Form: 76 Vers: 05 ID#: SIS

The Sister Study
Health Update

**** Please fill out this form even if there are no changes to report. ****

It is important to the Sister Study that we stay updated on your health. Please take a few minutes to fill out this form and let us know if you have been diagnosed with any of the following conditions ***since January 2019****.*

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

We ask that the Sister Study participant fill out the form. Sometimes this is not possible...

- ○ Mark here if you are the participant filling this out for yourself. → **GO TO QUESTION 1 ON NEXT PAGE**
- ○ Mark here if someone is helping you fill out this questionnaire by either reading the questions to you and/or filling the bubbles for you.
- ○ Mark here if the participant cannot answer the questions for herself and you are completing the questionnaire on her behalf.

IF EITHER OF THESE ARE MARKED, PLEASE *ALSO* COMPLETE PAGE 7 OF THE INCLUDED "CONTACT INFORMATION UPDATE FORM"

What is your relationship to the participant?

- ○ Spouse/partner
- ○ Sister
- ○ Brother
- ○ Daughter
- ○ Son
- ○ Friend
- ○ Other, specify: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

If participant cannot answer the questions for herself and you are completing the questionnaire on her behalf, what are the condition(s) that prevent her from answering the questions for herself?

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1. Since January 2019, has a doctor or other health professional told you that you had any of the following conditions?

Please mark a response for each question.	NEVER DIAGNOSED	DIAGNOSED BEFORE JAN. 2019	DIAGNOSED JAN. 2019 OR LATER	If Jan. 2019 or later, give month and year of diagnosis. MONTH/YEAR
a. Breast cancer	○ Never	○ Before Jan. 2019	○ Jan. 2019 or later	/ 2 0
b. Ductal carcinoma in situ of the breast or DCIS	○ Never	○ Before Jan. 2019	○ Jan. 2019 or later	/ 2 0
c. Lobular carcinoma in situ of the breast or LCIS	○ Never	○ Before Jan. 2019	○ Jan. 2019 or later	/ 2 0
d. Lung cancer	○ Never	○ Before Jan. 2019	○ Jan. 2019 or later	/ 2 0
e. Ovarian cancer	○ Never	○ Before Jan. 2019	○ Jan. 2019 or later	/ 2 0
f. Cancer of the uterus or endometrium. Please do not include non-cancerous conditions such as fibroids, endometriosis, or pre-cancer.	○ Never	○ Before Jan. 2019	○ Jan. 2019 or later	/ 2 0
g. Cancer of the colon or rectum	○ Never	○ Before Jan. 2019	○ Jan. 2019 or later	/ 2 0
h. Thyroid cancer	○ Never	○ Before Jan. 2019	○ Jan. 2019 or later	/ 2 0
i. Melanoma Please do not include non-melanoma skin cancers, such as basal cell carcinoma and squamous cell carcinoma.	○ Never	○ Before Jan. 2019	○ Jan. 2019 or later	/ 2 0
j. Any other type of cancer Please do not include non-melanoma skin cancers, such as basal cell carcinoma and squamous cell carcinoma.	○ Never	○ Before Jan. 2019	○ Jan. 2019 or later	/ 2 0
If before Jan. 2019, specify type(s)			**If Jan. 2019 or later, specify type(s):**	
k. Heart attack or myocardial infarction (MI)	○ Never	○ Before Jan. 2019	○ Jan. 2019 or later	/ 2 0
			Were you a patient in a hospital overnight? ○ NO ○ YES	
l. Other heart disease, e.g., angina, congestive heart failure, arrhythmias	○ Never	○ Before Jan. 2019	○ Jan. 2019 or later	/ 2 0
If before Jan. 2019, specify type(s):			**If Jan. 2019 or later, specify type(s):**	

Please mark a response for each question.	NEVER DIAGNOSED	DIAGNOSED BEFORE JAN. 2019	DIAGNOSED JAN. 2019 OR LATER	If Jan. 2019 or later, give month and year of diagnosis. MONTH/YEAR
m. Stroke (this does not include TIA or "mini-stroke")	○ Never	○ Before Jan. 2019	○ Jan. 2019 or later	/ 2 0
n. Mini-stroke or TIA (transient ischemic attack)	○ Never	○ Before Jan. 2019	○ Jan. 2019 or later	/ 2 0
o. Thyroid disease, e.g., Graves' disease, overactive thyroid/hyperthyroidism, thyroiditis, underactive thyroid/ hypothyroidism, or other	○ Never	○ Before Jan. 2019	○ Jan. 2019 or later	/ 2 0
If before Jan. 2019, specify type(s):			**If Jan. 2019 or later, specify type(s):**	
p. Autoimmune disease, e.g. rheumatoid arthritis, lupus, scleroderma, multiple sclerosis, or other	○ Never	○ Before Jan. 2019	○ Jan. 2019 or later	/ 2 0
If before Jan. 2019, specify type(s):			**If Jan. 2019 or later, specify type(s):**	
q. Parkinson's disease	○ Never	○ Before Jan. 2019	○ Jan. 2019 or later	/ 2 0
r. Hypertension or high blood pressure	○ Never	○ Before Jan. 2019	○ Jan. 2019 or later	/ 2 0
s. Diabetes	○ Never	○ Before Jan. 2019	○ Jan. 2019 or later	/ 2 0
t. Hip, wrist or other fracture	○ Never	○ Before Jan. 2019	○ Jan. 2019 or later	/ 2 0
If before Jan. 2019, specify type(s):			**If Jan. 2019 or later, specify type(s):**	
u. Any other major illness	○ Never	○ Before Jan. 2019	○ Jan. 2019 or later	/ 2 0
If before Jan. 2019, specify type(s):			**If Jan. 2019 or later, specify type(s):**	

2. Have you gone through menopause?

- ○ Yes
- ○ No
- ○ Don't know

3. Have you had a menstrual period in the past 10 years?

- ○ Yes
- ○ No → **GO TO QUESTION 5**

4. What month and year did you have your <u>last</u> menstrual period or how old were you when you had your <u>last</u> menstrual period?

		/					**OR**				
MONTH			YEAR					AGE			

5. Have you ever smoked at least one cigarette per day for six months or longer?

- ○ Yes
- ○ No → **GO TO QUESTION 8**

6. What best describes your smoking status?

- ○ Stopped smoking cigarettes
- ○ Currently smoking cigarettes

7. During the years you smoked, how many cigarettes do/did you usually smoke per day?

- ○ Less than one pack per day
- ○ One pack per day
- ○ More than one pack per day

8. Are you currently using hormones for hormone replacement therapy (HRT)? Please include pills and patches. Common brand and generic names are Prempro, Premarin, Estrace, estradiol, Provera, medroxyprogesterone, etc.

- ○ Yes
- ○ No

9. Have you received a COVID-19 vaccine?

○ No → **GO TO QUESTION 10 ON NEXT PAGE**

○ Yes

↓

9a. Which of the following applies? I have received...

○ 1 vaccine shot and I am not fully vaccinated (e.g., Pfizer/BioNTech or Moderna) →
What month and year did you receive this shot? __ __ / 2 0 __ __ (MONTH / YEAR)

○ 1 vaccine shot and I am fully vaccinated (e.g., Johnson & Johnson/Janssen) →
What month and year did you receive this shot? __ __ / 2 0 __ __ (MONTH / YEAR)

○ 2 vaccine shots and I am fully vaccinated (e.g., Pfizer/BioNTech or Moderna) →
What month and year did you receive the **2nd shot**? __ __ / 2 0 __ __ (MONTH / YEAR)

9a1. Have you received a booster vaccine shot?

○ No → **GO TO QUESTION 10 ON NEXT PAGE**

○ Yes, 1 booster of Johnson & Johnson/Janssen
○ Yes, 1 booster of Pfizer/BioNTech
○ Yes, 1 booster of Moderna

What month and year did you receive the booster shot? __ __ / 2 0 __ __ (MONTH / YEAR)

10. Have you ever been sick with suspected or confirmed COVID-19, whether or not you were tested for active COVID-19 infection at that time?

- ○ I had a positive COVID-19 test but never felt sick
- ○ No, I have not been sick with COVID-19
- ○ Probably not: I was sick with some of the same symptoms but don't think it was COVID-19

GO TO QUESTION 11 ON PAGE 8

- ○ Yes, I was sick with suspected/confirmed COVID-19

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10a. What was the approximate date you started feeling sick? *If you had this more than once, report for the time <u>when you were the most sick</u>.*

MONTH ____ / YEAR 2 0 ____ ____

10a1. When you were sick with COVID-19 or symptoms similar to COVID-19, which of the following symptoms did you experience? (*If you were sick **with COVID-19 symptoms** more than once, please report for the <u>time you were the most sick</u>.) Please mark all that apply.*

- ○ Chills
- ○ Congestion or runny nose
- ○ Diarrhea
- ○ Fever
- ○ Headache
- ○ Nausea or vomiting
- ○ New loss of taste or smell
- ○ Persistent cough
- ○ Rash on skin, or red/purple discoloration of fingers or toes
- ○ Skipped meals (loss of appetite)
- ○ Unusual chest pain or pressure/ tightness
- ○ Unusual shortness of breath or difficulty breathing
- ○ Unusual severe fatigue
- ○ Unusual severe muscle or body aches
- ○ Other significant symptoms, please specify:

  ____

- ○ I did not have any symptoms → **GO TO Q11, Pg8**

10b. How many days until you recovered? That is, how many days until you felt well enough to resume your normal activities?

DAYS ____ ____ ____ **OR** ○ Not yet recovered →

b1. Approximately how many days have you been sick <u>so far</u>? ____ ____ ____ # DAYS

10c. Were you admitted to the hospital? *Do NOT include visit(s) to the Emergency Department only.*

○ No

○ Yes →

c1. How many days in hospital so far? *Do NOT include days in long-term rehabilitation/rehab.*

DAYS

c2. Did you go to a long-term rehabilitation/rehab facility after hospital discharge?

○ No
○ Yes

10d. Are you still experiencing symptoms due to COVID-19?

○ No → **GO TO QUESTION 11 ON NEXT PAGE**

○ Yes

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10d1. Which symptoms have you continued to experience? *(Please mark all that apply.)*

HEAD/SENSORY

- ○ Difficulty thinking or concentrating
- ○ Dry eyes and mouth
- ○ Loss of sense of taste
- ○ Loss of sense of smell
- ○ Memory loss
- ○ Runny or stuffy nose
- ○ Trouble with vision
- ○ Vertigo or dizziness

PAIN

- ○ Chest pain
- ○ Ear pain or ear discharge
- ○ Headache
- ○ Joint pain
- ○ Muscle pain
- ○ Nerve pain

OTHERS

- ○ Cough
- ○ Chills or shivering
- ○ Diarrhea
- ○ Fatigue
- ○ Fainting
- ○ Feeling feverish
- ○ Insomnia
- ○ Lack of appetite
- ○ Nausea or vomiting
- ○ Rash
- ○ Shortness of breath
- ○ Sore throat or itchy/scratchy throat
- ○ Sweats
- ○ Trouble breathing
- ○ Other symptom(s) you continue to experience due to COVID-19

Please specify other symptoms:

11. Have you ever had a positive test result for COVID-19 infection?

○ No

○ Yes

11a. What was the sample collection date of the first positive test?

		/	2	0		
MONTH			YEAR			

11b. Was it confirmed with a second test?

○ No

○ Yes

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

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