

## Privacy Act Statement

### You have rights under the Privacy Act.

#### The following statement describes how that ACT applies to this study:

The Privacy Act System of Records Notice (SORN) for this study is N6500-1. The SORN was published on the Defense Privacy and Civil Liberties Division (DPCLD) website on November 14, 2014, and can be found here:  
<https://dpcl.d.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570396/n06500-1/>

**Authority:** Authority to request this information is granted under 10 USC 136, Under Secretary of Defense for Personnel and Readiness, 10 USC 1782, Surveys of Military Families, 10 USC 2358, Research and Development Projects, Under Secretary of Defense Memorandum #: 99-028, 30 SEP 99 "Establishment of DoD Centers for Deployment Health" and Executive Order 9396, Numbering System for Federal Accounts Relating to Individual Persons.

**Purpose:** This questionnaire was designed to assess a variety of factors that have motivated and/or discouraged Millennium Cohort participants to stay connected with the study. It will also help capture information that will allow the study staff improve and create new strategies to keep the cohort interested in the study.

**Routine Uses:** The information provided in this questionnaire will be maintained in data files at the Deployment Health Research Department at the Naval Health Research Center and used only for program improvement. Use of these data may be granted to other federal and non-federal medical research agencies as approved by the Naval Health Research Center's Institutional Review Board. In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act, these records or information contained therein may specifically be disclosed outside the DoD as a routine use pursuant to 5 U.S.C. 552a(b)(3).

**NOTE:** All disclosures to the DVA and HHS must have prior approval of the Naval Health Research Center Institutional Review Board and a Memorandum of Understanding must be entered into to ensure the right and obligations of the signatories are clear. Access to data 1) is provided on need-to-know basis only; 2) must adhere to the rule of minimization in that only information necessary to accomplish the purpose for which the disclosure is being made is releasable; and 3) must follow strict guidelines established in the data sharing agreement. To the Social Security Administration (SSA) for considering individual claims for benefits for which that SSA is responsible. The DoD 'Blanket Routine Uses' that appear at the beginning of the Navy's compilation of systems of records notices apply to this system.

**NOTE:** This system of records contains individually identifiable health information. The DoD Health Information Privacy Regulation (DoD 6025.18-R) issued pursuant to the Health Insurance Portability and Accountability Act of 1996, applies to most such health information. DoD 6025.18-R may place additional procedural requirements on the uses and disclosures of such information beyond those found in the Privacy Act of 1974 or mentioned in this system of records notice.

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

### Agency Disclosure Notice

The public reporting burden for this collection of information, OMB Control Number 0703-0064, is estimated to average 8 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. Send comments regarding the burden estimate or burden reduction suggestions to the Department of Defense, Washington Headquarters Services, at [whs.mc-alex.esd.mbx.dd-dod-information-collections@mail.mil](mailto:whs.mc-alex.esd.mbx.dd-dod-information-collections@mail.mil). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

**Disclaimer: Answers to this survey are not monitored in real time.**

**We understand that some of the questions you may encounter are quite personal and sensitive. While every response is incredibly valuable in our study, you do not have to answer all survey questions. You always have the option to skip any questions and leave them blank.**

**To help protect your privacy, the Millennium Cohort Study has obtained a Certificate of Confidentiality from the National Institutes of Health. We can use the Certificate to legally refuse to disclose information that may identify you in any federal, state, or local civil, criminal administrative, legislative, or other proceedings (for example, if there was a court subpoena).**

## SLEEP QUALITY

We would like to begin by asking you some questions about your sleeping pattern. Even if you are deployed, underway, participating in training, or have a newborn disturbing your sleep, please answer the following questions about your current sleep pattern.

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

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

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

3. Please rate your sleep pattern for the **past 2 weeks**.

	Non e	Mil d	Modera te	Sever e	Very severe
Difficulty falling asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Problem waking up too early	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Snoring	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

- Very satisfied
- Satisfied
- Moderately satisfied
- Dissatisfied
- Very dissatisfied

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

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

6. How **noticeable** to others do you think your sleep pattern is in terms of impairing the quality of your life?
- Not at all noticeable
  - A little
  - Somewhat
  - Much
  - Very much noticeable
7. How **worried/distressed** are you about your current sleep pattern?
- Not at all worried
  - A little
  - Somewhat
  - Much
  - Very much worried

## PHYSICAL HEALTH

These next questions are about your physical health, how you feel, and how well you are able to do your daily activities.

8. Over the **past 3 years**, approximately how many days were you hospitalized because of illness or injury? Exclude hospitalization for pregnancy and childbirth.
- None
  - 1 day
  - 2-5 days
  - 6-10 days
  - 11-15 days
  - 16-20 days
  - 21-60 days
  - > 60 days
9. Over the **past 3 years**, approximately how many days were you unable to work or perform your usual activities because of illness or injury? Exclude lost time for pregnancy and childbirth.
- None
  - 1 day
  - 2-5 days
  - 6-10 days
  - 11-15 days
  - 16-20 days
  - 21-60 days
  - > 60 days
10. In the **last 3 years**, have you had persistent or recurring problems with any of the following?

	No	Yes
Unusual muscle pains	<input type="radio"/>	<input type="radio"/>
Unusual fatigue	<input type="radio"/>	<input type="radio"/>
Forgetfulness	<input type="radio"/>	<input type="radio"/>
Confusion	<input type="radio"/>	<input type="radio"/>
Frequent bladder infections	<input type="radio"/>	<input type="radio"/>
Shortness of breath	<input type="radio"/>	<input type="radio"/>

Cough	0	0
Severe headache	0	0

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

	Not bothered	Bothered a little	Bothered a lot
Stomach pain	0	0	0
Back pain	0	0	0
Pain in your arms, legs, or joints (knees, hips, etc.)	0	0	0
Pain or problems during sexual intercourse	0	0	0
Headaches	0	0	0
Chest pain	0	0	0
Dizziness	0	0	0
Fainting spells	0	0	0
Feeling your heart pound or race	0	0	0
Shortness of breath	0	0	0
Constipation, loose bowels, or diarrhea	0	0	0
Nausea, gas, or indigestion	0	0	0
<b>Women only:</b> Menstrual cramps or other problems with your periods	0	0	0

12. On a **typical day**, how much time do you spend sitting? (e.g., at work, commuting, watching TV, playing video games, or using a computer)

hours per day

13. How tall are you?  feet  inches

14. What is your current weight?  pounds

15. In a **typical week**, how much time do you spend participating in...

	<b># of days per week you exercise</b>		<b>On those days, how many <b>minutes per day</b> on average do you exercise?</b>	
<b>STRENGTH TRAINING</b> or work that strengthens your muscles? (such as lifting/pushing/pulling weights)	Days	AND	minutes	OR O none O cannot physically do
<input type="text"/> <b>VIGOROUS</b> exercise or work that causes heavy sweating or large increase in breathing or heart rate? (such as running, active sports, marking, biking)	Days	AND	minutes	OR O none O cannot physically do
<input type="text"/> <b>MODERATE or LIGHT</b> exercise or work that causes light sweating or slight increases in breathing or heart rate? (such as walking, cleaning, slow jogging)	Days	AND	<input type="text"/> minutes	OR O none O cannot physically do

16. Has your doctor or other health professional **ever** told you that you have COVID-19 (Coronavirus disease 2019) or have you **ever** tested positive for SARS-CoV-2 (including at home testing, testing sites, and healthcare settings)?

- No
- Yes, once (or multiple times within a 14-day period)
- Yes, more than once where you were tested at least 14 days apart

If **YES**, what was the month/year of your **first** diagnosis/positive test?

month       year

17. Since the beginning of the COVID-19 pandemic, have you **ever**:

Become seriously ill with COVID-19?       No     Yes

If **YES**, what was the month/year of when illness began?       year       month

Been hospitalized with COVID-19?       No     Yes

If **YES**, what was the month/year of your first hospitalization?       year       month

Recovered from COVID-19?       No     Yes

If **YES**, what was the month/year of your recovery (no longer experiencing symptoms)?

month       year

Experienced longer term health issues after you recovered from COVID-19?       No     Yes

18. Please indicate how many of the initial COVID-19 series and booster vaccinations you have received:

	None	Some	Entire
Initial series	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Booster or updated yearly vaccine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

What was the month/year of your **first** dose of vaccination?

month  year

19. In the **last 12 months**, how long did you take prescription narcotics for pain relief, such as Codeine, OxyContin, Percocet, Vicodin?

- Never
- Less than 1 week
- 1-2 weeks
- 3-4 weeks
- More than 4 weeks

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

	No	Yes	If <b>YES</b> , in what year were you first diagnosed?
Hypertension (high blood pressure)	0	0	
High cholesterol requiring medication	0	0	
Coronary heart disease	0	0	
Heart attack	0	0	
Stroke	0	0	
Emphysema/COPD (chronic obstructive pulmonary disease)	0	0	
Chronic bronchitis	0	0	
Asthma	0	0	
Depression	0	0	
Posttraumatic stress disorder	0	0	
Diabetes or sugar diabetes	0	0	
Significant vision loss even with glasses or contact lenses	0	0	
Significant hearing loss	0	0	
Tinnitus/ringing of the ears	0	0	
Migraine headaches	0	0	
Degenerative joint disease (osteoarthritis)	0	0	
Lupus	0	0	
Multiple sclerosis	0	0	
Ulcerative colitis	0	0	
Crohn's disease	0	0	
Sleep apnea	0	0	
Infertility	0	0	
Parkinson's disease	0	0	
Basal cell (BCC) or squamous cell (SCC) skin cancer	0	0	
Other cancer, excluding BCC or SCC (please specify)	0	0	
Sexually transmitted infections (HPV, Chlamydia, Gonorrhea, Syphilis, etc.)	0	0	
Any dementia (e.g., mild cognitive impairment, Alzheimer's Disease, Frontotemporal Dementia, Lewy Body Dementia, etc.)	0	0	
Chronic Traumatic Encephalopathy (CTE)	0	0	
Autoimmune hypothyroidism (i.e., Hashimoto's disease)	0	0	
Autoimmune hyperthyroidism (i.e., Graves' disease)	0	0	
Traumatic brain injury (not including injuries that resulted in only a concussion)	0	0	
Concussion	0	0	
<b>Women:</b> Gestational diabetes (diabetes during pregnancy)	0	0	
<b>Women:</b> Preeclampsia/eclampsia	0	0	
<b>Women:</b> Pelvic inflammatory disease (PID)	0	0	
<b>Women:</b> Polycystic ovarian syndrome (PCOS)	0	0	
<b>Women:</b> Uterine fibroids	0	0	
<b>Women:</b> Post-partum depression	0	0	
<b>Women:</b> Post-partum anxiety	0	0	

## WELL-BEING

**These next questions are about how you feel mentally, or physically and how things have been going over the past couple of weeks. Some of these questions will seem slightly repetitive, but we assure you that each has a specific purpose.**

21. In general, would you say your health is:

- Excellent
- Very good
- Good
- Fair
- Poor

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

	No, not limited at all	Yes, limited a little	Yes, limited a lot
<b>Moderate activities</b> , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing <b>several</b> flights of stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

	No, none of the time	Yes, a little of the time	Yes, some of the time	Yes, most of the time	Yes, all of the time
<b>Accomplished less</b> than you would like	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Were limited in the <b>kind</b> of work or other activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

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

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



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

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

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

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

- None
- Very mild
- Mild
- Moderate
- Severe
- Very severe

28. During the **past 4 weeks**, how much of the time...

	None of the time	A little of the time	Some of the time	A good bit of the time	Most of the time	All of the time
Have you felt <b>calm and peaceful</b> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you have <b>a lot of energy</b> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you felt <b>downhearted and blue</b> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

29. About how many times **each week** do you eat from a fast-food restaurant (such as hamburgers, tacos, or pizza)?

- None
- Once a week
- 2-3 times/week
- 4-7 times/week
- 8-14 times/week
- 15 or more times/week

30. Do you often feel that you can't control **what** or **how much** you eat?

- No
- Yes

31. Do you often eat, **within any 2 hour period**, what most people would regard as an usually **large** amount of food?

- No

O Yes

32. If you marked **YES** to either of the above, how often has this been, on average, in the **LAST 3 MONTHS**?

- Less than once a week
- At least once a week
- At least twice a week
- More than twice a week

33. Below is a list of problems that people sometimes have in response to a very stressful experience. Please indicate how much you have been bothered by each problem in the **past month**.

	Not at all	A little bit	Moderately	Quite a bit	Extremely
Repeated, disturbing, and unwanted memories of the stressful experience?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Repeated, disturbing dreams of the stressful experience?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling very upset when something reminded you of the stressful experience?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Avoiding memories, thoughts, or feelings related to the stressful experience?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble remembering important parts of the stressful experience?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Blaming yourself or someone else for the stressful experience or what happened after it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having strong negative feelings such as fear, horror, anger, guilt, or shame?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Loss of interest in activities that you used to enjoy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling distant or cut off other people?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Irritable behavior, angry outbursts, or acting aggressively?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Taking too many risks or doing things that could cause you harm?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Being "super alert" or watchful or on guard?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Feeling jumpy or easily startled?	0	0	0	0	0
Having difficulty concentrating?	0	0	0	0	0
Trouble falling or staying asleep?	0	0	0	0	0

34. Indicate the degree to which each statement describes your feelings or behavior:

	Not at all	A little	Moderately	A lot	Very much
I often find myself getting angry at people or situations	0	0	0	0	0
When I get angry, I get really mad	0	0	0	0	0
When I get angry, I stay mad	0	0	0	0	0

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

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	0	0	0
Feeling down, depressed, or hopeless	0	0	0	0
Trouble falling or staying asleep, or sleeping too much	0	0	0	0
Feeling tired or having little energy	0	0	0	0
Poor appetite or overeating	0	0	0	0
Feeling bad about yourself- or that you are a failure or have let yourself or your family down	0	0	0	0
Trouble concentrating on things, such as reading the newspaper or watching television	0	0	0	0
Moving or speaking so slowly that other people could have noticed, or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	0	0	0
Thoughts that you would be better off dead or of hurting yourself in some way	0	0	0	0

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

	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious or on edge	0	0	0	0
Not being able to stop or control worrying	0	0	0	0

37. Please read each statement and write the number for the answer that best reflects your own views.

	Disagree	Somewhat disagree	Neutral	Somewhat agree	Agree
I hide my aches and pains from others.	0	0	0	0	0
I manage my own problems without help from anyone.	0	0	0	0	0

The next questions are about thoughts of hurting yourself. We are aware that many of these next questions are quite personal, and we would appreciate your candid response.

If you or someone you know needs help with their emotions or behavioral health, please contact one of these numbers:

Emergency: 911

988 Suicide & Crisis Lifeline: 988

The Veterans Crisis Line: 1-800-273-TALK (8255) and Press 1 or Text: 838255

Chat Online: <http://www.veteranscrisisline.net/get-help/chat>

Military One Source: 1-800-342-9647

Chat Online: <https://livechat.militaryonesourceconnect.org/chat/>

The Defense Center of Excellence (DCoE): 1-866-966-1020

Wounded Soldier and Family Hotline: 1-800-984-8523

CONUS DSN: 421-3700

OCONUS DSN: 312-421-3700

Please choose the statement or phrase that best applies to you. Select ONE ANSWER for each question.

38. Have you ever thought about or attempted to kill yourself?

Never

It was just a brief passing thought

I have had a plan at least once to kill myself but did not try to do it

I have had a plan at least once to kill myself and really wanted to die

I have attempted to kill myself, but did not want to die

I have attempted to kill myself, and really hoped to die

39. How often have you thought about killing yourself in the past year?

- Never
- Rarely (1 time)
- Sometimes (2 times)
- Often (3-4 times)
- Very Often (5 or more times)

40. Have you ever told someone that you were going to commit suicide, or that you might do it?

- No
- Yes, at one time, but did not really want to die
- Yes, at one time, and really wanted to do it
- Yes, more than once, but did not want to do it
- Yes, more than once, and really wanted to do it

41. How likely is it that you will attempt suicide someday?

- Never
- No chance at all
- Rather Unlikely
- Unlikely
- Likely
- Rather Likely
- Very Likely

42. Have you ever intentionally hurt yourself (e.g., cut or hit yourself) without any intention of killing yourself?

- No
- Yes

43. Please circle or mark one number per line to indicate your response as it applies to the **past 7 days.**

	Not at all	A little bit	Somewh at	Quite a bit	Very much
I have a reason for living	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel a sense of purpose in my life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

44. The following statements are intended to assess your beliefs about your current problems. Please read each statement carefully and circle the number that best describes **how you feel right now.**

	Strongly disagree	Disagr ee	Neutr al	Agre e	Stron gly agree
It is unbearable when I get this upset.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I can't imagine anyone being able to withstand this kind of pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I don't deserve to live another moment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



sorrows.

My family is willing to help me make decisions.

I can talk about my problems with my friends.

49. In the **past 3 years**, about how often have you participated in or volunteered for any of the following community groups or organizations?

	Never	Once or twice	Once a month	Once a week	More than once a week
<b>Veteran Service Organizations</b> (e.g., Veterans of Foreign Wars, American Legions, Disabled American Veterans, Wounded Warrior Project, Iraq and Afghanistan Veterans of America)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Other veteran-oriented groups</b> (e.g., virtual or social media groups and/or in-person social or activity groups)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Community service or volunteer organizations/events</b> (e.g., local shelter, Kiwanis club)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Other social groups</b> (e.g., churches or other religious groups, sports teams, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

	Not bothered	Bothered a little	Bothered a lot
The stress of taking care of children, parents, or other family members	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having no one to turn to when you have a problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulties with husband/wife, partner/lover, or boyfriend/girlfriend	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Little or no sexual desire or pleasure during sex	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

51. In the **past 12 months**, how much have you experienced difficulty coping with grief over the death of someone close?

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

52. Military service can entail doing or witnessing acts that may affect one's emotional well-being, relationships, and later quality of life. When considering your own feelings, beliefs, and

behaviors related to things that you did/saw in the military, **please indicate how much you personally agree or disagree with each statement.**

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
I am ashamed of myself because of things that I did/saw during my military service.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am troubled because I violated my morals by failing to do something that I should have done during my military service.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel guilt about things that happened during my military service that cannot be excused.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The moral failures that I witnessed during my military service have left a bad taste in my mouth.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Things I saw/did in the military have caused me at times to lose faith in the basic goodness of humanity.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## MILITARY SERVICE

The following questions are about your military service. Even if you left military service, please try to answer all of the questions that apply to you.

53. Since 2001, did you retire, separate, or leave the service for any reason?

- No
- Yes

What was the year of your most **recent** retirement/separation?  Year

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

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



55. Since your most recent separation date, have you rejoined any branch of the military for any reason? (Including the Reserves or National Guard).  
 No  
 Yes

56. In the **last 3 years**, how often have you experienced the following during deployment? If you have **NOT** deployed in the last 3 years, please choose **NO**.

	No	1 time	More than 1 time	List most recent year of exposure
Feeling that you were in great danger of being killed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Being attacked or ambushed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Receiving small arms fire	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Clearing/searching homes or buildings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Having an improvised explosive device (IED) or booby trap explode near you	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Being wounded or injured	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Seeing dead bodies or human remains	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Having a member of your unit be seriously injured or killed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Being directly responsible for the death of an enemy combatant	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Being directly responsible for the death of a non-combatant	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Being exposed to smoke from burning trash and/or feces	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

57. Based on your most recent/last duty assignment, please indicate how much you agree or disagree for each item.

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
I feel a sense of camaraderie between myself and others in my unit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I was impressed by the quality of leadership in my unit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I was supported by the military	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

58. **All participants:** How satisfied are/were you with each of the following aspects of your military service?

N/A    Very satisfied    Satisfied    Neither satisfied    Dissatisfied    Very dissatisfied

	ed	ed	ed	nor dissatisfie d	ed	ed
Pay and housing allowance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medical/health care for you and your family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pace of promotions/chance for advancement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Frequencies of deployments/unaccompanied tours	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Impact on spouse's employment and career opportunities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Time with family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

59. **All participants:** What is your overall feeling about your military service?

- Negative
- Somewhat negative
- Neither negative nor positive
- Somewhat positive
- Positive

60. Are you **currently** an **Active Duty** service member or on **title 10 Active Duty orders**?

- No
- Yes

61. Where do you **currently** live?

- On-base
- Off-base
- Aboard a ship

The next questions are about safety and firearms. Some people keep guns for recreational purposes such as hunting or sport shooting. People also keep guns in the home for protection. Please include firearms such as pistols, revolvers, shotguns, and rifles, but not BB guns or guns that cannot fire. Include those kept in a garage, outdoor storage area, or motor vehicle.

62. (Active-Duty version) Do you currently have a personal firearm(s) (e.g., not a military-issued firearm(s)) at your **on-base** residence?

(Veteran version) Are any firearms now kept in or around your home?

- No
- Yes
- Don't know/not sure
- Prefer not to answer

(Active Duty version) Are any of these firearm(s) at your **on-base** residence now **loaded**?

(Veteran version) Are any of these firearms now **loaded**?

- No
- Yes
- Don't know/not sure
- Prefer not to answer

(Active Duty version) Are any of these firearm(s) at your **on-base** residence now **unlocked**?

(Veteran version) Are any of these loaded firearms **unlocked**?

- No
- Yes
- Don't know/not sure
- Prefer not to answer

63. How much do you agree or disagree with the following statements?

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
Firearms should be stored in a firearm safe.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Firearms should be stored locked and unloaded with ammunition stored separately when they are not in use.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having a firearm in the house makes it a safer place to be.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anyone who has a firearm(s) should have conversations with their family about firearm safety.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## LIFE EXPERIENCES

The following questions are about harassment, which is behavior that is unwelcome or offensive, whether oral, written (including through electronic devices or communications), or physical, that creates an intimidating, hostile, or offensive environment. Activities or actions undertaken for a proper military or governmental purpose, such as combat survival training, are not considered harassment.

64. In the **last 3 years**, how often have you experienced...

	Not at all	Rarely	Monthly	Daily	Did you experience this as part of your military duties?
<input type="checkbox"/> Discrimination? (i.e., differential or unfair treatment based on your race, color, religion, sex, gender identity national origin, or sexual orientation)	0	0	0	0	
<input type="checkbox"/> Bullying? (i.e., acts of aggression with the intent of physically or psychologically harming a person)	0	0	0	0	
<input type="checkbox"/> Hazing? (i.e., acts that physically or psychologically injure or create a risk of injury in order to humiliate or "toughen up" people to fit into a group)	0	0	0	0	
<input type="checkbox"/> Sexual harassment? (i.e., repeated offensive comments or gestures of a sexual nature that may affect a person's job, pay, work performance, or career)	0	0	0	0	

We are aware that many of these next questions about your experiences are quite personal, and we would appreciate your candid response. We want to assure you that all of your answers will be kept strictly confidential.

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

	No	Yes	If YES, list most recent year
<input type="checkbox"/> You moved or changed residence more than once	0	0	→
<input type="checkbox"/> You changed job, assignment, or career path involuntarily (for example, you lost a job, or you had to take a job you did not like)	0	0	→
<input type="checkbox"/> You or your partner had an unplanned pregnancy	0	0	→
<input type="checkbox"/> You were divorced or separated	0	0	→
<input type="checkbox"/> Suffered major financial problems (such as bankruptcy)	0	0	→
<input type="checkbox"/> Suffered forced sexual relations or sexual assault	0	0	→
<input type="checkbox"/> Suffered a violent assault	0	0	→
<input type="checkbox"/> Had a family member or loved one who became severely ill	0	0	→
<input type="checkbox"/> Had a family member or loved one who died	0	0	→
<input type="checkbox"/> Suffered a disabling illness or injury	0	0	→
<input type="checkbox"/> Experienced infidelity or unfaithfulness in a committed relationship	0	0	→

66. In the **past 3 years**, how many times have you had unwanted experiences where a person(s) sexually touched you (e.g. intentional touching of genitalia, breasts or buttocks), made you

sexually touch them, or attempted to or actually made you have sexual intercourse/oral or anal sex (including penetration with finger/object) **without your consent?**

- Never
- Once
- Twice
- A few times
- Many times

You indicated that you have experienced unwanted sexual contact or sexual assault. These unwanted experiences may vary in severity and can happen to women and men. Please answer the next questions thinking about any experiences, in the past 3 years, no matter who did it to you or where it happened, even if you or others were drinking or intoxicated. Please include unwanted sexual experience(s) without your consent involving any type of sexual contact, forced sexual relations, or sexual assault.

Your individual answers on this survey are confidential and will not be reported to anyone outside the Millennium Cohort Study team. If you have experienced any of these situations, please consider calling the free National Sexual Assault Hotline at 1-800-656-HOPE (4673) or visiting <https://rainn.org/>

67. **In the past 3 years**, did any of the unwanted sexual experiences occur during your military service, no matter who did it or where it happened?

- No
- Yes

Please answer the next questions thinking about any unwanted sexual experiences, **in the last 3 years, no matter who did it to you or where it happened**, even if you or others were drinking or intoxicated. Please include unwanted sexual experience(s) without your consent involving any type of sexual contact, forced sexual relations, or sexual assault.

Your individual answers on this survey are confidential and will not be reported to anyone outside the Millennium Cohort Study team.

68. In the **past 3 years**, at the time that any of the unwanted sexual experiences occurred, was/were the offender(s)...? (please mark all that apply)

	No	Yes
Your spouse/significant other?	<input type="radio"/>	<input type="radio"/>
Other friend(s), relative(s), acquaintance(s)?	<input type="radio"/>	<input type="radio"/>
Someone from work (e.g., co-worker, supervisor)?	<input type="radio"/>	<input type="radio"/>
Unknown person (s)?	<input type="radio"/>	<input type="radio"/>

## ALCOHOL, TOBACCO, & VAPE USE

**For the questions below, please refer to the following definitions:**

**Cigarette** refers to tobacco cigarettes such as Marlboro, Camel, etc.

**E-cigarette/vape** refers to electronic nicotine vapor products such as JUUL, SMOK, Suorin, Vuse, and blu. Electronic vapor products include e-cigarettes, vapes, vape pens, e-cigars, ehookahs, hookah pens, and mods (**do not count marijuana** electronic vapor products)

**Smokeless tobacco** refers to chewing tobacco, snuff, dip, snus, or dissolvable tobacco products, such as Copenhagen, Grizzly, Skoal, or Camel Snus

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

	No	Yes
Cigarettes	<input type="radio"/>	<input type="radio"/>
Cigars	<input type="radio"/>	<input type="radio"/>
Electronic cigarettes or vape products	<input type="radio"/>	<input type="radio"/>
Pipes	<input type="radio"/>	<input type="radio"/>
Smokeless tobacco (chew, dip, snuff)	<input type="radio"/>	<input type="radio"/>

71. Do you **CURRENTLY** use *electronic cigarettes* or *vape* products?

- No, not at all
- Yes, some days
- Yes, every day

72. Have you used *electronic cigarettes* or *vape* products in the past (more than a year ago)?

- No, not at all
- Yes, some days
- Yes, every day

73. Are you using (or have you used) e-cigarettes or vaping products ...? (Mark all that apply.)

- To quit combustible cigarette smoking
- In places where combustible cigarette smoking is not allowed
- As a replacement for using combustible cigarettes
- Because they are cheaper than combustible cigarettes
- Because they are safer than combustible cigarettes
- Other

74. In **your lifetime**, have you smoked at least 100 cigarettes (5 packs)?

- No
- Yes

75. Do you **CURRENTLY** smoke cigarettes?

- No, not at all
- Yes, some days
- Yes, every day

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

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

77. Have you ever tried to quit smoking (e-cigarettes or cigarettes)?

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

Alcoholic beverages include beer, wine and liquor (such as whiskey, gin etc.) For the purpose of this questionnaire:

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

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

- Never
- Rarely
- Monthly
- Weekly
- Daily

79. In the **past year**, on how many **days** did you have 5 or more drinks of any alcoholic beverage? (If NONE, please enter 0)

days

80. **Last week**, how many drinks of alcoholic beverages did you have? (If NONE, please enter 0)

Mon	Tues	Wed	Thurs	Fri	Sat	Sun
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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

	No	Yes
You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health	<input type="radio"/>	<input type="radio"/>
You drank alcohol, were high from alcohol, or hung over while you were working, going to school, or taking care of children or other responsibilities	<input type="radio"/>	<input type="radio"/>
You missed or were late for work, school, or other activities because you were drinking or hung over	<input type="radio"/>	<input type="radio"/>
You had a problem getting along with people while you were drinking	<input type="radio"/>	<input type="radio"/>
You drove a car after having several drinks or after drinking too much	<input type="radio"/>	<input type="radio"/>

## FAMILY AND RELATIONSHIPS

82. How many children do you have? (Please include biological, adopted, foster, legal guardianship, and stepchildren of all ages).  Child(ren)

83. Are any of your children aged 17 or younger?

- No
- Yes

84. Including yourself, how many people currently reside in your household? (Please do not include anyone that does not live and sleep in your household the majority of the time, such as visiting relatives.

Adults (18 and older)  Children (17 and younger)

85. In general, how well do you feel you are coping with the day-to-day demands of parenthood/raising children?

- I do not have children
- Very poorly

- Poorly
- Fair
- Somewhat well
- Very well

\*Question 86 will be seen by those MCS participants that are/were previously married to a spouse who is/was a participant in the FSC. All other participants will see item 87.

If a participant indicates on question 86 they are divorced or widowed, in subsequent survey cycles they will begin seeing question 87.

86. What is your current marital status to the **individual you were married to in <Month Year>** (\*month and year are the MCS participant's previous survey completion dates)?

- Currently married
- Separated
- Divorced
- Widowed

87. What is your **current** marital status?

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

88. (If married →) Has your spouse **ever** served in the US military? (select all that apply).

- No
- Yes, Reserve or National Guard
- Yes, Active Duty

If Yes, is your spouse **currently** serving in the US military?

- No
- Yes, Reserve or National Guard
- Yes, Active Duty

89. Please choose one of the following to describe your current relationship status:

- Not dating
- Dating casually
- In a committed relationship, living separately
- In a committed relationship, living together

90. Taking things all together, how would you describe your relationship with your significant other?

- |                       |                       |                       |                       |                       |                       |                       |                       |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Very<br>unhappy       |                       |                       |                       |                       |                       |                       | Very<br>happy         |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 1                     | 2                     | 3                     | 4                     | 5                     | 6                     | 7                     | 8                     |



91. I feel that I can trust my partner completely.

- Very strongly disagree
- Strongly disagree
- Mildly disagree
- Neutral
- Mildly agree
- Strongly agree
- Very strongly agree

<<If not currently married or committed relationship >>

92. Have you been in any type of relationship in the **last 12 months** (including someone you dated and/or had a sexual relationship with, an ex-spouse, boyfriend, or girlfriend)?

- No
- Yes

**Sometimes in close relationships, people do or say things that are hurtful during a disagreement or in a difficult situation. In the next series of questions, please tell us if something like this has occurred in your relationship.**

**Pop-up message: If you are experiencing physical or emotional abuse from your spouse, please consider calling the toll-free National Domestic Violence Hotline at 1-800-799-SAFE (7233) or visiting <http://www.hotline.org/>.**

*Skip/exit button to quickly decline if the abuser is close by or can see the survey.*

93. How often has this happened in the **past 12 months**?

	Never	Rarely	Sometimes	Fairly often	Frequently
<b>You</b> screamed or cursed at your partner (Examples: yelled at them, swore at them, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Your partner</b> screamed or cursed at you (Examples: yelled at you, swore at you, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>You</b> insulted or talked down to your partner (Examples: called them names, belittled them, etc. )	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Your partner</b> insulted or talked down to you (Examples: called you names, belittled you, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>You</b> threatened your partner with harm (Examples: threatened to hit, throw something, or hurt them; intimidated them; punched a wall in front of them, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Your partner</b> threatened you with harm (Examples: threatened to hit, throw something, or hurt you, intimidated you; punched a wall in front of you, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>You</b> physically hurt your partner (Examples: pushed, slapped, grabbed, punched, kicked, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Your partner</b> physically hurt you (Examples: pushed, slapped, grabbed,	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

punched, kicked, etc.)

## WOMEN'S SECTION

The women's health section covers topics such as menstruation, birth control, and pregnancy. If these items do not apply to you, please use the skip button at the bottom of this page to skip this section.

We realize that some of the following questions are very sensitive, but it is important to answer them as accurately as you can.

As a reminder, to help protect your privacy, the Millennium Cohort Study has obtained a Certificate of Confidentiality from the National Institutes of Health. We can use the Certificate to legally refuse to disclose information that may identify you in any federal, state, or local civil, criminal administrative, legislative, or other proceedings (for example, if there was a court subpoena).

94. How many times have you been pregnant? Include live births, stillbirths, miscarriages, and other pregnancies. If you are currently pregnant, be sure to count this pregnancy.

Pregnancy(ies)

How many births (live born children and stillbirths) have you had? (Count each set of twins or multiples as 1).

Birth(s)

95. Are you currently pregnant?

- No
- Yes
- Not sure

96. Not including right now, have you been pregnant **in the last three years**?

- No
- Yes

Not including right now, how many times have you been pregnant **in the last three years**?

97. What was the outcome of your **most recent pregnancy**?

- Single live birth
- Single stillbirth
- Multiple birth
- Miscarriage or spontaneous abortion (including chemical pregnancy)
- Elective or therapeutic abortion
- Tubal or ectopic pregnancy
- Molar pregnancy

How many babies did you deliver?

How many of these babies were live born?

98. About how many gestational weeks was your **most recent pregnancy** when it ended?

Weeks OR  Do not recall

99. When did your **most recent pregnancy** end (regardless of the outcome)? Fill in with as much detail as you can recall.

Month  Day  Year

100. Thinking back to just before your **most recent pregnancy**, how did you feel about becoming pregnant?

- I wanted to be pregnant later
- I wanted to be pregnant sooner
- I wanted to be pregnant then
- I didn't want to be pregnant then or at any time in the future
- I wasn't sure what I wanted

101. These next questions ask about your behaviors before and during your **most recent pregnancy**.

	In the 3 months before your last pregnancy...	During the last 3 months of your last pregnancy...
Did you smoke cigarettes?	<input type="radio"/> No, not at all <input type="radio"/> Yes, some days <input type="radio"/> Yes, every day	<input type="radio"/> No, not at all <input type="radio"/> Yes, some days <input type="radio"/> Yes, every day
How many alcohol drinks did you have in an average week?	<input type="radio"/> I didn't drink then <input type="radio"/> Less than 1 drink a week <input type="radio"/> 1 to 3 drinks a week <input type="radio"/> 4 to 7 drinks a week <input type="radio"/> 8 to 13 drinks a week <input type="radio"/> 14 drinks or more a week	<input type="radio"/> I didn't drink then <input type="radio"/> Less than 1 drink a week <input type="radio"/> 1 to 3 drinks a week <input type="radio"/> 4 to 7 drinks a week <input type="radio"/> 8 to 13 drinks a week <input type="radio"/> 14 drinks or more a week

102. About how much weight would you say you gained during your **most recent pregnancy**?

- Less than 20 pounds
- 20 to 35 pounds
- More than 35 pounds

103. These next questions ask about the live born infant(s) from your **most recent pregnancy**.

Baby 1	Baby 2	Baby 3	Baby 4
What was this baby's sex at birth? <input type="radio"/> Male <input type="radio"/> Female	What was this baby's sex at birth? <input type="radio"/> Male <input type="radio"/> Female	What was this baby's sex at birth? <input type="radio"/> Male <input type="radio"/> Female	What was this baby's sex at birth? <input type="radio"/> Male <input type="radio"/> Female
What was this baby's weight at delivery?	What was this baby's weight at delivery?	What was this baby's weight at delivery?	What was this baby's weight at delivery?

_____ grams _____ pounds _____ ounces <input type="radio"/> Don't know  If "Don't know:" Was this baby's birth weight less than 5 pounds or was it 5 pounds or more? <input type="radio"/> < 5 pounds <input type="radio"/> ≥ 5 pounds	_____ grams _____ pounds _____ ounces <input type="radio"/> Don't know  If "Don't know:" Was this baby's birth weight less than 5 pounds or was it 5 pounds or more? <input type="radio"/> < 5 pounds <input type="radio"/> ≥ 5 pounds	_____ grams _____ pounds _____ ounces <input type="radio"/> Don't know  If "Don't know:" Was this baby's birth weight less than 5 pounds or was it 5 pounds or more? <input type="radio"/> < 5 pounds <input type="radio"/> ≥ 5 pounds	_____ grams _____ pounds _____ ounces <input type="radio"/> Don't know  If "Don't know:" Was this baby's birth weight less than 5 pounds or was it 5 pounds or more? <input type="radio"/> < 5 pounds <input type="radio"/> ≥ 5 pounds
Did this baby live for at least 28 days? <input type="radio"/> No <input type="radio"/> Yes	Did this baby live for at least 28 days? <input type="radio"/> No <input type="radio"/> Yes	Did this baby live for at least 28 days? <input type="radio"/> No <input type="radio"/> Yes	Did this baby live for at least 28 days? <input type="radio"/> No <input type="radio"/> Yes

104. Have you ever used oral contraceptives (birth control pills)?

- No
- Yes

If yes, how many years in total have you used birth control pills? Exclude time periods when you temporarily stopped.

- Less than on year
- 1-2 years
- 3-4 years
- 5-9 years
- 10 or more years

Age when last used  years old  PR check if currently taking.

If **currently** using oral contraceptives:

How many consecutive years have you been using oral contraceptives?

- Less than one year
- 1-2 years
- 3-4 years
- 5-9 years
- 10 or more years

Why are you using oral contraceptives (check all that apply)?

- Birth control
- Acne
- Menstrual cramps or painful periods
- To regulate periods
- To suppress/stop periods
- To treat vaginal bleeding
- Other

105. Do you **currently** use any of these other forms of contraception?

- Hormonal IUD (e.g., Mirena)
- Depo Provera injection
- Copper IUD (e.g., ParaGard)
- Vaginal ring (e.g., NuvaRing)
- Implant (e.g., Nexaplon)
- Patch (e.g., Ortho Evra)
- None of the above

How many consecutive years have you been using this current form of contraception?

- Less than one year
- 1-2 years
- 3-4 years
- 5-9 years
- 10 or more years

106. Have you had a hysterectomy? (This is an operation to take out your uterus or womb)

- No
- Yes

If **YES**, what was your age at surgery?  years

107. How would you describe your current menstrual status?

- Premenopause (before menopause)
- Perimenopause/menopause transition (changes in periods, but have not gone 12 months in a row without a period)
- Postmenopause (after menopause)

If PREMENOPAUSAL, are your periods usually regular?

- No
- Yes

If POSTMENOPAUSAL, was your menopause

- Spontaneous ("natural")
- Surgical (removal of both ovaries)
- Due to chemotherapy or radiation therapy
- Other

108. What was your age when you had your **last period**?  years

## HEALTH CARE

109. What kind of health coverage or insurance do you currently have? (Mark all that apply)

- No health coverage or insurance
- VA health care (Department of Veterans Affairs/Veterans Health Administration)
- TRICARE or military health insurance plan
- Medicaid
- Medicare
- Other private insurance

110. Please select the answer that best reflects your own views about seeking mental health care.

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
I would prefer to manage psychological problems on my own.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I do not trust mental health professionals.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I do not know where to get help for psychological problems.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mental health services are not available.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mental health care can be helpful for those who need it.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would be seen as weak.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It would be too embarrassing.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would prefer to seek help from another source (e.g., Chaplain).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am concerned others would think less of me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am concerned it would impact my job.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

111. In the **last 12 months**, how many times did you receive **ANY** mental health services (including therapy sessions, group sessions, counseling)?

- None
- 1-3 times
- 4-5 times
- 6-8 times

- 9-12 times
- 13-20 times
- 20-29 times
- 30 or more times

For the next questions about specific mental health treatments, please do your best to estimate how much therapy and/or any medication you received for each condition. If you received therapy or medication to treat more than one condition, please count that therapy or medication for all conditions listed.

112. In the **last 12 months**, have you received therapy or medication for any of the following?

	Not at all	Rarely	Total number of group sessions	Total number of individual sessions	Are you taking or did you take medication for this condition
PTSD or PTS symptoms	<input type="radio"/>	<input type="radio"/>			
Depression	<input type="radio"/>	<input type="radio"/>			
Anxiety	<input type="radio"/>	<input type="radio"/>			
Relationship/family issues	<input type="radio"/>	<input type="radio"/>			
Substance abuse	<input type="radio"/>	<input type="radio"/>			
Sleep related problems	<input type="radio"/>	<input type="radio"/>			

## DEMOGRAPHICS

113. What is today's date? (**Paper only**)

114. What are the last four digits of your Social Security Number? (**Paper only**)

115. What year were you born? (**Paper only**) \_\_\_\_\_ year

116. What is the **highest level** of education that you have **completed**?

- Less than high school completion/diploma
- High school degree/GED/or equivalent
- Some college, no degree

- Associate's degree
- Bachelor's degree
- Master's, doctorate, or professional degree

117. Which of the following **best** describes your employment status?

- Full-time (greater than or equal to 30 hours per week)
- Part-time (less than 30 hours per week)
- Not employed, looking for work
- Not employed, not looking for work
- Not employed, retired
- Not employed, disabled
- Homemaker
- Other, please specify:



118. Which best describes the financial condition of you and your family?

- Very comfortable and secure
- Able to make ends meet without much difficulty
- Occasionally have some difficulty making ends meet
- Tough to make ends meet but keeping our heads above water
- In over our heads

119. These next questions are about the financial status of you and your household.

	No	Yes
Are you able to pay for all necessary expenses each month, such as mortgage/rent, debt payments, and groceries?	<input type="radio"/>	<input type="radio"/>
Does your household have at least 3 months of your typical income set aside in case of an unexpected financial event?	<input type="radio"/>	<input type="radio"/>
Does your household have the insurance coverage you and/or your family would need if an unexpected financial event were to occur (for example, disability insurance, property insurance, and/or life insurance)?	<input type="radio"/>	<input type="radio"/>
Has your household begun to set aside money for retirement?	<input type="radio"/>	<input type="radio"/>
Is your household more than one month behind on your debt payments (for example, mortgage or credit card)?	<input type="radio"/>	<input type="radio"/>
Are you currently concerned that you will lose your housing and be unable to find stable alternative housing?	<input type="radio"/>	<input type="radio"/>

120. How many total months were you away from home in the past year for reasons related to your military or civilian work (e.g., work-related travel, deployments, training, temporary duty, TDY/TAD)?

months

121. At any time in the **last 6 years** have you found it necessary to sleep in a shelter, on the streets, or in another non-residential setting because of having no other place to stay? (Please only refer to instances during or after military service)

- No
- Yes

If **YES**, please indicate the dates of **your most recent situation**:

Month  Year OR if it is currently ongoing

122. These next questions are about the food eaten in your household in the last 12 months and whether you were able to afford the food you need.

	Never true	Sometimes true	Often true
I worried whether my food would run out before I got money to buy more	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The food that I bought just didn't last, and I didn't have money to get more	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**We realize that some of the following questions are very sensitive, but it is important to answer them as accurately as you can. We want to assure you that all of your answers will be kept strictly confidential.**

123. What sex were you assigned at birth, on your original birth certificate?

- Male
- Female

124. How would you describe your current gender?

- Male
- Female
- Transgender, male to female
- Transgender, female to male
- Prefer not to answer
- Not listed, please specify \_\_\_\_\_

125. Do you consider yourself to be:

- Heterosexual or straight
- Gay or Lesbian
- Bisexual
- Prefer not to answer
- Something else, please specify \_\_\_\_\_

126. Who have you EVER had sex with?

- Men only
- Women only
- Both men and women
- I have not had sex
- Prefer not to answer

## **OCCUPATIONAL/ENVIRONMENTAL EXPOSURES & INJURY**

The following questions pertain to your time in military service.

127. In the military, were you **ever** employed as a firefighter?

- No
- Yes, I am currently employed as a firefighter in the military
- Yes, but I am not currently employed as a firefighter in the military

How old were you when you were **first** employed as a firefighter  in the military?

About how many **total** years and/or months were you employed as a firefighter in the military?

years

months

128. In the military, were you **ever** exposed to synthetic firefighting foam (aqueous film forming foam) **for at least once a week** in any job you had?

- No
- Yes
- Don't know

foam? If **first** were exposed to synthetic firefighting years

About how long in **total** were you exposed to synthetic firefighting foam?

years months

About how many **days per week** were you exposed on average? Days

protective clothing such as masks, gloves, and/or coveralls?

- Never
- Some of the time
- Most of the time
- All of the time

Are you **currently exposed** to synthetic firefighting foam **at least once a week**?

- No
- Yes
- Don't know

129. Have you **ever** been exposed to a blast or explosion, such as that from a bomb, improvised explosive device, a controlled demolition, a land mine, a grenade, etc.?

- No
- Yes

When did these blasts/explosions occur? (Check all that apply.)

- Before military service
- During military service
- After military service

Approximately how many blasts or explosions have you been exposed to in **your lifetime**?

- times while deployed
- times while not deployed

Considering your history of blast exposure, have you ever been exposed to any blast while...

(Check all that apply.)

- In a vehicle
- Indoors in an enclosed space
- Outdoors in an enclosed space (like an alley) or near a structure (like a building)
- Outdoors in an open field

When was your **most recent** exposure to a blast or explosion?  Month  
Year



What caused the injury? (Please choose the single best answer)

- Blast/explosion
- Military training
- Fighting with someone
- Bullet/fragment
- Playing sports/recreation activity/PT
- Other
- Motor vehicle crash
- Fall
- Don't know

Right after the injury, were you dazed?

- No
- Yes
- Don't know

How long did it last?

- Less than 1 minute
- 1 minute but less than 10 minutes
- 10 minutes but less than 30 minutes
- 30 minutes but less than 24 hours
- 24 hours or more
- Don't know

Right after the injury, were you confused or not thinking clearly?

- No
- Yes
- Don't know

How long did it last?

- Less than 1 minute
- 1 minute but less than 10 minutes
- 10 minutes but less than 30 minutes
- 30 minutes but less than 24 hours
- 24 hours or more
- Don't know

Were you unable to remember things that happened right before the injury, the actual injury itself, and/or things that happened right after the injury?

- No
- Yes
- Don't know

If you had memory gaps or could not remember the injury, how long was it after the injury before you started remembering **NEW** things again?

- Less than 1 hour
- 1 hour to 24 hours



What caused the injury? (Please choose the single best answer)

- Blast/explosion
- Military training
- Fighting with someone
- Bullet/fragment
- Playing sports/recreation activity/PT
- Other
- Motor vehicle crash
- Fall
- Don't know

Right after the injury, were you dazed?

- No
- Yes
- Don't know

How long did it last?

- Less than 1 minute
- 1 minute but less than 10 minutes
- 10 minutes but less than 30 minutes
- 30 minutes but less than 24 hours
- 24 hours or more
- Don't know

Right after the injury, were you confused or not thinking clearly?

- No
- Yes
- Don't know

How long did it last?

- Less than 1 minute
- 1 minute but less than 10 minutes
- 10 minutes but less than 30 minutes
- 30 minutes but less than 24 hours
- 24 hours or more
- Don't know

Were you unable to remember things that happened right before the injury, the actual injury itself, and/or things that happened right after the injury?

- No
- Yes
- Don't know

If you had memory gaps or could not remember the injury, how long was it after the injury before you started remembering **NEW** things again?

- Less than 1 hour
- 1 hour to 24 hours
- More than 24 hours but less than 7 days
- 7 days or more
- Don't know

Were you unconscious or knocked out?

- No
- Yes
- Don't know

How long were you unconscious or knocked out?

- Less than 1 minute
- 1 minute but less than 10 minutes
- 10 minutes but less than 30 minutes
- 30 minutes but less than 24 hours
- 24 hours or more
- Don't know

When this injury happened, were any parts of your body injured OTHER THAN your head?

- No
- Yes
- Don't know

Did this injury disrupt your personal and/or work activities for more than 1 day?

- No
- Yes
- Don't know

Did you get a medical evaluation/treatment for this injury?

- No
- Yes
- Don't know

Where did you get evaluated/treated? (Check all that apply)

- In the field by a medic
- Outpatient clinic/doctor's office
- Emergency room/urgent care center
- Admitted to the hospital as an INPATIENT → how many nights? \_\_\_\_
- Don't know

## VETERAN'S SECTION

134. Are you **currently** retired or separated from the military?

- No
- Yes

135. How would you describe your return to civilian life after military service?

- Very Easy
- Somewhat Easy
- Somewhat Difficult
- Very Difficult



136. How long did it take you to find paid employment after leaving the military?

- Less than 1 month
- 1 to 4 months
- 5 to 8 months
- 9 months to 1 year
- More than 1 year
- I have been pursuing my education or training since leaving the military
- I have not found paid employment
- I have not looked for paid employment

137. In the **first few years** after you left the military, did you ever:

	No	Yes	Did this occur during the first year after you left the military?
Have trouble paying bills?	<input type="radio"/>	<input type="radio"/> →	
Receive unemployment compensation?	<input type="radio"/>	<input type="radio"/> →	
Struggle with alcohol use?	<input type="radio"/>	<input type="radio"/> →	
Struggle with substance use?	<input type="radio"/>	<input type="radio"/> →	
Have trouble finding or keeping housing?	<input type="radio"/>	<input type="radio"/> →	
Have trouble getting medical care for self/family?	<input type="radio"/>	<input type="radio"/> →	
Struggle with hunger or receive help buying food?	<input type="radio"/>	<input type="radio"/> →	
End a serious relationship?	<input type="radio"/>	<input type="radio"/> →	
Have a child (biological, adopted, or foster)?	<input type="radio"/>	<input type="radio"/> →	
Start a business?	<input type="radio"/>	<input type="radio"/> →	
Buy a house?	<input type="radio"/>	<input type="radio"/> →	
Get married?	<input type="radio"/>	<input type="radio"/> →	
Complete your education?	<input type="radio"/>	<input type="radio"/> →	

138. Tell us about your VA benefits. What VA benefits are you aware of? What benefits have you applied for?

	I am aware of this benefit	I have applied	I have applied and I have received this benefit	I have applied but I am not eligible for this benefit	I have not applied but I intend to	I have not applied and I do not intend to
VA Home loan guaranty	0	0	0	0	0	0
VA Disability compensation	0	0	0	0	0	0
VA Health benefits	0	0	0	0	0	0
VA Vocational benefits (ex. Veteran Readiness & Employment)	0	0	0	0	0	0
VA Education benefits (ex: GI Bill)	0	0	0	0	0	0
Veteran's Group Life Insurance (VGI)	0	0	0	0	0	0
VA Caregiver Support Program	0	0	0	0	0	0

We realize that the following questions are very sensitive. Responses to these items are voluntary and you may skip them if you choose. We want to assure you that all of your answers will be kept strictly confidential.

139. In the **past 12 months**, how often have you used cannabis (marijuana, pot, grass, hash, etc.)?  
 Never  
 Less than monthly  
 Monthly  
 Weekly  
 Daily or almost daily

During the **past 12 months**, what was the primary mode you used marijuana?  
 [Please select one. Did you...]  
 Smoke it (for example, in a joint, bong, pipe, or blunt)  
 Eat it (for example, in brownies, cakes, cookies, or candy)  
 Drink it (for example, in tea, cola, alcohol)

- Vaporize it (for example, in an e-cigarette-like vaporizer or other vaporizing device)
- Dab it (for example, using waxes or concentrates)
- Use it some other way
- Don't know/Not Sure
- Prefer not to answer

When you used marijuana or hashish during the **past 12 months**, was it for medical reasons to treat or decrease symptoms of a health condition [such as: nausea, loss of appetite], or was it for non-medical reasons to get pleasure or satisfaction (such as: excitement, to “fit in” with a group, increased awareness, to forget worries, for fun at a social gathering).

- Only for medical reasons to treat or decrease symptoms of a health condition
- Only for non-medical purposes to get pleasure or satisfaction
- Both medical and non-medical reasons
- Don't know/Not Sure
- Prefer not to answer

140. In the **past 12 months**, how often have you used any drugs, including cocaine or crack, heroin, methamphetamine (crystal meth), hallucinogens, or ecstasy/MDMA?

	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Cocaine, crack, or methamphetamine (crystal meth)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heroin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hallucinogens	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ecstasy/MDMA	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

141. In the **past 12 months**, how often have you used any of the following prescription medications for non-medical reasons (e.g., get high/feel good) or taken more pills than prescribed by a doctor?

	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Prescription opiate pain reliever (for example, Percocet, Vicodin, Oxycontin, hydrocodone)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Prescription medication for anxiety (for	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

example, Xanax, Ativan, Valium, or Klonopin)

Prescription medication for sleep problems (for example Ambien or Lunesta)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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Prescription medication for ADHD (for example, Adderall, Ritalin)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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