUESTION 12

Yes



11a. 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



In previous questionnaires, we have asked whether any of your grandparents have had cancer. However, we did not ask you which grandparent was diagnosed with cancer.

Were any of the following blood relatives EVER diagnosed with BREAST cancer?		a. If Yes, at what age were they diagnosed?	
12. Grandmother on <u>mother's</u> side.	<input type="radio"/> No <input type="radio"/> I don't know	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> OR <input type="radio"/> I don't know <small>AGE</small>
13. Grandmother on <u>father's</u> side.	<input type="radio"/> No <input type="radio"/> I don't know	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> OR <input type="radio"/> I don't know <small>AGE</small>
14. Grandfather on <u>mother's</u> side.	<input type="radio"/> No <input type="radio"/> I don't know	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> OR <input type="radio"/> I don't know <small>AGE</small>
15. Grandfather on <u>father's</u> side.	<input type="radio"/> No <input type="radio"/> I don't know	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> OR <input type="radio"/> I don't know <small>AGE</small>

Were any of the following blood relatives EVER diagnosed with OVARIAN cancer?		a. If Yes, at what age were they diagnosed?	
16. Grandmother on <u>mother's</u> side.	<input type="radio"/> No <input type="radio"/> I don't know	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> OR <input type="radio"/> I don't know <small>AGE</small>
17. Grandmother on <u>father's</u> side.	<input type="radio"/> No <input type="radio"/> I don't know	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> OR <input type="radio"/> I don't know <small>AGE</small>

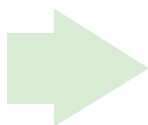
Please use a ballpoint pen for this form



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

No → GO TO QUESTION 19

Yes



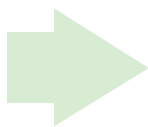
18a. What is/are the relative(s)' relationship to you?  
*(Please mark all that apply.)*

- 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 Alzheimer's disease?

No → GO TO QUESTION 20

Yes



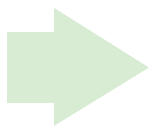
19a. What is/are the relative(s)' relationship to you?  
*(Please mark all that apply.)*

- 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 diabetes?

No → GO TO THE NEXT PAGE, QUESTION 21

Yes



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

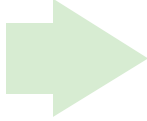
- Mother
- Father
- Sister
- Brother
- Daughter
- Son
- Other relative related to you by blood



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

No → GO TO QUESTION 22

Yes



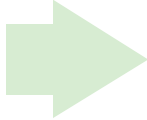
21a. What is/are the relative(s)' relationship to you?  
(Please mark all that apply.)

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

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

No → GO TO THE NEXT PAGE, QUESTION 23

Yes



22a. 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, 2012**.

Has a doctor or other health professional told you that you had...	NEVER OR BEFORE 1/1/2012	DIAGNOSED 1/1/2012 OR LATER	a. If diagnosed January 1, 2012 or later, what month and year were you diagnosed?
23. 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, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> MONTH YEAR
24. ductal (breast) carcinoma in situ (DCIS)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> MONTH YEAR
25. lobular (breast) carcinoma in situ (LCIS)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> MONTH YEAR
26. lung cancer?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> MONTH YEAR
27. ovarian cancer?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> MONTH YEAR
28. cancer of the uterus or endometrium? Please do <b>not</b> include non-cancerous conditions such as fibroids, endometriosis, or pre-cancer.	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> MONTH YEAR
29. cancer of the colon or rectum?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> MONTH YEAR
30. Hodgkin's disease or Hodgkin's lymphoma?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> MONTH YEAR
31. non-Hodgkin's lymphoma?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> MONTH YEAR
32. leukemia?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> MONTH YEAR





Has a doctor or other health professional told you that you had...	NEVER OR BEFORE 1/1/2012	DIAGNOSED 1/1/2012 OR LATER	a. If diagnosed January 1, 2012 or later, what month and year were you diagnosed?
33. melanoma?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="text-align: center;"> <input type="text"/> / <input type="text"/> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>
34. skin cancer (not melanoma)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012 <b>If diagnosed before January 1, 2012, was it... (Please mark all that apply.)</b> <input type="radio"/> basal cell? <input type="radio"/> squamous cell? <input type="radio"/> other?	<input type="radio"/> Diagnosed January 1, 2012 or later	<p>a. MONTH/YEAR DIAGNOSED</p> <div style="text-align: center;"> <input type="text"/> / <input type="text"/> </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> <input type="radio"/> basal cell? <input type="radio"/> squamous cell? <input type="radio"/> other?
35. any other type of cancer not already listed?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012 <b>If diagnosed before January 1, 2012, please specify what type(s) of cancer:</b> <input type="text"/> <input type="text"/>	<input type="radio"/> Diagnosed January 1, 2012 or later	<p>a. MONTH/YEAR DIAGNOSED</p> <div style="text-align: center;"> <input type="text"/> / <input type="text"/> </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> <input type="text"/> <p>c. If you were diagnosed with a second <b>other</b> type of cancer January 1, 2012 or later, what month and year were you diagnosed?</p> <div style="text-align: center;"> <input type="text"/> / <input type="text"/> </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> <input type="text"/>

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 had this condition in the past 12 months?														
36. hypertension or high blood pressure?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first diagnosed before</u> January 1, 2012 <input type="radio"/> Yes, <u>first diagnosed</u> January 1, 2012 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="2" style="text-align: center; font-size: 8px;">YEAR</td> <td colspan="2"></td> </tr> </table> </div>			/	2	0			MONTH			YEAR				<input type="radio"/> No <input type="radio"/> Yes
		/	2	0													
MONTH			YEAR														
37. angina?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first diagnosed before</u> January 1, 2012 <input type="radio"/> Yes, <u>first diagnosed</u> January 1, 2012 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="2" style="text-align: center; font-size: 8px;">YEAR</td> <td colspan="2"></td> </tr> </table> </div>			/	2	0			MONTH			YEAR				<input type="radio"/> No <input type="radio"/> Yes
		/	2	0													
MONTH			YEAR														
38. cardiac arrhythmia (irregular heartbeat)?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first diagnosed before</u> January 1, 2012 <input type="radio"/> Yes, <u>first diagnosed</u> January 1, 2012 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="2" style="text-align: center; font-size: 8px;">YEAR</td> <td colspan="2"></td> </tr> </table> </div>			/	2	0			MONTH			YEAR				<input type="radio"/> No <input type="radio"/> Yes
		/	2	0													
MONTH			YEAR														
39. congestive heart failure?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first diagnosed before</u> January 1, 2012 <input type="radio"/> Yes, <u>first diagnosed</u> January 1, 2012 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="2" style="text-align: center; font-size: 8px;">YEAR</td> <td colspan="2"></td> </tr> </table> </div>			/	2	0			MONTH			YEAR				<input type="radio"/> No <input type="radio"/> Yes
		/	2	0													
MONTH			YEAR														



Has a doctor or other health professional told you that you had...	NO	YES	b. Have you had another incident since then?
40. 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, 2012  <input type="radio"/> Yes, my <u>first</u> heart attack was January 1, 2012 or later ↓  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: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 40px; height: 30px; display: flex; align-items: center; justify-content: center;"> <span style="font-size: 1.2em;">2</span> <span style="font-size: 1.2em; margin-left: 10px;">0</span> </div> </div> <div style="display: flex; justify-content: space-around; width: 100%; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>	<input type="radio"/> No  <input type="radio"/> Yes ↓ 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: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 40px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> </div> <div style="display: flex; justify-content: space-around; width: 100%; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>
41. 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, 2012  <input type="radio"/> Yes, my <u>first</u> stroke was January 1, 2012 or later ↓  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: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 40px; height: 30px; display: flex; align-items: center; justify-content: center;"> <span style="font-size: 1.2em;">2</span> <span style="font-size: 1.2em; margin-left: 10px;">0</span> </div> </div> <div style="display: flex; justify-content: space-around; width: 100%; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>	<input type="radio"/> No  <input type="radio"/> Yes ↓ 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: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 40px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> </div> <div style="display: flex; justify-content: space-around; width: 100%; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>
42. 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, 2012  <input type="radio"/> Yes, my <u>first</u> mini-stroke was January 1, 2012 or later ↓  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: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 40px; height: 30px; display: flex; align-items: center; justify-content: center;"> <span style="font-size: 1.2em;">2</span> <span style="font-size: 1.2em; margin-left: 10px;">0</span> </div> </div> <div style="display: flex; justify-content: space-around; width: 100%; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>	<input type="radio"/> No  <input type="radio"/> Yes ↓ 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: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 40px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> </div> <div style="display: flex; justify-content: space-around; width: 100%; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>

Please use a ballpoint pen for this form



Since January 1, 2012, have you had...	NEVER OR BEFORE 1/1/2012	1/1/2012 OR LATER	a. How many times has this happened since January 1, 2012?	b. What was the month and year that this <b>first</b> happened since January 1, 2012?
43. a hip fracture?	<input type="radio"/> Never <input type="radio"/> Before January 1, 2012	<input type="radio"/> January 1, 2012 or later	<input type="text"/> # TIMES	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH                      YEAR
44. a wrist fracture?	<input type="radio"/> Never <input type="radio"/> Before January 1, 2012	<input type="radio"/> January 1, 2012 or later	<input type="text"/> # TIMES	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH                      YEAR
45. a spine (vertebral) fracture?	<input type="radio"/> Never <input type="radio"/> Before January 1, 2012	<input type="radio"/> January 1, 2012 or later	<input type="text"/> # TIMES	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH                      YEAR
46. a rib fracture?	<input type="radio"/> Never <input type="radio"/> Before January 1, 2012	<input type="radio"/> January 1, 2012 or later	<input type="text"/> # TIMES	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH                      YEAR

		a. If yes, how many times?	b. Age at first injury?	c. Age at most recent injury?
47. Have you <b>ever</b> 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"/> AGE	<input type="text"/> AGE



Has a doctor or other health professional ever told you that you had...

**NO**

**YES**

48. diabetes?

No

Yes, first diagnosed before January 1, 2012

Yes, first diagnosed January 1, 2012 or later →

a. What month and year were you diagnosed?

		/	2	0		
MONTH			YEAR			

b. Do you still have this condition?

No

Yes

c. Do you currently take insulin for diabetes?

No → **GO TO 48e**

Yes →

d. If yes, when did you first use insulin?

		/				
MONTH			YEAR			

e. Do you currently take other medications for diabetes?

No

Yes → **(Please report medications in question 174.)**

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 had this condition in the past 12 months?														
49. asthma?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first diagnosed before</u> January 1, 2012 <input type="radio"/> Yes, <u>first diagnosed</u> January 1, 2012 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="2" style="text-align: center; font-size: 8px;">YEAR</td> <td colspan="2"></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 diagnosed before</u> January 1, 2012 <input type="radio"/> Yes, <u>first diagnosed</u> January 1, 2012 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="2" style="text-align: center; font-size: 8px;">YEAR</td> <td colspan="2"></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 diagnosed before</u> January 1, 2012 <input type="radio"/> Yes, <u>first diagnosed</u> January 1, 2012 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="2" style="text-align: center; font-size: 8px;">YEAR</td> <td colspan="2"></td> </tr> </table> </div>			/	2	0			MONTH			YEAR				<input type="radio"/> No <input type="radio"/> Yes
		/	2	0													
MONTH			YEAR														
52. lost any adult teeth due to disease or decay (please do not count wisdom teeth extractions, or teeth lost due to accidents, violence, or orthodontistry)?	<input type="radio"/> No	<input type="radio"/> Yes, first diagnosed before January 1, 2012 <input type="radio"/> Yes, first diagnosed January 1, 2012 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="2" style="text-align: center; font-size: 8px;">YEAR</td> <td colspan="2"></td> </tr> </table> </div>			/	2	0			MONTH			YEAR				<input type="radio"/> No <input type="radio"/> Yes
		/	2	0													
MONTH			YEAR														



Since January 1, 2012, has a doctor or other health professional told you that you had...	<b>NEVER OR BEFORE 1/1/2012</b>	<b>DIAGNOSED 1/1/2012 OR LATER</b>	a. If diagnosed January 1, 2012 or later, what month and year were you diagnosed?
53. allergic rhinitis, hay fever, or seasonal allergies?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="margin: 0 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> </div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>
54. emphysema?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="margin: 0 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> </div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>
55. chronic obstructive pulmonary disease (COPD)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="margin: 0 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> </div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>
56. Graves' disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="margin: 0 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> </div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>
57. other hyperthyroidism (overactive thyroid)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="margin: 0 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> </div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>
58. Hashimoto's thyroiditis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="margin: 0 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> </div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>
59. other hypothyroidism (underactive thyroid)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="margin: 0 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> </div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>
60. an enlarged thyroid or goiter?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="margin: 0 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> </div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>

Please use a ballpoint pen for this form



Since January 1, 2012, has a doctor or other health professional told you that you had...	<b>NEVER OR BEFORE 1/1/2012</b>	<b>DIAGNOSED 1/1/2012 OR LATER</b>	a. If diagnosed January 1, 2012 or later, what month and year were you diagnosed?
61. thyroid nodules?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/> MONTH YEAR
62. 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, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	a. MONTH/YEAR DIAGNOSED <input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/> MONTH YEAR  b. Please specify the problem: <input type="text"/>
63. osteoporosis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/> MONTH YEAR
64. osteopenia, or low bone density?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/> MONTH YEAR
65. osteoarthritis (age-related arthritis)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/> MONTH YEAR
66. rheumatoid arthritis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/> MONTH YEAR
67. multiple sclerosis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/> MONTH YEAR
68. scleroderma or systemic sclerosis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/> MONTH YEAR





Since January 1, 2012, has a doctor or other health professional told you that you had...	NEVER OR BEFORE 1/1/2012	DIAGNOSED 1/1/2012 OR LATER	a. If diagnosed January 1, 2012 or later, what month and year were you diagnosed?
69. systemic lupus erythematosus (SLE)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> MONTH      YEAR
70. discoid lupus?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> MONTH      YEAR
71. Sjögren's syndrome?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> MONTH      YEAR
72. Crohn's disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> MONTH      YEAR
73. ulcerative colitis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> MONTH      YEAR
74. shingles?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 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 1/1/2012	DIAGNOSED 1/1/2012 OR LATER	a. If diagnosed January 1, 2012 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, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> MONTH YEAR
76. polycystic ovarian syndrome or PCOS?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> MONTH YEAR
77. ovarian cysts?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> MONTH YEAR
78. uterine fibroids or fibroid tumors?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> MONTH YEAR
79. gallstones or gallbladder disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> MONTH YEAR
80. Parkinson's disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> MONTH YEAR
81. Alzheimer's disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> MONTH YEAR
82. cognitive impairment?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> MONTH YEAR
83. kidney failure requiring dialysis or transplant?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> MONTH YEAR



Has a doctor or other health professional told you that you had...	NEVER OR BEFORE 1/1/2012	DIAGNOSED 1/1/2012 OR LATER	a. If diagnosed January 1, 2012 or later, what month and year were you diagnosed?
84. kidney stones?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> MONTH                      YEAR
85. gout?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> MONTH                      YEAR
86. cataracts?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> MONTH                      YEAR
<b>86a. detached retina?</b>	<input type="radio"/> <b>Never diagnosed</b> <input type="radio"/> <b>Diagnosed before</b> January 1, 2012	<input type="radio"/> <b>Diagnosed January 1, 2012 or later</b>	<input type="text"/> / <input type="text"/> <b>MONTH                      YEAR</b>
87. glaucoma?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> MONTH                      YEAR
88. macular degeneration?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> MONTH                      YEAR
89. pulmonary embolism?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> MONTH                      YEAR
90. deep vein thrombosis, DVT, or deep vein blood clots in your legs or somewhere else?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> MONTH                      YEAR

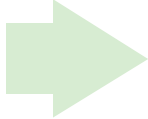
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Endometriosis is a health problem in women in which tissue that looks and acts like the lining of the uterus grows outside of the uterus. Endometriosis is different from endometrial polyps or endometrial cancer.

91. Has any doctor told you that you have endometriosis?

No → GO TO THE NEXT PAGE, QUESTION 94

Yes



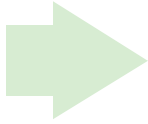
92. How old were you when you were first diagnosed with endometriosis?		<input type="text"/> <input type="text"/> AGE	
Was your endometriosis confirmed by...			Age at procedure?
93a. Laparoscopy (insertion of a thin, lighted tube through a small incision in the abdomen to examine organs)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> AGE
93b. Laparotomy (traditional abdominal surgery, which requires a larger incision)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> AGE
93c. Ultrasound?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> AGE
93d. Magnetic Resonance Imaging (MRI)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> AGE
93e. Hysterectomy for suspected endometriosis?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> AGE
93f. Hysterectomy for other reason?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> AGE
93g. Other, please specify: <input type="text"/>	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> AGE



94. Some people experience problems with urinary incontinence, the leakage of urine. In the past 12 months, have you accidentally leaked urine?

- No → GO TO THE NEXT PAGE, QUESTION 95
- I don't know

Yes



94a. How frequently does this happen?	<input type="radio"/> Every day <input type="radio"/> 3 - 6 times per week <input type="radio"/> Once or twice per week <input type="radio"/> 2 - 3 times per month <input type="radio"/> Once per month <input type="radio"/> A few times per year
94b. How much of a problem, if any, is/was the urine leakage for you?	<input type="radio"/> A big problem <input type="radio"/> A small problem <input type="radio"/> Not a problem
94c. Have you talked with your doctor or other health provider about your urine leakage?	<input type="radio"/> No <input type="radio"/> Yes
94d. Have you taken any medications for your urinary incontinence?	<input type="radio"/> No <input type="radio"/> Yes
94e. Have you had any other treatments for your urinary incontinence?	<input type="radio"/> No → GO TO QUESTION 95 <input type="radio"/> Yes
94f. If so, what treatments have you had for your urinary incontinence? (Please mark all that apply.)	<input type="radio"/> Bladder training <input type="radio"/> Exercises <input type="radio"/> Surgery <input type="radio"/> Other, specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

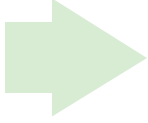
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95. Have you been told that you have pelvic prolapse? You may have heard it called "cystocele," "rectocele," "urethrocele," or "dropped bladder."

No → GO TO THE NEXT PAGE, QUESTION 96

Yes



95a.	Have you had surgery to correct pelvic prolapse?	<input type="radio"/> No → GO TO QUESTION 96
		<input type="radio"/> Yes
95b.	How many surgeries have you had to correct pelvic prolapse?	<input type="text"/> # SURGERIES
95c.	How old were you when you had your first surgery?	<input type="text"/> AGE
95d.	How old were you when you had your second surgery?	<input type="text"/> AGE
95e.	How old were you when you had your third surgery?	<input type="text"/> AGE



## SURGERIES

Since January 1, 2012, have you had...	NEVER OR BEFORE 1/1/2012	HAD PROCEDURE 1/1/2012 OR LATER	a. If you had this procedure January 1, 2012 or later, what was the month and year?
96. gallbladder surgery?	<input type="radio"/> Never had procedure <input type="radio"/> Had procedure <u>before</u> January 1, 2012	<input type="radio"/> Had procedure January 1, 2012 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="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> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>
97. balloon angioplasty, stent placement, or other procedure to open or widen a heart artery? These procedures are different from the test used to diagnose a blockage.	<input type="radio"/> Never had procedure <input type="radio"/> Had procedure <u>before</u> January 1, 2012	<input type="radio"/> Had procedure January 1, 2012 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="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> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>
98. coronary artery bypass graft surgery?	<input type="radio"/> Never had procedure <input type="radio"/> Had procedure <u>before</u> January 1, 2012	<input type="radio"/> Had procedure January 1, 2012 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="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> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>

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99. Since January 1, 2012, 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 <b>lasting six or more weeks?</b>	<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"/>
q. A problem with sneezing or a runny nose or blocked nose when you did not have a cold or the flu?	<input type="radio"/>	<input type="radio"/>





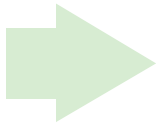
99. Since January 1, 2012, have you experienced any of the following medical symptoms? (Please mark a response for each item below.)

	No	Yes
r. feeling light-headed, dizzy, or weak when standing from sitting or lying down?	<input type="radio"/>	<input type="radio"/>
s. getting up regularly at night to pass urine?	<input type="radio"/>	<input type="radio"/>
t. unexplained pains (not due to known conditions such as arthritis)?	<input type="radio"/>	<input type="radio"/>
u. dribbling of saliva during daytime?	<input type="radio"/>	<input type="radio"/>

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

No → GO TO QUESTION 101

Yes



100a. How old were you the **first time** you noticed this problem? 

AGE	

100b. Are there any reasons (such as head injury) that explain the decrease in your sense of smell?

No

Yes, specify:

	NO	YES	a. If yes, for how many years have you had this symptom?
101. Since January 1, 2012, 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
102. Since January 1, 2012, 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

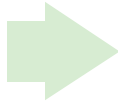
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103. Since January 1, 2012, have you had a mammogram, breast ultrasound, or breast MRI?

No → GO TO THE NEXT PAGE, QUESTION 104

Yes



103a. How many times did you have a mammogram, breast ultrasound, or breast MRI since January 1, 2012?

--	--

# TIMES

103b. What was the month and year of your most recent mammogram, breast ultrasound, or breast MRI?

		/	2	0		
MONTH			YEAR			

103c. Since January 1, 2012, have you been told you had abnormal findings on a mammogram, breast ultrasound, or breast MRI?

No → GO TO THE NEXT PAGE, QUESTION 104

Yes  
↓

103d. What was the month and year of your most recent test with abnormal findings?

		/	2	0		
MONTH			YEAR			

103e. Which breast showed abnormal findings at the most recent test?

- Left breast
- Right breast
- Both breasts

103f. 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



104. Since January 1, 2012, have you had a breast cyst or cysts drained (aspirated) or removed?

No → GO TO QUESTION 105

Yes



104a. On how many occasions have you had this since January 1, 2012?	<input type="text"/> <input type="text"/> # OCCASIONS
104b. What was the month and year of your most recent procedure?	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> MONTH YEAR
104c. 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

Please use a ballpoint pen for this form

105. Since January 1, 2012, have you had a needle biopsy to diagnose or rule out a breast condition?

No → GO TO THE NEXT PAGE, QUESTION 106

Yes



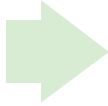
105a. On how many occasions have you had this since January 1, 2012?	<input type="text"/> <input type="text"/> # OCCASIONS
105b. What was the month and year of your most recent procedure?	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> MONTH YEAR
105c. On which breast was the most recent needle biopsy performed?	<input type="radio"/> Left breast <input type="radio"/> Right breast <input type="radio"/> Both breasts



106. Since January 1, 2012, 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 QUESTION 107

Yes



106a. On how many occasions have you had this since January 1, 2012?

--	--

# OCCASIONS

106b. What was the month and year of your most recent procedure?

		/	2	0		
MONTH			YEAR			

106c. On which breast was the most recent biopsy performed?

- Left breast
- Right breast
- Both breasts

107. Since January 1, 2012, have you had a breast lump or lumps removed (lumpectomy or excisional biopsy)?

No → GO TO THE NEXT PAGE, QUESTION 108

Yes



107a. On how many occasions have you had this since January 1, 2012?

--	--

# OCCASIONS

107b. What was the month and year of your most recent procedure?

		/	2	0		
MONTH			YEAR			

107c. On which breast was the most recent lumpectomy or excisional biopsy performed?

- Left breast
- Right breast
- Both breasts



Since January 1, 2012, have you had...	NEVER OR BEFORE 1/1/2012	1/1/2012 OR LATER	a. Why was this done?	b. If you had this procedure January 1, 2012 or later, what was the month and year?
108. a mastectomy of your left breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2012	<input type="radio"/> Yes, January 1, 2012 or later	<input type="radio"/> To treat breast cancer <input type="radio"/> To prevent breast cancer <input type="radio"/> Both	<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;"> </div> <div style="margin-left: 5px;">YEAR</div> </div>
109. a mastectomy of your right breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2012	<input type="radio"/> Yes, January 1, 2012 or later	<input type="radio"/> To treat breast cancer <input type="radio"/> To prevent breast cancer <input type="radio"/> Both	<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;"> </div> <div style="margin-left: 5px;">YEAR</div> </div>

Since January 1, 2012, have you had...	NEVER OR BEFORE 1/1/2012	1/1/2012 OR LATER	a. If you had this procedure January 1, 2012 or later, what was the month and year?	b. Did you have a silicone gel implant?
110. breast reconstruction surgery on your left breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2012	<input type="radio"/> Yes, January 1, 2012 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;"> </div> <div style="margin-left: 5px;">YEAR</div> </div>	<input type="radio"/> No <input type="radio"/> Yes
111. breast reconstruction surgery on your right breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2012	<input type="radio"/> Yes, January 1, 2012 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;"> </div> <div style="margin-left: 5px;">YEAR</div> </div>	<input type="radio"/> No <input type="radio"/> Yes

Please use a ballpoint pen for this form



Since January 1, 2012, 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, 2012, have you had...	NEVER OR BEFORE 1/1/2012	1/1/2012 OR LATER	a. If you had this January 1, 2012 or later, what was the month and year?
112. fibrocystic or <b>benign nonproliferative</b> 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, 2012	<input type="radio"/> Yes, January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>
113. fibroadenoma?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2012	<input type="radio"/> Yes, January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </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



Since January 1, 2012, 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, 2012, have you had...	NEVER OR BEFORE 1/1/2012	1/1/2012 OR LATER	a. If you had this January 1, 2012 or later, what was the month and year?
114. benign breast disease?	<input type="radio"/> Never <input type="radio"/> Yes, before January 1, 2012	<input type="radio"/> Yes, January 1, 2012 or later	<input type="text"/> / <input type="text"/> MONTH                      YEAR
115. proliferation without atypia? For example, sclerosing adenosis, intraductal papilloma, moderate hyperplasia, suspicious calcifications, etc.	<input type="radio"/> Never <input type="radio"/> Yes, before January 1, 2012	<input type="radio"/> Yes, January 1, 2012 or later	<input type="text"/> / <input type="text"/> MONTH                      YEAR
116. atypical hyperplasia?	<input type="radio"/> Never <input type="radio"/> Yes, before January 1, 2012	<input type="radio"/> Yes, January 1, 2012 or later	<input type="text"/> / <input type="text"/> MONTH                      YEAR  b. What type? <input type="radio"/> Atypical ductal hyperplasia <input type="radio"/> Atypical lobular hyperplasia <input type="radio"/> Both <input type="radio"/> Don't know
117. ductal carcinoma in situ (DCIS)?	<input type="radio"/> Never <input type="radio"/> Yes, before January 1, 2012	<input type="radio"/> Yes, January 1, 2012 or later	<input type="text"/> / <input type="text"/> MONTH                      YEAR
118. lobular carcinoma in situ (LCIS)?	<input type="radio"/> Never <input type="radio"/> Yes, before January 1, 2012	<input type="radio"/> Yes, January 1, 2012 or later	<input type="text"/> / <input type="text"/> MONTH                      YEAR
119. breast cancer?	<input type="radio"/> Never <input type="radio"/> Yes, before January 1, 2012	<input type="radio"/> Yes, January 1, 2012 or later	<input type="text"/> / <input type="text"/> MONTH                      YEAR
120. other changes?	<input type="radio"/> Never <input type="radio"/> Yes, before January 1, 2012	<input type="radio"/> Yes, January 1, 2012 or later	<input type="text"/> / <input type="text"/> MONTH                      YEAR

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121. 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

Since January 1, 2012, have you had...	NEVER OR BEFORE 1/1/2012	1/1/2012 OR LATER	a. If you had this procedure January 1, 2012 or later, what was the month and year?
122. breast reduction surgery on your <b>left</b> breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2012	<input type="radio"/> Yes, January 1, 2012 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="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">0</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;"></div> </div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>
123. breast reduction surgery on your <b>right</b> breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2012	<input type="radio"/> Yes, January 1, 2012 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="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">0</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;"></div> </div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>

Since January 1, 2012, have you had...	NEVER OR BEFORE 1/1/2012	1/1/2012 OR LATER	a. If you had this procedure January 1, 2012 or later, what was the month and year?	b. Did you have a silicone gel implant?
124. breast enlargement surgery on your <b>left</b> breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2012	<input type="radio"/> Yes, January 1, 2012 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="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">0</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;"></div> </div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>	<input type="radio"/> No <input type="radio"/> Yes
125. breast enlargement surgery on your <b>right</b> breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2012	<input type="radio"/> Yes, January 1, 2012 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="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">0</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;"></div> </div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>	<input type="radio"/> No <input type="radio"/> Yes





Since January 1, 2012, have you had...	NEVER OR BEFORE 1/1/2012	1/1/2012 OR LATER	a. If you had this procedure January 1, 2012 or later, what was the month and year?	b. Was this a silicone gel implant?
126. a breast implant surgically removed from your <b>left</b> breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2012	<input type="radio"/> Yes, January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center; margin-right: 5px;">/</div> <div style="display: flex; gap: 5px;"> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;">0</div> </div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>	<input type="radio"/> No <input type="radio"/> Yes
127. a breast implant surgically removed from your <b>right</b> breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2012	<input type="radio"/> Yes, January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center; margin-right: 5px;">/</div> <div style="display: flex; gap: 5px;"> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;">0</div> </div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>	<input type="radio"/> No <input type="radio"/> Yes

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## MENSTRUAL HISTORY

127a. Have you had a menstrual period or pregnancy in the past 10 years?

- No → GO TO PAGE 39, QUESTION 128
- Yes → GO TO THE NEXT PAGE, QUESTION 127b1



127b1. Are you currently pregnant or breastfeeding?

- No → GO TO NEXT QUESTION, 127b2
- Yes → GO TO PAGE 36, QUESTION 127h

127b2. 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 127e.

127c. Why did your periods stop? Please choose one response that best describes your situation.

- 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 147 and 148).
- 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:

127d. 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 36, QUESTION 127h



## BOX B

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

127e. 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			

127f. 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.

GO TO PAGE 36,  
QUESTION 127h

OR

- My periods stopped sometime in the last 12 months. → GO TO QUESTION 127g

127g. Why did your periods stop? Please choose one response that best describes your situation.

- 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 147 and 148).
- 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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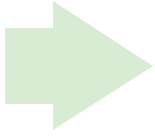


REPRODUCTIVE HISTORY AND HORMONES

127h. Have you had a pregnancy since January 1, 2012?

No → GO TO PAGE 38, QUESTION 127o

Yes



127h1. Are you currently pregnant?

No

Yes

127h2. How many times have you been pregnant since January 1, 2012 (including your current pregnancy, if you are pregnant now)?

# TIMES



THIS SECTION IS FOR WOMEN WHO HAVE BEEN PREGNANT SINCE JANUARY 1, 2012.  
ALL OTHERS GO TO THE NEXT PAGE, QUESTION 127o.

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	FIRST PREGNANCY (since January 1, 2012)	SECOND PREGNANCY (since January 1, 2012)
127i. 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
127j. 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
127k. What month and year did this pregnancy end?	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR <b>OR</b> <input type="radio"/> Still pregnant now	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR <b>OR</b> <input type="radio"/> Still pregnant now
127l. 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
127m. 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 127n <input type="radio"/> Did not breastfeed/ not applicable → GO TO NEXT PREGNANCY OR QUESTION 127o	<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 127n <input type="radio"/> Did not breastfeed/ not applicable → GO TO NEXT PREGNANCY OR QUESTION 127o
127n. Are you still breastfeeding?	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes

IF YOU HAVE HAD MORE THAN 2 PREGNANCIES SINCE JANUARY 1, 2012,  
PLEASE ANSWER THE SAME QUESTIONS FOR EACH PREGNANCY AND  
RECORD YOUR ANSWERS ON A SEPARATE SHEET OF PAPER.



127o. Since January 1, 2012, have you used any hormonal birth control?

No → **GO TO THE NEXT PAGE, QUESTION 128**

Yes



Since January 1, 2012, have you used...	NO	YES	If yes, how many months in all have you used this since January 1, 2012?	Are you currently using this?
127p. birth control pills?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
127q. birth control patches?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
127r. a hormonal IUD (intrauterine device)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
127s. a Norplant implant?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
127t. a Nuva Ring?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
127u. Depo Provera?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
127v. any other hormonal 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



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

Since January 1, 2012, have you used...		NO	YES	a. If yes, how many months in all have you used this since January 1, 2012?	b. Do you currently use this female hormone product(s)?
128.	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
129.	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
130.	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
131.	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
132.	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
133.	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
134.	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

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Since January 1, 2012, have you used...	NO	YES	If yes, how many months in all have you used this since January 1, 2012?
135. vaginal estrogen creams, rings, or suppositories?	<input type="radio"/> No	<input type="radio"/> Yes	<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>
136. any other estrogen products, including "natural" estrogens?	<input type="radio"/> No	<input type="radio"/> Yes	<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, 2012? (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, 2012, have you used...	NO	YES	a. If yes, how many months in all have you used this since January 1, 2012?	b. Do you currently use this?	c. Why did you use this?
137. 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	<input type="radio"/> Treat breast cancer <input type="radio"/> Prevent breast cancer <input type="radio"/> Another reason
138. ospemifene or Ospheña?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> Treat breast cancer <input type="radio"/> Prevent breast cancer <input type="radio"/> Another reason
139. 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	<input type="radio"/> Treat breast cancer <input type="radio"/> Prevent breast cancer <input type="radio"/> Another reason
<b>Aromatase inhibitors:</b>					
140. 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	<input type="radio"/> Treat breast cancer <input type="radio"/> Prevent breast cancer <input type="radio"/> Another reason
141. 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	
142. 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	
143. other aromatase inhibitor?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes	
Please specify: <input type="text"/>					
144. Herceptin?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes	
145. testosterone?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes	
146. 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, 2012, have you had...	NEVER OR BEFORE 1/1/2012	HAD PROCEDURE 1/1/2012 OR LATER	If you had this procedure January 1, 2012 or later, what was the month and year?
147. a hysterectomy (surgical removal of the uterus)?	<input type="radio"/> Never had procedure <input type="radio"/> Had procedure <u>before</u> January 1, 2012	<input type="radio"/> Had procedure January 1, 2012 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 148 <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
148. 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, 2012	<input type="radio"/> Had procedure January 1, 2012 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?
149.	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
150.	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

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. How often did/do these occur in a typical week?	
151.	hot flashes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<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	c. 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  d. Have you experienced any symptoms in the past 12 months?  <input type="radio"/> No <input type="radio"/> Yes

Please use a ballpoint pen for this form



## MEDICATIONS

Since January 1, 2012, have you used any prescription medicines to treat or to prevent...		NO	YES	a. If yes, are you currently taking this?
152.	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
153.	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
154.	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
155.	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
155a.	angina?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
156.	diabetes?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
157.	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
158.	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



Since January 1, 2012, have you used any prescription medicines to treat or to prevent...		NO	YES	a. If yes, are you currently taking this?
159.	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
160.	osteoarthritis?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
161.	migraines?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
162.	depression?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
163.	asthma?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
164.	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
165.	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, 2012, 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, 2012?	
166.	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
167.	“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
168.	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
169.	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
170.	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
171.	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
172.	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
173.	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>







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
<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
<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



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)

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 and Quality of Life

### Version 1

**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: ⊗ ✓

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, 2012 = 

0	6
---	---

 / 

0	7
---	---

 / 

2	0	1	2
---	---	---	---

  
(month) (day) (year)

Version 1

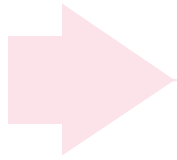


Your continued participation in the Sister Study is completely voluntary and greatly appreciated. If you are not comfortable answering a question, just skip it and go to the next one. All information you share will be kept confidential.

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

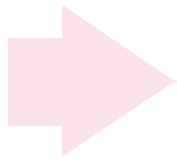
1. Which of the following best describes your **current** marital status? Please choose the **one** response that best describes your current situation.

- Never married
- Widowed
- Divorced
- Separated



**GO TO QUESTION 2**

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



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

# YEARS

OR  Less than 1 year

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

Man

Woman

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

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

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

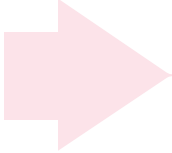
- 1
- 2
- 3-4
- 5-6
- 7-8
- More than 8



4. Have you ever smoked at least 10 cigarettes or more?

No → GO TO QUESTION 5

Yes



4a. What is your current smoking status?	<input type="radio"/> Former smoker <input type="radio"/> Current smoker			
4b. When did you first start smoking?	<input type="radio"/> Before 2012 <input type="radio"/> 2012 <input type="radio"/> 2013 <input type="radio"/> 2014 <input type="radio"/> 2015			
4c. Did you smoke at least 10 cigarettes since January 1, 2012?	<input type="radio"/> No <input type="radio"/> Yes			
4d. When did you last smoke?	<input type="radio"/> I am a current smoker <input type="radio"/> I last smoked in 2015 <input type="radio"/> I last smoked in 2014 <input type="radio"/> I last smoked in 2013 <input type="radio"/> I last smoked in 2012 <input type="radio"/> I last smoked before 2012			
4e. During the years you smoked, 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			
4f. During the years you smoked, how many cigarettes do/did you usually smoke per day on the days 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, 2012, how many regular smokers have you lived with (not counting yourself, if you smoke)?

- None
- 1
- 2
- 3-4
- 5 or more



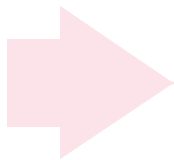
6. About how many hours or minutes per day are you exposed to other people's tobacco smoke (include all locations—home, work, and all other places you spend time where others might smoke)?

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

6a. Have you ever used an electronic cigarette or e-cigarette, such as NJOY, Blu, or Smoking Everywhere, even one or two times?

No → GO TO QUESTION 7

Yes



6b.	Do you now use e-cigarettes...	<input type="radio"/> Every day <input type="radio"/> Some days <input type="radio"/> Not at all
6c.	What brand of e-cigarette do/did you use?	<input type="text"/> BRAND
6d.	About how many disposable e-cigarettes or e-cigarette cartridges have you used in the past year?	<input type="radio"/> None <input type="radio"/> 1 or more puffs but never a whole one <input type="radio"/> 1-10 <input type="radio"/> 11-20 <input type="radio"/> 21-50 <input type="radio"/> 51-99 <input type="radio"/> 100 or more





Since January 1, 2012... NO	YES	a. IF YES, in which years since January 1, 2012 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"/> 2012 <input type="radio"/> 2013 <input type="radio"/> 2014 <input type="radio"/> 2015	<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"/> 2012 <input type="radio"/> 2013 <input type="radio"/> 2014 <input type="radio"/> 2015	<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"/> 2012 <input type="radio"/> 2013 <input type="radio"/> 2014 <input type="radio"/> 2015	<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"/> 2012 <input type="radio"/> 2013 <input type="radio"/> 2014 <input type="radio"/> 2015	<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

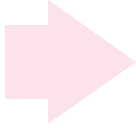
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11. Since January 1, 2012, did you ever drink four or more alcoholic beverages in a row, in one sitting?

No → GO TO QUESTION 12

Yes



11a. How often has this happened since January 1, 2012?

- 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, 2012, has a doctor or other health professional told you that your drinking was hurting your health?

No

Yes



Since January 1, 2012... NO	YES	a. IF YES, in which years since January 1, 2012 did you drink this? (Please mark all that apply.)	b. About how often did you drink this?	c. On average, how many drinks did you have on the days that you drank this?
13. have you drunk regular coffee? <input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> 2012 <input type="radio"/> 2013 <input type="radio"/> 2014 <input type="radio"/> 2015	<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
14. have you drunk decaffeinated coffee? <input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> 2012 <input type="radio"/> 2013 <input type="radio"/> 2014 <input type="radio"/> 2015	<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
15. have you drunk tea or iced tea (not herbal teas)? <input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> 2012 <input type="radio"/> 2013 <input type="radio"/> 2014 <input type="radio"/> 2015	<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
16. have you drunk decaffeinated tea or decaffeinated iced tea? <input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> 2012 <input type="radio"/> 2013 <input type="radio"/> 2014 <input type="radio"/> 2015	<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

Please use a ballpoint pen for this form



Since January 1, 2012... NO	YES	a. IF YES, in which years since January 1, 2012 did you drink this? (Please mark all that apply.)	b. About how often did you drink this?	c. On average, how many drinks did you have on the days that you drank this?
17. have you drunk regular green tea? <input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> 2012 <input type="radio"/> 2013 <input type="radio"/> 2014 <input type="radio"/> 2015	<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
18. have you drunk decaffeinated green tea? <input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> 2012 <input type="radio"/> 2013 <input type="radio"/> 2014 <input type="radio"/> 2015	<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
19. have you drunk regular soft drinks? <input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> 2012 <input type="radio"/> 2013 <input type="radio"/> 2014 <input type="radio"/> 2015	<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
20. have you drunk decaffeinated soft drinks? <input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> 2012 <input type="radio"/> 2013 <input type="radio"/> 2014 <input type="radio"/> 2015	<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



In all, how many years did you regularly drink...

20d. regular coffee?

- Never
- Less than one year
- 1-5 years
- 6-10 years
- 11-15 years
- More than 15 years

20e. decaffeinated coffee?

- Never
- Less than one year
- 1-5 years
- 6-10 years
- 11-15 years
- More than 15 years

20f. tea or iced tea (not herbal teas)?

- Never
- Less than one year
- 1-5 years
- 6-10 years
- 11-15 years
- More than 15 years

20g. decaffeinated tea or decaffeinated iced tea?

- Never
- Less than one year
- 1-5 years
- 6-10 years
- 11-15 years
- More than 15 years

Please use a ballpoint pen for this form



In all, how many years did you regularly drink...

20h. regular green tea?

- Never
- Less than one year
- 1-5 years
- 6-10 years
- 11-15 years
- More than 15 years

20i. decaffeinated green tea?

- Never
- Less than one year
- 1-5 years
- 6-10 years
- 11-15 years
- More than 15 years

20j. regular soft drinks?

- Never
- Less than one year
- 1-5 years
- 6-10 years
- 11-15 years
- More than 15 years

20k. decaffeinated soft drinks?

- Never
- Less than one year
- 1-5 years
- 6-10 years
- 11-15 years
- More than 15 years



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.

Please use a ballpoint pen for this form

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?

21. 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"/> <input type="text"/> AND <input type="text"/> <input type="text"/> HOURS PER DAY MINUTES PER DAY <input type="radio"/> Not sure
22. 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"/> <input type="text"/> AND <input type="text"/> <input type="text"/> HOURS PER DAY MINUTES PER DAY <input type="radio"/> Not sure
23. <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"/> <input type="text"/> AND <input type="text"/> <input type="text"/> HOURS PER DAY MINUTES PER DAY <input type="radio"/> Not sure

During the **past 7 days**, how much time did you...

24. 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"/> <input type="text"/> AND <input type="text"/> <input type="text"/> HOURS PER DAY MINUTES PER DAY <input type="radio"/> Not sure
25. 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"/> <input type="text"/> AND <input type="text"/> <input type="text"/> HOURS PER DAY MINUTES PER DAY <input type="radio"/> Not sure

26. 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



27. What percentage of your head hair is naturally gray right now? If you color your hair, what percentage would be gray if you didn't color it? (Please mark one.)

- Not gray at all
- Less than 25%
- 25-49%
- 50-74%
- 75-99%
- 100%
- I don't know

27a. How old were you when your hair turned at least 50% gray? (Please mark one.)

- My hair is not gray at all or it is less than 50% gray
- I was younger than 40
- I was between 40 and 49
- I was 50 years of age or older
- I don't know if my hair is 50% gray
- I know my hair is at least 50% gray but I do not know how old I was when it happened
- I don't know

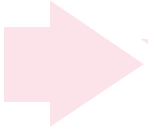




27b. Since January 1, 2012, have you used hair dye to color your hair?

No → GO TO THE NEXT PAGE, QUESTION 28

Yes



27c. In what years did you do this? *(Please mark all that apply.)*

- 2012
- 2013
- 2014
- 2015

27d. What color did you usually use?

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

27e. 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



28. Since January 1, 2012, 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

29. Since January 1, 2012, 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

30. Since January 1, 2012, 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?

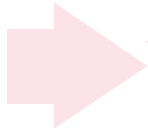
- Never
- Once
- Twice
- Three times
- Four or more times



31. Since January 1, 2012, about how often have you used chemical products for fleas or ticks on any pets in your household?

- I don't have any pets → GO TO QUESTION 32
- Never

- Once
- Twice
- Three times
- Four or more times



31a. Which of the following kinds of chemical flea or tick treatment was used on your pets? (Please mark all that apply.)

- Shampoos or dips
- Powders
- Sprays
- Pills
- Collars
- Topical drops applied to skin or fur
- Any other type of chemical product

31b. When flea or tick treatment was used on your pets, 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

32. In the past month, on average, how much time per day did you usually spend outdoors in daylight?

- Not at all
- Less than 30 minutes
- 30 minutes or more

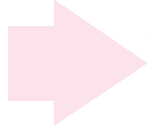




36. Since January 1, 2012, about how often has your residence been treated with insecticides or pesticides to control insects, rodents, or other pests, either inside or around the foundation?

Never → GO TO THE NEXT PAGE, QUESTION 37

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



36a. 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

36b. When pest control chemicals were applied since January 1, 2012, 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

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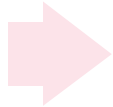
37. Since January 1, 2012, about how often was the garden or yard around this residence treated with weed killers or insecticides, including those labeled organic such as pyrethrum or rotenone?

- Never
- Not applicable



**GO TO QUESTION 38**

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



37a. When weed killers or insecticides were used in the garden or yard since January 1, 2012, 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

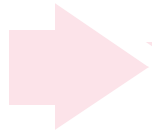
38. Since January 1, 2012, about how often have you personally used household cleaning solutions other than dish washing and laundry detergents?

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

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**?

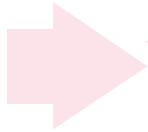
- Little or no traffic
- Light traffic, moving at or above the speed limit
- Heavy traffic, moving below the speed limit
- Congested or "stop and go"
- Heavy traffic, moving at or above the speed limit



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



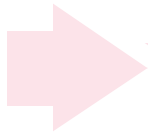
40a. What is the traffic condition that best describes your travel time by bicycle or motorcycle on most days?

- 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

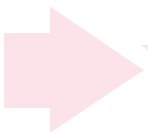


41a. What is the traffic condition that best describes your travel time by foot on most days?

- 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, 2012 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 PAGE 24, QUESTION 56.

Yes → GO TO THE NEXT PAGE, QUESTION 43

Please use a ballpoint pen for this form



IF YOU DID NOT HAVE A JOB SINCE JANUARY 1, 2012, GO TO PAGE 24, QUESTION 56.

43. How many different jobs have you had since January 1, 2012?

--	--

 # OF JOBS

Please tell us about the jobs you have had since January 1, 2012, starting with the most recent and working backwards.

	JOB 1	JOB 2												
44. When did you first start this job?	<input type="radio"/> Before 2012 <input type="radio"/> 2012 <input type="radio"/> 2013 <input type="radio"/> 2014 <input type="radio"/> 2015	<input type="radio"/> Before 2012 <input type="radio"/> 2012 <input type="radio"/> 2013 <input type="radio"/> 2014 <input type="radio"/> 2015												
45. When did you last have this job?	<input type="radio"/> 2012 <input type="radio"/> 2013 <input type="radio"/> 2014 <input type="radio"/> 2015 <input type="radio"/> I still work there	<input type="radio"/> 2012 <input type="radio"/> 2013 <input type="radio"/> 2014 <input type="radio"/> 2015 <input type="radio"/> I still work there												
46. Where did/do 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-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 30px; height: 20px;"></td> <td style="border: 1px solid black; width: 30px; height: 20px;"></td> <td style="border: 1px solid black; width: 30px; height: 20px;"></td> <td style="border: 1px solid black; width: 30px; height: 20px;"></td> <td style="border: 1px solid black; width: 30px; height: 20px;"></td> <td style="border: 1px solid black; width: 30px; height: 20px;"></td> </tr> </table> STATE      ZIP CODE  <div style="border: 1px solid black; height: 30px; margin-bottom: 5px;"></div> COUNTY							<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-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 30px; height: 20px;"></td> <td style="border: 1px solid black; width: 30px; height: 20px;"></td> <td style="border: 1px solid black; width: 30px; height: 20px;"></td> <td style="border: 1px solid black; width: 30px; height: 20px;"></td> <td style="border: 1px solid black; width: 30px; height: 20px;"></td> <td style="border: 1px solid black; width: 30px; height: 20px;"></td> </tr> </table> STATE      ZIP CODE  <div style="border: 1px solid black; height: 30px; margin-bottom: 5px;"></div> COUNTY						

SPACE IS PROVIDED FOR TWO JOBS. IF YOU HAVE HAD MORE THAN TWO JOBS LASTING 12 MONTHS OR MORE SINCE JANUARY 1, 2012, PLEASE ANSWER THE SAME QUESTIONS FOR EACH JOB AND RECORD YOUR ANSWERS ON A SEPARATE SHEET OF PAPER.





	JOB 1	JOB 2
47. On a scale from 1 to 5, how <b>physically demanding</b> was/is 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/is 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 did/do 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 did/do 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

Please use a ballpoint pen for this form



**JOB 1**

**JOB 2**

52. How many hours per week did/do 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 did/do you usually work at this job?

START TIME: (mark one)

		:		
(hr)			(min)	

- AM
- PM

START TIME: (mark one)

		:		
(hr)			(min)	

- AM
- PM

STOP TIME: (mark one)

		:		
(hr)			(min)	

- AM
- PM

STOP TIME: (mark one)

		:		
(hr)			(min)	

- 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 did/do 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





55. While working at this job did/do you regularly...

JOB 1			JOB 2		
	NO	YES		NO	YES
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"/>

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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.

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

	Excellent	Very good	Good	Fair	Poor
a. In general, would you say your health is...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. 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"/>
c. In general, how would you rate your physical health?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. 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"/>
e. 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"/>
f. 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"/>

57. 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



58. 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

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

- None
- Mild
- Moderate
- Severe
- Extremely severe

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

No pain											Worst imaginable 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"/>	<input type="radio"/>	<input type="radio"/>
0	1	2	3	4	5	6	7	8	9	10	

61. 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"/>



62. 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"/>

63. Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half of the days	Nearly every day
a. Little interest or pleasure in doing things.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Feeling down, depressed, or hopeless.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Feeling nervous, anxious, or on edge.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Not being able to stop or control worrying.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



Since <b>January 1, 2012</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 <b>past 4 weeks</b> ?
64. 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
65. 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
66. 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
67. 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
68. 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
69. 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, 2012</b> , have you experienced...	NO	YES	a. Regardless of when this happened, how much distress or anxiety has this caused you in the <b>past 4 weeks</b> ?
70. 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
71. 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
72. 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
73. 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
74. 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





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

75. In the last several years...	No	Yes	Don't Know	Not applicable
a. 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"/>
b. has your interest in hobbies or activities decreased?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. 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"/>
d. 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"/>
e. have you noticed more problems remembering the month or year?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. 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"/>
g. has it become more difficult to remember appointments?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. do you notice more daily problems with thinking and/or memory?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please use a ballpoint pen for this form

Please answer the following questions about sleep.

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

--	--

# HOURS

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

--	--

# HOURS



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

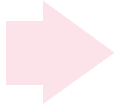
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# HOURS

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

No → **GO TO QUESTION 80**

Yes



79a. How many nights in a typical month do you have trouble sleeping?

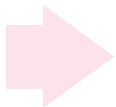
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# NIGHTS

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

No → **GO TO QUESTION 81**

Yes



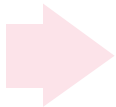
80a. In the **past month**, about how often did you feel excessively sleepy during the day?

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

81. 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 THE NEXT PAGE, QUESTION 82a**

Yes



81a. Has this happened more than 3 times?

- Yes
- No

81b. How old were you when you first knew you did this?

--	--

AGE



	No	Yes
82a. Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	<input type="radio"/>	<input type="radio"/>
82b. Has anyone observed you stop breathing during your sleep?	<input type="radio"/>	<input type="radio"/>
82c. Do you often feel tired or fatigued during daytime?	<input type="radio"/>	<input type="radio"/>
82d. Have you ever been told that you sleepwalk?	<input type="radio"/>	<input type="radio"/>

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you.

	Would never doze	Slight chance of dozing	Moderate chance of dozing	High chance of dozing
82e. Sitting and reading	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
82f. Watching television	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
82g. Sitting inactive in a public place (e.g. a theater or meeting)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
82h. A passenger in a car for an hour without a break	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
82i. Lying down to rest in the afternoon when circumstances permit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
82j. Sitting and talking to someone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
82k. Sitting quietly after a lunch without alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
82l. In a car, while stopped for a few minutes in traffic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please use a ballpoint pen for this form



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

No, not regularly → **GO TO PAGE 35, QUESTION 95**

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> 84. 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
85. 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	
86. 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	





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>					
87. 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	
88. 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
89. 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
90. 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

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>					
91. 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
92. 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	
93. 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
94. 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



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?
95. 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
96. 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
97. 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
98. 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
99. 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
100. 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

Please use a ballpoint pen for this form



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?
101.	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
102.	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
103.	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





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?
104.	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
105.	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
106.	Meditation/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
107.	Massage/therapeutic touch	<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
108.	Tai chi/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

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109. Typically when not taking laxatives, how often do you have bowel movements?

- Two or more times per day
- Once per day
- 5 to 6 times per week
- 3 to 4 times per week
- Less than three times per week

110. 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, 2012</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 <b>at least a month in the past year</b> ?
111.	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
112.	Vegan	<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
113.	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
114.	Gluten-free 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
115.	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



Have you ever had any of the following weight loss procedures?	NO	YES	a. What age did you have this?
116. Lap band	<input type="radio"/> No	<input type="radio"/> Yes	<div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto; display: flex; justify-content: space-between;"> <span style="width: 15px;"></span> <span style="width: 15px;"></span> </div> AGE
117. Bariatric surgery	<input type="radio"/> No	<input type="radio"/> Yes	<div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto; display: flex; justify-content: space-between;"> <span style="width: 15px;"></span> <span style="width: 15px;"></span> </div> AGE

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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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